Come Together

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

Summary
March 2012
Come Together

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

Summary
March 2012
This report on Nova Scotia’s mental health and addictions services is the product of nearly two years of consultation, research and debate. The Advisory Committee reviewed major reports about different aspects of the mental health and addictions systems in Nova Scotia and Canada. We consulted with more than 1,200 Nova Scotians, including mental health and addictions staff, health professionals outside the formal mental health and addictions system, individuals who live with mental illness and/or addictions, their family members and others affected by mental health and addictions issues. We also consulted with non-governmental organizations, 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.

The Advisory Committee reviewed thousands of pages of research about what works — and what doesn’t — in mental health and addictions policy and practice. We examined mental health and addictions services in Nova Scotia, across Canada and in other countries — including Australia, England, New Zealand, Scotland and the United States. We were also guided by the work of the Mental Health Commission of Canada.

What the Advisory Committee learned was that there are some very consistent themes to inform where and how mental health and addictions services can be strengthened, and a compelling case for action now.

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 chronic and problematic to acute and debilitating. Most of these symptoms could and should be treated and relieved. But many will not be.

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 illnesses 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 addictions 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.

The recommendations of the Mental Health and Addictions Strategy Advisory Committee (the Advisory Committee) are meant as a roadmap — to change the system; to root out stigma; and to spread the helping hands and tools of recovery to individuals, their families, professionals and communities across the province.
Although we know that our mental health and addictions system helps thousands of Nova Scotians every year, the flaws and gaps in that system put many other Nova Scotians at risk of falling through the cracks.

To some, this report may present a troubling picture of mental health and addictions care in Nova Scotia. This report is in no way an indictment of the hundreds of selfless and dedicated clinicians, other professionals and community organizations that work tirelessly to bring recovery, care and comfort to those who suffer. They work in a system that is not well-organized, lacks cohesion and accountability, is not easy to access, has been under-funded for decades and is often unprepared to respond to cultural, geographic, linguistic or racial differences. This report addresses these and other deficiencies. The Advisory Committee’s recommendations are intended to begin addressing problems that have persisted for generations as a result of financial neglect and societal ignorance.

It may be possible to put a dollar amount on the cost to taxpayers for services to address mental disorders, problematic substance abuse and gambling (although few seem to be able to agree easily on that point). It is harder, however, to put a figure on what untreated mental illness and addictions cost society overall. The price of lost potential of a youth who drops out of school, a mother who is unable to parent, a tradesperson who is unable to be employed or a citizen unable to contribute to society is incalculable.

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 may be yet another form of stigma regarding mental health and addiction issues. The low priority

---

The statistical dimensions of the problem — past, present and projected — are part of the story.

- One in five Canadians will experience a diagnosable mental health issue this year.

- In Nova Scotia, in 2002, alcohol abuse alone cost the province $419 million. That year profits returned to the province from alcohol sales totaled $158 million.

- Substance use and abuse is 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 those reporting binge drinking in the past month.

- Eighteen per cent of Nova Scotian youth reported using cannabis within the past 30 days. The use of painkillers and illicit substances other than cannabis for recreational purposes is almost equally widespread.

- The national economic burden of mental disorders was estimated a decade ago at $51 billion-a-year and matches the impacts of heart disease, diabetes and hypertension, combined.

- One in four Canadian workers will experience a mental health problem in the next 12 months. Five hundred thousand Canadians are absent from the job every day for psychiatric reasons.

- Mental illnesses and problems are the leading cause of short and long-term disability in Canada. Between 70 and 90 per cent of Canadians with serious mental illness are unemployed.

- Twenty-six per cent of students in Nova Scotia screened positive for increased risk of depression and 10 to 20 per cent of those who want help did not receive it.
is reflected in the relatively low investment of public dollars in these areas as compared to spending on other common diseases.

The Advisory Committee proposes 61 recommendations to help the province build a collaborative, effective and efficient mental health and addictions care system for Nova Scotians. This will require:

1. A revamped model of care for mental health and addictions services with a provincial and cross-jurisdictional focus to foster and lead a collaborative, cooperative approach that cuts across government departments and embraces family, community and natural supports for recovery.

