

# MILESTONES ON OUR JOURNEY

Transforming Mental Health and Addictions in Nova Scotia  
A Provincial Model for Promoting Positive Mental Health, Care and Support  
August 2017



# Mental Health and Addictions Health Services Planning Advisory Committee

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# A Message from the Senior Director Mental Health and Addictions - NSHA

I am delighted to provide you with this milestones report on our journey to transform Mental Health and Addictions (MHA) in Nova Scotia. The Mental Health and Addictions Health Services Planning Advisory Committee, which includes representatives from Nova Scotia Health Authority (NSHA), IWK Health Centre (IWK), Department of Health and Wellness (DHW), and the Department of Community Services (DCS), have been working hard over the last 27 months to plan, and identify priorities for action which will help improve the lives of people and their families experiencing mental health disorders and/or harmful substance use and gambling problems in Nova Scotia. The purpose of this report is to document the evolution of our work and to identify priorities for change that align with national strategies to transform mental health and addiction care and support across Canada.

MHA is one of seven health service streams tasked with completing a multi-year plan to establish a new provincial approach to a range of healthcare services. Our specific goal is to create a health service plan in collaboration with the IWK, other government departments and other health sectors, that establishes a full continuum of evidence-based mental health and addictions initiatives, services and supports to meet the needs of Nova Scotians across their lifespans.

We know the prevalence of mental health disorders and harmful substance use is high in Nova Scotia – one in five people live with a mental health problem, one in seven people will experience a substance use problem and an estimated 50,000 Nova Scotians were personally 'at risk' for gambling-related harm as an outcome of their gambling. We know Nova Scotians

are waiting far too long for the care and supports they need – a particular concern is children and adolescents. There has been limited support for families especially in adult services, and sadly many people who need our services are either not getting the help they need or may not seek help at all because of the pervasive stigma and discrimination that continues to exist in relation to mental health disorders, substance use and/or gambling problems.

Our planning process revealed the complexities of our system, its interconnectedness (or not) with other parts of the healthcare continuum and some fairly fundamental differences in how the work is done across the province. At the same time, it has given us a wonderful opportunity to ask some profound questions about who we serve, what services we should be offering and how to ensure those services are based in evidence and responsive to community needs.

Our health services planning process started with literature reviews, environmental scans and site visits (Spring 2016), which included conversations with many of our MHA team members and other stakeholders. Qualitative and quantitative evidence was compiled and recommendations were made to the MHA Advisory Committee by our project consultants and others. In the Spring of 2017 I conducted a series of engagement sessions with our MHA teams across the province. These sessions provided opportunity to share information with our MHA teams on our planning process to date; to engage in a dialogue about the initial priorities for action; and created a forum to collect feedback. We have had many interesting



Dr. Linda Courey, MHA Senior Director, NSHA

and thought-provoking discussions that have helped to further refine our views about improving and establishing MHA as a provincial program.

The recommendations for change contained in this milestones report are rooted in a model of service delivery that involves close collaboration with the IWK, as well as other significant partners (e.g. people with lived experience, primary care, emergency departments, other government departments, schools, municipalities, etc.); an increased and more strategic focus on promoting positive mental health; standardization of our approaches to basic processes (e.g. intake, triage, admissions, clinical training/supervision, quality and patient safety, etc.); and philosophies of care (e.g. integration, equitable access, recovery-oriented, trauma-informed practice, etc.). It recognizes our responsibility to assist other sectors in building their capacity to address the multiple needs of those who are at risk of developing mental health disorders, addictions or are experiencing mild to moderate problems, while at the same time ensuring that MHA is more readily available and capable of meeting the needs of those with more serious conditions. Articulating, as well as communicating and engaging partners, stakeholders, our MHA teams and the broader community in our vision will be critical as we move this plan forward together.

This report does not contain a finished plan or product. Rather, it describes some initial priorities that will guide

our journey over the next five to ten years. Our plan is to continue to create opportunities for feedback and input into a strategic planning process that will build on the recommendations and establish timelines for implementation. At the same time, we will continue to work on standardizing a number of processes, so Nova Scotians can expect to be treated in the same way, regardless of where they live. We also intend to mobilize our health promotion, clinical, decision support teams and quality resources more efficiently by operating as a single, coordinated program rather than as a loose amalgamation of zone-based services. In this way, we will be better positioned to build on some of the fine work that is already being done across the province, learn from each other and build something new together.

The development of this milestones report has been informed by the needs of individuals, families and communities; as well as research, leading practices and the hard work of many dedicated people who are committed to improving the lives of people and families living with mental health disorders and/or harmful substance use/ gambling. I would like to formally acknowledge and thank them for all for their efforts and meaningful contributions. Things will not change overnight but with your help, I know we can succeed in making the most of this opportunity to think and work differently, and to improve the quality of MHA service delivery and the overall health of Nova Scotians.