2. An increase in resources to spread treatment services more effectively and efficiently across the province, and to increase the capacity of communities to support recovery and provide access to the social determinants of health including housing, employment and the financial and other support individuals need in order to follow treatment plans.

3. Social change to relieve and eventually eliminate the stigma that attaches to mental health problems and addictions, end the discrimination faced by those who suffer, and ensure full inclusion and respect for differences in our diverse society.

4. A commitment to care for and empower the most vulnerable in our society — those with severe and persistent mental illness (such as schizophrenia, severe depression and bipolar disorder) and/or addictions — to participate in their recovery.

As a result of our research and consultation, we believe our recommendations set the right course for Nova Scotia’s mental health and addictions strategy. Simply put, there are four priority areas for action:

1. **Invest in health promotion, earlier intervention and faster access to services.**
   Priority must be given to children, youth and their families — where there is often the most profound impact of mental illness and substance abuse, as well as the greatest return on investment.

2. **Fix gaps within the systems of care.**
   This is most vital at key transition points where individuals and families leave one service and enter another.

3. **Create supportive communities.**
   In order to live healthy and productive lives, people with mental health and addiction problems need access to housing, employment opportunities, peer support and income assistance in communities where they can live free from stigma and discrimination.

4. **Strengthen collaboration.**
   We need to work more effectively together within care teams throughout the health system, across departments, and between jurisdictions that deliver, plan and/or fund some aspect of mental health and addictions support.
1. Invest in health promotion, earlier intervention and faster access to services.

Access to mental health and addiction services was identified as a challenge by virtually every person who participated in the Advisory Committee’s consultations. Wait times for outpatient service, major difficulties in accessing inpatient beds and lack of after-hours services were all cited as problematic. Long wait times for children and youth with symptoms of mental illness were of particular concern. Navigation of the system is difficult. There are disparities in services for marginalized populations and across regions or districts. In some cases, treatment only comes with drastic or tragic circumstances.

Approximately 50 per cent of provincial inmates suffer from mental illness and 77 per cent report substance abuse issues. Mental health and addictions services and trained staff are not sufficient to meet the needs of those who are in jail. The Advisory Committee recommends sufficient mental health and addictions services to ensure timely access and to meet the needs of those in custody of provincial correctional services.

An estimated 70 per cent of mental illnesses begin in childhood or adolescence. When investing resources in early intervention and access to treatment, priority should be given to the needs of children, youth and their families. This is where mental illness and substance abuse often have the most profound impact, and where strategic investment of resources can see the greatest return on investment.

The Advisory Committee also supports the reconfiguration of addictions inpatient beds for withdrawal management, opiate stabilization and structured treatment according to evidence and best practices. The province must ensure that youth-centered withdrawal management services are available, and should also support the development of community-based addictions care within culturally specific communities.

Our recommendations:

• A province-wide health promotion, early identification and intervention approach must be designed that:
  
  a) Aligns with other strategies (district, provincial, other jurisdictions, national).

  b) Targets the general population as well as specific population groups at risk.

  c) Addresses the special needs of youth and young adults including junior and senior high school and college/university students.

  d) Addresses the specific needs of seniors.
e) Provides resourcing for province-wide, distance-based early intervention and self management programs addressing mild to moderate mental health issues.

f) Recognizes and incorporates the different approaches to prevention and promotion required for mental health and addictions initiatives.

g) Collaborates with employers and unions to develop and implement workplace supports, opportunities for early identification of problems and linkages to appropriate interventions.

h) 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.

i) Includes information on access to locally available resources including alternatives to conventional treatment.

• Screening and intervention for mental health and addiction problems across the lifespan must be integrated into primary health care settings, ensuring effective and timely referral and follow-up processes that will:

a) Include an assessment of family supports and well-being in screening.

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

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

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

e) 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.

f) 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.

g) 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.

h) Support mental health programs to improve maternal and newborn attachment and health outcomes. Increased screening for addictions in the prenatal period could enhance newborn and mothers’ health.
• The findings and evaluations of youth health and wellness models established in some schools in the province should be used to inform how broader access to these models can strengthen mental health and addictions services.

• 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.

• 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 potentially negative impact on children’s development and well-being. The triage category must be adjusted to reflect this status.

• 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:

  a) **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).

  b) **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).

  c) **“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).

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

• In each DHA, there should be 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 multidimensional factors. Support and continuing professional education for these clinicians should be available through participation in the provincial Seniors Specialty Network.

• 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.
• There should be one or more “stabilization units” within the province for patients with dementia who are exhibiting difficult or dangerous behaviour, and where dementia care specialists 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.

• Home care programs should be funded that specialize in managing “high risk” individuals, those with mental health and addictions issues including those with persistent and severe mental illness.

• The health care needs of persons with severe and persistent mental illness (i.e.: schizophrenia, other psychotic disorders and bi-polar disorder) and concurrent disorders must be addressed through a comprehensive continuum of care. While this may be a comparatively small 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.

• 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.

• Programs and services with a provincial mandate must be clearly designated as such. Moreover, the use of these programs should be evaluated to ensure equitable access for persons from all parts of the province.

• Criteria should be developed for access to and funding of pharmacological treatments for mental health and addictions for individuals who demonstrate financial need.

• Additional mental health and addictions services should be provided to ensure timely access and to meet the need for service within provincial correctional services. The space requirements for such enhancements should be reviewed to ensure sufficient and appropriate treatment space is available within correctional facilities.

• A provincial system of inpatient psychiatric bed management should be implemented which includes consistent and clear admission criteria and policies.

• Adult inpatient psychiatric care should be provided 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). Equity of access to these units should be available to all Nova Scotians.

• The effectiveness of existing models of observation beds in psychiatric units that are accessible directly by emergency physicians or family physicians on-call should be reviewed to determine if implementation across all DHAs should become standard until such time as the location and management of inpatient psychiatric units have been implemented.

• Short stay, crisis mental health and addictions service capabilities must 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.
• One or two secure rooms within emergency settings in DHAs without in-patient services should be established to meet the need for short term stays and emergencies.

• The need for specialized tertiary level psychiatric beds and services for complex illnesses (e.g., psychogeriatrics, eating disorders, etc.) should be examined. These are distinct from acute care psychiatric units.

• Addictions inpatient beds for withdrawal management, opiate stabilization and structured treatment should be reconfigured according to evidence and best practice, utilizing alternative community-based approaches where possible.

• Access to evidence-based opiate substitution treatment should be increased.

• Withdrawal management services for youth should be available for management of addictions and concurrent (mental health and addictions) disorders. Separate adult access to treatment for concurrent disorders should be available.
2. Fix gaps within the systems of care.

Particular attention needs to be paid to fixing the gaps at key transition points where individuals and families leave one service and enter another.

**These gaps are far more than mere inconveniences.** They are where the mental health and addictions system can lose people - figuratively and literally. People can be discharged from care and have absolutely nowhere to go, or remain in institutional care simply because there is no place in the community where it is safer for them to live. There can be incomplete (or no) information about a person going from one service to another, risking an interruption or complete breakdown in their support plan.

For children and adolescents approaching key birthdays, there are additional challenges because various provincial government departments (and programs within them) use different ages to define the ‘youth’ they serve. There are also gaps in representation of our service providers from diverse groups such as Aboriginal people, African Nova Scotians and Francophones, and in geographic areas, requiring work to address them.

Mental health and addictions issues do not discriminate, and are found at every socio-economic strata. However, success in improving outcomes and creating more effective mental health and addictions services will be diminished if there is not also a commitment to address the inequities in the social and economic foundations of good health. Income, employment and education are key elements of this foundation. Adequate and safe housing is the keystone.

**Our recommendations:**

- A "Housing First" model should be adopted 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 addiction issues in communities across the province.

- Care teams should implement effective plans for timely and seamless continuity of care between services and across the lifespan (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.

- The age of transition from youth to adult service across government departments, especially the Department of Health and Wellness and the Department of Community Services, should be aligned.

- 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, must be ensured.
3. Create supportive communities so that people with mental health and addictions problems can live healthy and productive lives.

This includes having access to housing, employment opportunities, peer support and income assistance — and living free from stigma and discrimination.

Most mental illnesses and addictions have no single cause, but are the result of a complex mix of social, economic, psychological, biological and genetic factors. These problems are often complicated by the presence of other health conditions and can be compounded by a variety of social problems. When basic needs are not adequately met, health risks increase, the ability to access treatment is impaired and chances of recovery are diminished. Determinants of poor mental health and addiction — poverty, unemployment, low educational attainment, family distress, poor housing and isolation — are barriers to recovery and even perpetuate suffering from generation to generation.