# Introduction

Leading healthy, flourishing and productive lives are top priorities for Nova Scotians. Positive mental health and living a life free from the harms, risks and injuries associated with substance use and gambling are all fundamental to reaching this goal. Without mental wellness, hope and the possibility of recovery, it becomes very challenging for individuals and their families to live healthy lives and contribute to community in a meaningful way.

Creating opportunity, choice and support for people and their families to achieve positive mental health and recovery is different from the absence of a mental health disorder or curing a disease. Positive mental health is a state of well-being. In fact,

*“...it allows us to feel, think, and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual wellbeing that respects the importance of culture, equity, social justice, interconnections, and personal dignity<sup>2</sup>.”*

Mental health disorders and/or harmful substance use/gambling are health conditions; they refer to ranges of patterns of behaviour, thinking or emotions experienced by a person that brings levels of distress, suffering or impairment in areas such as school, work, social relations and family interactions. There are many different types of mental health disorders. Worldwide, anxiety and mood disorders are the most prevalent, while disorders such as schizophrenia and bipolar disorder are less common<sup>3</sup>. Alcohol continues to be the substance used most frequently amongst adults and youth in Nova Scotia and the rest of Canada; after tobacco it is the drug that causes the greatest amount of harm<sup>4</sup>.

In any given year, one in five people will experience a mental health problem and one in seven people report experiencing a substance use problem at some point in their life<sup>6</sup>. An estimated one in 16 Nova Scotians were personally ‘at risk’ for gambling-related-harm as an outcome of their gambling, and approximately one in 12 claimed to have experienced harm or to have known someone who did as a result of another person’s gambling at some time in the past<sup>7</sup>. Estimates suggest that half of all lifetime cases of mental health disorders start by age 14 and three quarters by age 24<sup>8</sup>.

Nova Scotians report one of the highest lifetime prevalence rates of mental health disorders in Canada (i.e. 41.7 per cent in Nova Scotia compared to 33.1 per cent in Canada). This gap is wider for those who are most disadvantaged in Nova Scotia, compared to those living in more advantaged conditions. When we take into account individuals, families, communities,

**Mental wellness and the belief that recovery is possible are integral components to improved health outcomes for people, families and communities<sup>1</sup>.**

**Mental health problems cost approximately \$51 billion per year in Canada alone. This estimate includes health care costs, lost productivity, and reductions in health-related quality of life<sup>5</sup>.**

and the broader society, every Nova Scotian is either directly or indirectly impacted by these health conditions.

Not unlike other areas in Canada, many Nova Scotians and their families living with mental health disorders or experiencing harms as a result of substance use/gambling do not seek out help or are unable to access the care and support they need. There are many reasons for this, including: lack of awareness; fear; as well as service accessibility, availability and affordability. Despite considerable progress made across the country to combat stigma and discrimination, it continues to be one of the most commonly reported obstacles in accessing and participating in mental health and addictions care and support. Many people say they are fearful of being labelled as someone who has a mental health or addiction problem. Further, the stigma has been frequently noted by people and families as being worse than living with the mental health disorder, harmful substance use/gambling problem itself.

In planning services and supports for Nova Scotia, it is important to recognize it is possible for all people to experience positive mental health, regardless of whether or not they are living with a mental health disorder or experiencing harmful substance use/gambling. Furthermore, for many people and their families, achieving positive mental health contributes to their recovery journey.

“Recovery is the process of change through which people create opportunity to improve their health and wellness, live self-directed lives and strive to reach their full potential, despite the fact they may be experiencing ongoing limitations caused by their mental health disorder and/or harmful substance use/gambling”<sup>10</sup>.

Stigma prevents approximately two-thirds of people living with a mental illness from getting the help they need<sup>9</sup>. According to the American Journal of Medicine, about one in 10 people who need help with their addiction will actually access the supports they need.



Digby Neck by Bruce Dienes

# Health Services Planning Background

On April 1, 2015, nine separate health organizations in Nova Scotia (i.e. District Health Authorities or DHAs) were brought together to form one new provincial health organization, now known as Nova Scotia Health Authority (NSHA). The creation of NSHA was much more than rewriting geographic boundaries (health zones) and a new organizational structure; rather, it was a recognition that we need and can do better for people, families and communities in Nova Scotia. It's an opportunity to reshape the health system to improve the lives of Nova Scotians and achieve better health outcomes. To do this successfully, NSHA works closely with IWK Health Centre (IWK)<sup>11</sup>, Nova Scotia Department of Health and Wellness (DHW), cross-sectoral stakeholders, and other community partners. This involves sharing knowledge, experience and resources<sup>12</sup>.

In the spring of 2015, Nova Scotia Government requested DHW, NSHA and IWK collaborate to develop and implement a multi-year plan, with the goal of creating an accessible health system that offers the right care, in the right place, at the right time. Project teams involving employees and physicians came together to lead the planning process. The teams committed to using the best available evidence and engaging Nova Scotians in the planning, implementation and evaluation process. A project steering committee involving leaders from NSHA, IWK and DHW continues to provide oversight to the planning process, hereafter called Health Services Planning (HSP)<sup>13</sup>.