Our mental health and addictions services system requires more than a focus on early, effective and easily accessible treatments. Health promotion plays an absolutely critical role. Public awareness and other educational efforts are needed to reduce stigma and discrimination associated with these disorders. Effective collaboration at and across all levels of service delivery and program decision-making is vital to effective services, treatment and positive outcomes. Healthy communities help to create a sense of belonging, which leads to better mental health for everyone.

Determinants that contribute to poor mental health and addiction are disproportionately evident among some groups, including First Nations, racial, ethnic and linguistic minorities. While this report offers recommendations specific to these groups, the Advisory Committee emphasizes that all recommendations are inclusive of all racial, ethnic, cultural and diverse populations.

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 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.

Recognition that diverse groups in our society have diverse needs in health care is vital. The Advisory Committee encourages an examination of existing mental health and addictions services and initiatives to ensure they are evidence-based and reflect best and wise practices for specific populations. These communities include Aboriginal/First Nations; African Nova Scotians; immigrant populations; homeless people and the Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) communities.

A lack of awareness and knowledge about health promotion, prevention, identification and treatment of mental health and addictions issues is evident in workplaces, schools and government services. The Advisory Committee believes government should make mental health and addictions knowledge and awareness a core competency for health professionals at all levels and for staff of other public services,
including teachers and child care workers, who come in contact with individuals who suffer from mental health and addictions issues.

All of this requires strong leadership and a commitment at all levels of society. If Nova Scotia wants a sustainable, high quality of life for its citizens, attention to mental health and addictions issues is not optional. It is essential.

Our recommendations:

• 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.

• Coordinated efforts are required across government to address and reduce poverty and its effects on persons with mental health issues and addictions. The provincial poverty reduction strategy should be acted upon.

• 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 should be increased to promote wellness, prevent relapse and enhance recovery.

• Mental health and addictions awareness and knowledge should be 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.

• Best practice anti-stigma education should be provided 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.

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

• Psychologically safe workplaces should be advanced in Nova Scotia (consider the standards under development by the Mental Health Commission of Canada). 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.

• The development of community-based supportive care for mental health and addictions within specific cultural communities in the province should be advanced, including on-site care to populations that cannot, for a variety of reasons, access that care in clinical settings.

• A partnership with the Mental Health Commission of Canada and its “Peer Project” should be formalized 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.
• The current state of peer support service delivery in Nova Scotia should be reviewed with recommendations made for proceeding under the Mental Health Commission of Canada’s Peer Project model.

• Collaboration with members of diverse populations and communities, including immigrant communities, is required to eliminate barriers and support initiatives that have been demonstrated to reduce health disparities, consistent with the Provincial Cultural Competence Guidelines.

• Efforts must be focused on the recruitment of mental health and addictions professionals from diverse communities and for work in rural areas.

• Best/wise and evidence-based practices to meet the needs of specific diverse populations must be identified. This must take place in collaboration with identified community groups. A DHA and IWK Provincial Network for Services to Diverse Communities should be established to support this process and the work of providers.

• Interpreter and translation services (including sign language) should be available as required in clinical settings.

• Community-based, culturally-competent mental health and addictions services for Aboriginal populations should be implemented. Capacity development should be supported and relationships strengthened, particularly between First Nations communities and DHA/IWK mental health and addictions programs. Initiatives aimed at increasing Aboriginal mental health and addictions service providers should be supported.

• 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 this community across the life span. The DHAs and IWK must address the recruitment, retention and promotion of African Nova Scotian health care providers; and the Department of Health and Wellness should 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 Scotia community.

• Acadians and the Francophone population must have timely access to 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.
4. Strengthen collaboration.

We need to work more effectively together within care teams, across departments, between jurisdictions and among academics and clinicians that deliver, plan, research or fund some aspect of mental health and addictions treatment/support.

We have far too many silos confronting people who need services. This lack of coordination also makes it challenging for providers of mental health and addictions services to ensure they are offering the best care.