Mental Health and Addictions (MHA) was one of the seven health service streams selected to engage in HSP. In the summer of 2015, a Mental Health and Addictions Advisory Committee (the Advisory Committee) was established, with a mandate to provide strategic leadership and guidance to MHA's health services planning process. The work of the Advisory Committee continues and is guided by NSHA's commitment, "to achieve excellence in health, healing and learning through working together<sup>14</sup>," and IWK's commitment, "to passionately pursue a healthy future for women, children, youth, and families."<sup>15</sup>

Seven work streams engaged in Nova Scotia's Health Services Planning Process:

1. Primary Health Care
- 2. Mental Health & Addictions**
3. Cancer Care
4. Emergency Services
5. Maternal & Neonatal Care
6. Surgical Services
7. Critical & Trauma Care



## Purpose and Objectives

The overall goal for the Advisory Committee was to strategically plan for a full continuum of services and systems supports to better meet the needs of Nova Scotians across their lifespans. The plan is intended to serve as a road map or framework, which will help further guide the development and implementation of a provincial model for *Promoting Positive Mental Health, Care and Support in Nova Scotia*.

The goal of this report, titled *Milestones on Our Journey to Transform Mental Health and Addictions in Nova Scotia* (the Milestones Report), is to share our experiences and highlight the key milestones in our planning journey to date. It is our hope the Milestones Report serves as a document that profiles the evolution of the planning process, shows the beginnings of a provincial model for MHA in Nova Scotia and proposes an action agenda (the Action Agenda) to create linkages to national priorities aimed at transforming care and supports for people and their families living with mental health disorders and/or harmful substance use/gambling.

The Action Agenda (see page 49) will lay out key focus areas (Pillars), with strategic action areas required to transform MHA in Nova Scotia.

While the planning process and the proposed Action Agenda outlined in this report are essential to our success, they may also be considered ambitious when we contemplate the magnitude of the issues faced by Nova Scotians. Establishing a system of care and community supports that truly meets the needs of all people and their families living with mental health, substance use and/or gambling problems is no easy task. This is just the beginning, as there are no miracle solutions or single strategy that will work. Mental Health and Addictions leadership, physicians and employees in Nova Scotia will do their part, but transforming mental health and addictions care and supports will require commitment and leadership from everyone in the province of Nova Scotia.

**We all have a role to play in promoting positive mental health and supporting people's recovery journey in Nova Scotia.**

# Planning Methods and Engagement Process

## Strategic Project Management

Creating the beginnings for a provincial model of *Promoting Positive Mental Health, Care and Support* required the Advisory Committee to: have a clear understanding of the current state of initiatives, programs and services across the province; extensively review the evidence related to best and promising practices; identify the components of a full continuum of care and supports (from health promotion strategies to specialized treatment services); and evaluate the specific needs of Nova Scotia communities, such as social determinants of health, prevalence of disorders, and other population health status indicators.

Throughout the planning process, there was involvement and ongoing communication with NSHA's Project Management Office (PMO) for Health Services Planning, members of the Advisory Committee, Executive Leadership Team at NSHA and IWK, as well as the other six health services planning streams. This provided opportunity to share project milestones, successes, challenges, and to identify synergies for service alignment. The project management process commenced in the summer of 2015 and the planning journey is expected to continue and evolve.

## Tiered framework to Guide System Design for Mental Health and Addictions in Nova Scotia

The best way to help guide our thinking around the care, supports and strategies needed for children, adolescents, adults, seniors, families and our communities is to utilize the "tiered framework." This framework has been adapted from the 2008 National Treatment Strategy: *A Systems Approach to Substance Use in Canada*<sup>17</sup> and is currently in use in Nova Scotia. Using the tiered framework allows us to expand traditional thinking and service planning by using the "continuum-of-care" to define, plan, deliver and evaluate care, supports and services beyond the specialized treatment sector. Essentially, the tiered framework makes caring and supporting people and their families living with or at-risk for mental health disorders and/or harmful substance use/gambling everyone's business.

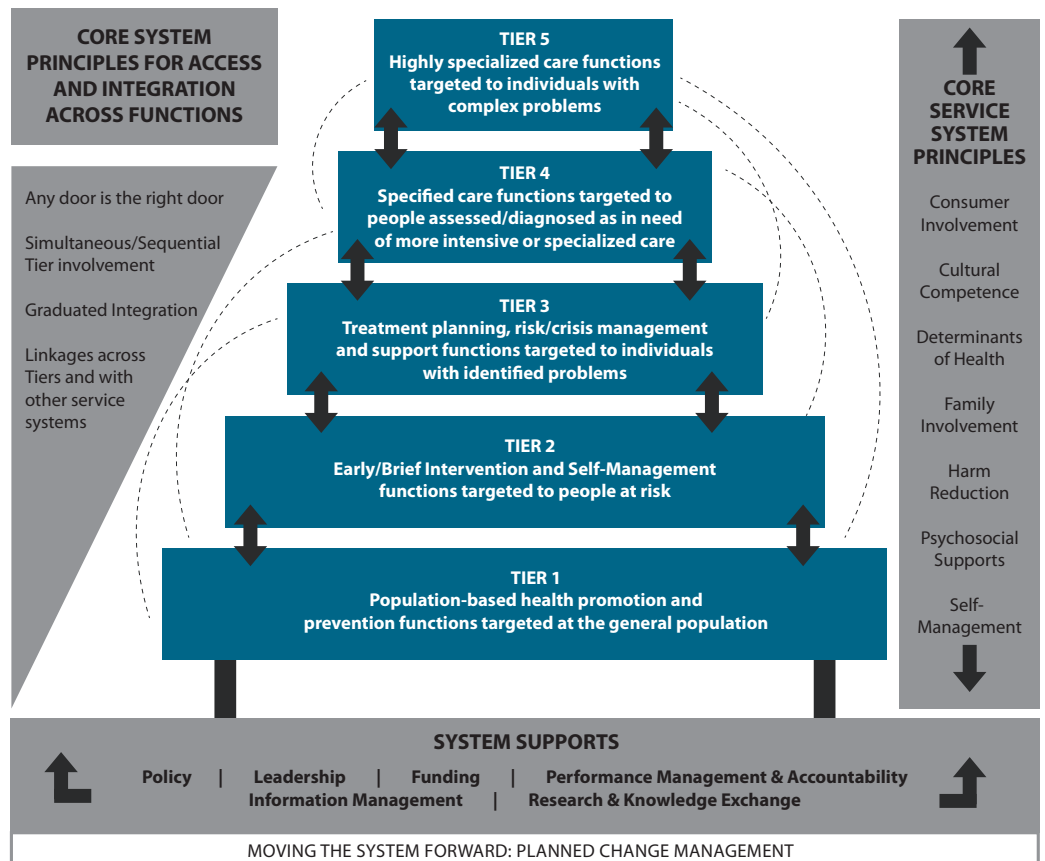
Social Determinants of Health are often referred to as "*the different factors that affect health.*" At every stage of life health is determined by complex interactions between social and economic factors, physical environments and individual behaviors. The combined influences of these factors determine the health status of our population<sup>16</sup>.

The tiered framework involves overlaying levels of severity and complexity of mental health problems and harmful substance use/gambling experienced by Nova Scotians on top of levels of care. That is, the levels of specialization and resource intensity of services and strategies required to prevent or otherwise address the problems. The tiered model is usually presented as a triangle, with the bottom level (Tier 1) reaching the largest groups of people – the strategies are intended to improve health status of an entire population. Each subsequent tier offers a more focused or specialized level of care and support, for a smaller portion of people in need. For instance, the top tier (Tier 5) would be the most acute and severe problems requiring the most intensive, and costly services – very few people would need this level of care.

It is important for us to be aware that people cannot be categorized as belonging to one tier or another. The reality is the trajectory for some people involves moving across the tiers, when changes occur with their conditions. The need for seamless transitions across the continuum of tiers is critical, as we know the needs of people change over time. Many people will actually never require formal treatment services within the Mental Health and Addictions system.

In brief, what this means is we know the needs of people and their families can change over time. The tiered model recognizes some people move up and down the tiers or level of care in order to match their needs to evidence-based support and care available. For example, a person with severe symptoms may need intensive or acute level of service for a period of time; however, they will still need access to care, support and involvement of their primary care provider. We need a balanced approach; people need to be able to access intensive care, treatments and supports when they need them, and at the same time they need to have the ability to easily transition to a different level of care when their needs change (e.g. lower acuity level). The principles underlying this framework, as well as the supports required for its full implementation, are described in the diagram to the right.

Note: The model below has been further adapted by Dr. Brian Rush since the original version: Rush (2010) and Rush & Nadeau (2011), building upon the Tiered Model described in the National Treatment Strategy of the National Treatment Strategy Working Group (2008).



# Planning Models – Population Health Planning and Needs-Based Planning

Population Health Planning and Needs-Based Planning are the two evidence-based models selected by the Advisory Committee to guide the overall planning process and system design for MHA in Nova Scotia.

- **Population Health Planning**<sup>18</sup> is an integrated and collaborative planning process that takes into account environmental, economic, political, social, cultural, and behavioural factors that contribute to health and wellness of communities and populations, rather than solely addressing personal risk factors for illness and disease. Principles and values explicit in health promotion underpin the population health planning model.
- **Needs-Based Planning**<sup>19</sup> is a planning tool designed to systematically measure the need for care, supports and treatment for people and their families living with mental health, substance use and/or gambling problems. The model further identifies the required service capacities based on local population need and problem severity. This approach to planning aims to improve provincial coordination and delivery of care, services and supports by identifying needs, gaps and opportunities.