Some silos are due to the way we train professionals and their scope of practice, even though this does not always meet the needs of individuals and families. Some are due to the way we have become used to administering resources, even though it often results in inefficiencies. Others are due to the reality that a wide range of agencies, sectors and jurisdictions are necessarily involved in the lives of people needing mental health and addictions services – and the issues they deal with are incredibly complex.

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.

Being able to collaborate means that everyone across the mental health and addictions system is using the same information for planning and decision-making. Knowing how well the system is performing, and how it can be improved, requires having access to the right data. 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 information systems in place to collect data, measure outcomes and evaluate interventions are inadequate for Mental Health Services — and Addictions Services use a different information system altogether. This compromises the quality of policy development, program planning and service delivery. It can result in missed opportunities to make system improvements, lost time and wasted money because steps and processes need to be repeated. There can be breakdown in communication that disrupts care — and sometimes prevents people from getting services at all.

Our recommendations:

- Mental Health and Addictions Services across the province should 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.

- A Memorandum of Understanding between District Health Authorities/IWK and First Nation communities should be developed 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. Relationships between District Health Authorities/IWK and First Nation communities must be strengthened to build a shared understanding of mental health and addictions needs and how to address them most effectively.

- Confusion over federal and provincial health care mandates must be resolved to ensure appropriate and timely mental health and addictions services are available to military families.

- DHA and IWK approved guidelines must be developed and implemented for a collaborative approach to information sharing among teams of mental health and addictions 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.

- Province-wide person-centered and family-inclusive approaches to mental health and addictions services must be developed and implemented.

- 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 levels.

- The physical co-location of mental health and addictions services where feasible and joint collaborative approaches to care should be undertaken.

- Shared protocols and policies aimed at coordinating mental health and addictions services should be developed. These protocols should consider the following:
  
  a) A single access point for information on mental health and addictions for service providers and the general public.

  b) A coordinated intake and assessment process that uses common tools.

  c) A common data base and/or the ability to share information about patients across service providers.

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

  e) A framework for evaluation that uses service indicators that measure success of collaborative interventions for concurrent disorders.

  f) Manage concurrent disorders by early identification and use of interventions that integrate mental health and addiction care.

  g) Develop expertise in management of concurrent disorders and ensure availability of such services across the province.

  h) Mental health and addictions services clinicians should be cross-trained to promote a common understanding of both addictions and mental health.

  i) Ensure all clients are screened for mental health and addictions issues.

  j) Support capacity building across the province with a Concurrent Disorders Network.
• Greater uptake of the shared care model of collaborative mental health and addictions care should be encouraged. 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.

• Research and knowledge exchange and evaluation should be expanded and integrated, ensuring utilization of wise/best practices and scientific evidence-based therapeutic approaches across the system.

• Core competency standards should be developed, 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.

• A standard Authorization for Release of Confidential Information for use across the province for mental health and addictions services should be developed and implemented. Its appropriate use for all staff (clinical, support and clerical) must be clarified to ensure it is universally accepted and consistently applied across all DHAs and the IWK. In addition, a provincial policy that accommodates privacy and confidentiality of the individual within family-based, collaborative/shared care approaches should be developed. This should include clear direction for information sharing and exceptions. There is also the need to clarify the privacy and confidentiality guidelines as they relate to specific populations such as youth and seniors.

• Standardized information systems across all DHAs and the IWK should be implemented. 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.

• A provincial/multi-DHA/IWK Mental Health Inpatient Services Committee to which all inpatient services would be accountable should be established to ensure appropriate utilization and accessibility.

• To ensure public accountability, there is a need for 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.
Conclusion

THIS REPORT AND RECOMMENDATIONS REFLECT WHAT WE HEARD and learned through consultation and considering the best evidence available to us. We recognize that our findings 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 we offer are faithful to those who came forward to tell us of their experiences, are based on the evidence of what approaches are most likely to be successful, and build on significant areas of work that are underway — some of which began while we were still deliberating.

We also acknowledge that 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 are recommending 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 to bring services to communities without the individual or the provider needing to travel are but 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 final caution: Nova Scotia cannot afford the cost of not acting on these recommendations. The current and future wellbeing of every Nova Scotian and our communities depends on it.
Advisory Committee Members

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, Healthynovascotians.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.