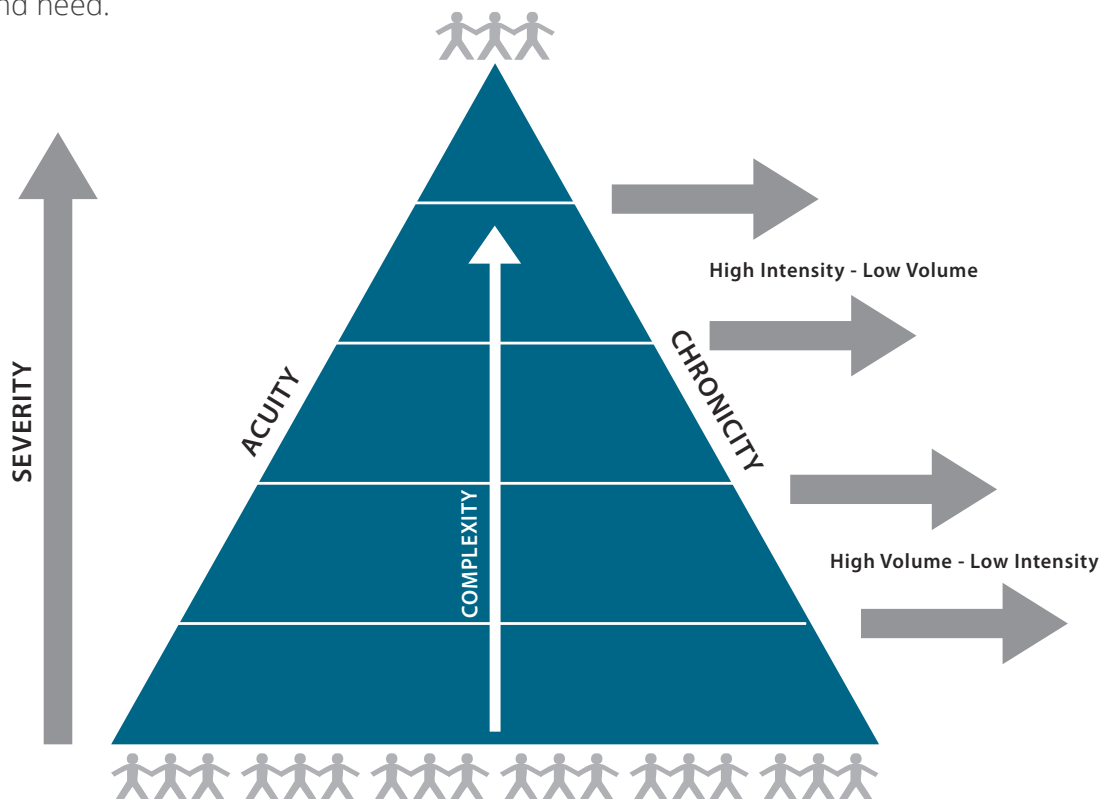


Kejimikujik "Keji" National Park by Bruce Dienes

# A. Population Health Pyramid and Needs-Based Planning in Mental Health and Addictions

The Population Health Pyramid has been used as a foundational framework to ground needs-based planning for MHA in Nova Scotia. The idea behind this is that when planning for system design, consideration should be given to the health needs of the entire population rather than (re) configuring services and supports solely based on those who are currently accessing services or sought assistance in the past. This approach requires us to consider the strengths and needs of entire communities, and across the full spectrum of risk, harm and injury associated with mental health, substance use and gambling problems, including, but not limited to, severe disorders.

The image below illustrates the population health pyramid, combined with the five different levels of problem severity and corresponding types of interventions<sup>20</sup> (Tiers). The highest levels of severity are associated with the fewest number of people, who in turn need the most specialized and/or intensive care. People with lower levels of problem severity are more numerous and their needs can be met by less intensive or less specialized care, which can be made more widely available in a variety of health and social service contexts, as well as in more informal community/family networks of support. This is distinct from health promotion strategies which are relevant to all people in the population; that is to say, across all dimensions of severity and need.



## B. Population Health Data Sets and Nova Scotia's Needs-Based Planning Estimates

Epidemiological data was drawn from various demographic, mental health, substance use and gambling data sets. National surveys with significance to the Nova Scotia population and provincial surveys were reviewed and incorporated into the needs-based planning model estimates. Further, the data from the surveys was analyzed, interpreted and described using a health equity lens at the provincial, and when available, at the community level. The following is a list of survey data sets used to inform the planning process and the Action Agenda:

- Canadian Census (2011)<sup>21</sup>
- National Household Survey (2011)<sup>22</sup>
- Canadian Community Health Survey (2011-12)<sup>23</sup>
- Canadian Community Health Survey – Mental Health (2012)<sup>24</sup>
- Canadian Tobacco, Alcohol and Drugs Survey (2013)<sup>25</sup>
- Nova Scotia Student Drug Use Survey 2012: Technical Report<sup>26</sup>
- Mental Health and Addictions Epidemiological and Demographic Analysis<sup>27</sup>
- 2012 Canadian Survey on Disability<sup>28</sup>
- The Health of the Nova Scotia Mi'kmaq Population: Results of the Regional Health Survey for the On-Reserve Population 2008-10<sup>29</sup>
- Participation and Activity Limitation Survey (2006; PALS)<sup>30</sup>
- 2013 Nova Scotia Adult Gambling Information Collection Project (2016)<sup>31</sup>
- Canadian Youth Smoking Survey (2012)<sup>32</sup>
- Nova Scotia Adolescent Gambling Surveillance Technical Report (2011)<sup>33</sup>

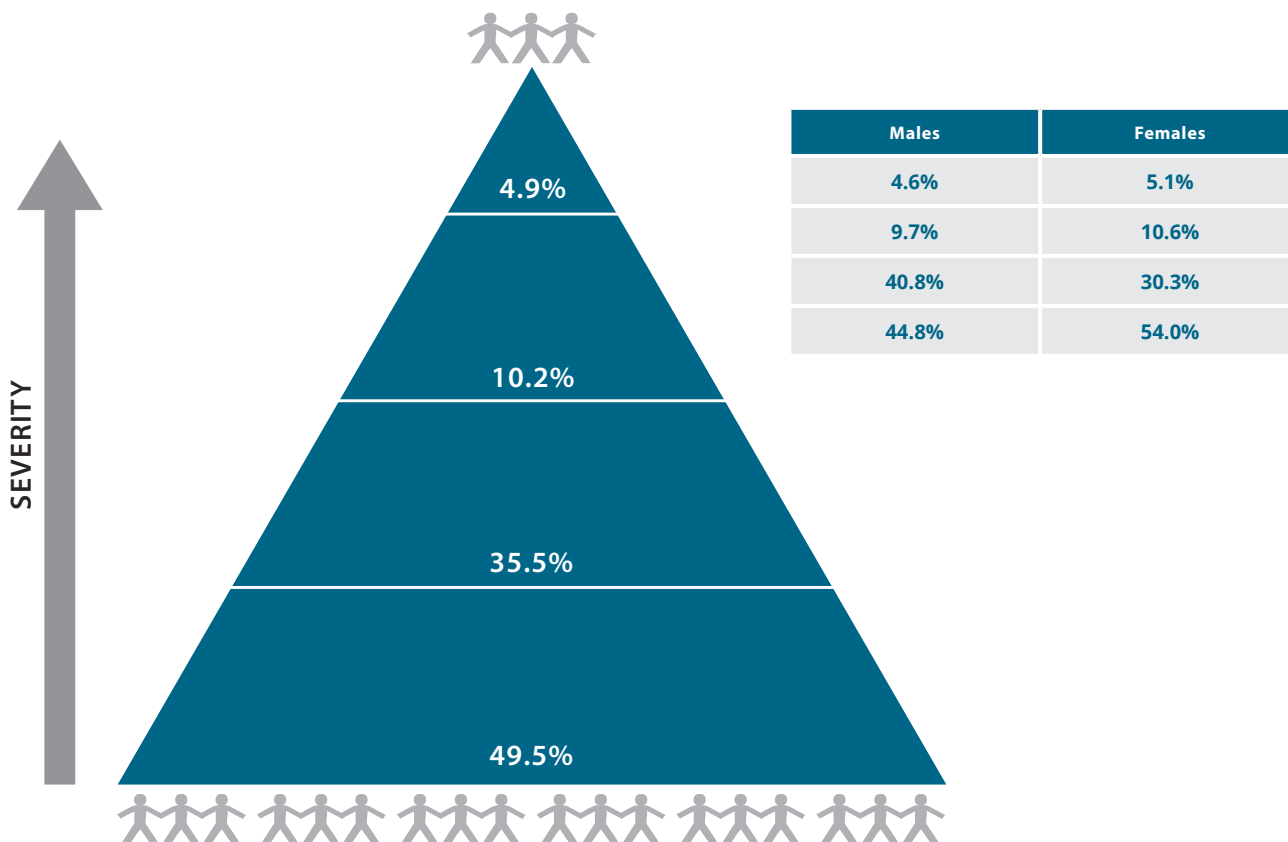


South Shore by Bruce Dienes

## C. Needs-Based Planning Estimates for Adults in Nova Scotia – the Treatment Gap

To gain a better perspective on the level of community need for mental health and addictions in Nova Scotia, a set of criteria for defining the need for integrated mental health and addictions care and support was done using the 2012 Canadian population survey data on mental health, substance use and addiction (aged 15 and over). Definitions were established for Tiers 1-4/5<sup>34</sup>, which were partly diagnostic but moderated by impairment and the subjective need for help. The results of the analysis were projected by age and gender categories for Nova Scotia. The figure below maps the estimates of mental health and substance use needs for Nova Scotia adults on to the four levels of care/tiers.

Secondary data sets were collated on population trends, community characteristics, system costs and mental health and addictions service utilization statistics in Nova Scotia – for both child and adult services. Data was also reviewed related to projected staffing needs/current capacity using data collated from the Choice and Partnership Approach (CAPA) processes<sup>35</sup>. These data sets were utilized to further inform the needs-based planning model by estimating system capacity and current demand.



The table below shows the application of national distribution of mental health and addictions needs to Nova Scotia's population aged 15 and over. According to the size of the population in Nova Scotia, it has been derived the total number of people in need of Tier 3 and Tier 4/5 level mental health and addictions care and support is 122,199; when Tier 2 (mild and moderate severity) is included, the estimate of need changes to 409,491 people.

<b>Tier/ Level</b>	<b>Percentage of Nova Scotians in-need</b>	<b>Estimated number of Nova Scotians in-need</b>
Tier 1	<b>49.5</b>	<b>400,588</b>
Tier 2	<b>35.5</b>	<b>287,292</b>
Tier 3	<b>10.2</b>	<b>82,545</b>
Tier 4/5	<b>4.9</b>	<b>39,654</b>
<b>Tiers 2-4/5 Total</b>	<b>50.6</b>	<b>409,491</b>
<b>Tiers 3-4/5 Total</b>	<b>15.1</b>	<b>122,199</b>

Adjustments need to be considered in the survey projections based on several groups in Nova Scotia that would not have been included in the national survey data sets – people who are experiencing homelessness, admitted to hospital and who are incarcerated at the time of the survey. Incorporating these estimates into our overall projections of the number of people at each level of severity would result in about 125,240 in need at the Tiers 3-4/5 severity level and about 410,000 people in need when Tier 2 is included.

Establishing the treatment gap is the final step in the needs-based planning process. In brief, the population level survey data was used to establish levels of problem severity amongst Nova Scotians or the needs, and the treatment gap was calculated by comparing the projected need against the current volume service utilization.

Service utilization data was analyzed for Mental Health and Addictions at NSHA and IWK (Tier 3-4/5). We found approximately 41,201 people aged 15 and up were reached in 2014-15. This represents an unduplicated count of people engaged in service and essentially is the best estimate of Mental Health and Addictions current system capacity (i.e. Tier 3-4/5). This means that 66 per cent of people in Nova Scotia who are in need of care and/or support are not engaged or accessing our services, a.k.a. the treatment gap. The estimates are presented in the table on the next page.



Tier/ Level	Percentage of Nova Scotians in-need	Estimated number of Nova Scotians in-need
Tier 1	49.5	400,588
Tier 2	35.5	287,292
Tier 3	10.2	82,545
Tier 4/5	4.9	39,654
Tiers 2-4/5 Total	50.6	409,491
<b>Tiers 3-4/5 Total</b>	<b>15.1</b>	<b>122,199</b>

In-need: 122,199	Current Services 41,201
<b>Coverage: About 34%</b>	

The data estimates referenced above do not take into account all people with different levels of severity that may be serviced by other care teams outside the formal Mental Health and Addictions system, such as through the Department of Community Services' Community and Residential Programs, emergency services, mobile crisis teams and primary care. Utilization data was gathered from these other care areas: Community and Residential Programs (1,110 cases), emergency services (14,388 visits), the mobile crisis team (4,644 unique callers), and physicians' billing (170,494 patients, all ages combined). It should be noted there are many challenges with using these data sets in estimating overall system capacity, such as duplicate counting, inclusion of patients under age 15 in primary care billing data, etc. Given these limitations, the new capacity estimates were established by adding the unduplicated count of 41,201 people to these additional cases. People presenting in settings such as primary care and emergency departments have a full range of severity; as a result, the estimates for system capacity and the treatment gap were done across Tiers 2 to 4/5. The total number of people in need is 409,491 and our current system capacity is 231,837, or a treatment gap of 43 per cent. The estimates are presented in the table below.

Tier/ Level	Percentage of Nova Scotians in-need	Estimated number of Nova Scotians in-need
Tier 1	49.5	400,588
Tier 2	35.5	287,292
Tier 3	10.2	82,545
Tier 4/5	4.9	39,654
Tiers 2-4/5 Total	50.6	409,491
<b>Tiers 3-4/5 Total</b>	<b>15.1</b>	<b>122,199</b>

In-need: 409,491	Current Services 231,837
<b>Coverage: About 57%</b>	

# D. Needs-Based Planning Estimates for Children and Adolescents in Nova Scotia—The Treatment Gap

There is currently no national-level population survey data that assesses prevalence of mental health disorders among young children and adolescents in Canada. Researchers at Simon Fraser University in B.C. have worked to address this gap by locating and synthesizing the results of high-quality epidemiological surveys published between 2003 and 2013<sup>36</sup>. To maximize generalizability to the Canadian population, the researchers selected surveys with samples greater than 500 children and with response rates greater than 70 per cent; from relatively high-income countries; used DSM-IV or ICD-10 criteria for defining mental health diagnoses, as well as measures of impairment; and incorporated reports from multiple sources including youth, parents and teachers. The results were reported separately for males and females and prevalence rates reported over a period of three, six or 12 months for a wide range of disorders. For the purpose of our planning process, these estimates were used to predict prevalence rates of disorders amongst children and adolescents living in Nova Scotia.

The prevalence of mental health disorders for children and adolescents aged 4-17 is 12 per cent, meaning about 16,300 children and adolescents in Nova Scotia are in need of mental health and addictions care and support (Tiers 3-4/5). Service utilization data was analyzed for Mental Health and Addictions at NSHA and IWK (Tiers 3-4/5). We found that approximately 8,041 children and adolescents were reached in 2014-15. This represents an unduplicated count of children and adolescents and essentially is the best estimate of the Mental Health and Addictions current system capacity for children and adolescents (i.e. Tiers 3-4/5). The population pyramid for adults referenced above could not be developed for the younger age group, but the estimates including the treatment gap (51 per cent) are presented in the table below.

Tier/ Level	Percentage of NS Children and Adolescents in-need	Estimated number of NS Children and Adolescents in-need
Tier 1	unknown	unknown
Tier 2	unknown	unknown
Tier 3-4/5 Total	12.6	16,310

In-need:  
16,310

Current Services  
8,041

Coverage: About 49.3%

# Evidence-Based Reviews and Research Synthesis

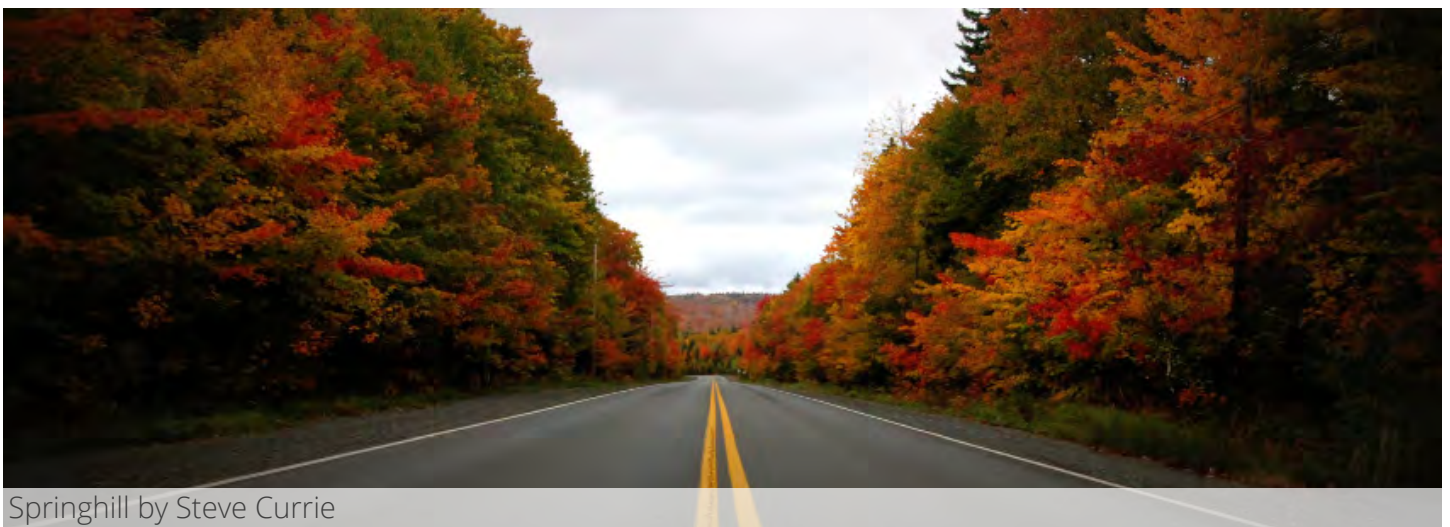
Three comprehensive evidence-based reviews were prepared for the Advisory Committee; these reviews served as foundational documents to our planning process and development of the Action Agenda. The reports summarized the latest research and evidence-based practices in mental health and addictions. The Advisory Committee used the information to identify gaps in the current system in relation to what the evidence says is needed to create a system that can truly meet the needs and improve health outcomes of people, their families and communities experiencing mental health disorders and/or harmful substance use/gambling.

## A. Evidence-Based Review for Health Promotion

This report outlined a situational assessment of current health status data trends and the latest evidence-based approaches for the following priority issues:

- Promoting positive mental health and health equity;
- Preventing inequities, risks, injuries and harms from alcohol;
- Preventing inequities, risks, injuries and harms from tobacco;
- Preventing inequities, risks, injuries and harms from other drugs; and
- Preventing inequities, risks, injuries and harms from gambling.

Our review also outlined an evidence-based operational model for health promotion practice in Mental Health and Addictions, hereafter called the *Promoting Positive Mental Health Action Plan* (See Appendix A).



Springhill by Steve Currie

## B. Evidence-Based Review for Clinical Services and Supports

A literature review summarizing evidence-based practices for mental health and addiction treatment system was developed to assist the Advisory Committee in identifying gaps in the current system, in relation to the best available research evidence. The research review built on a review done in the addictions sector by one of our project consultants and was expanded to include evidence-based mental health services. The review outlines treatment models/settings, but did not drill down to the level of specific clinical interventions or cover all relevant sub-populations and diagnostic groupings. The evidence in the report is organized around the following seven principles:

1. Broad systems approach
2. Collaboration across multiple stakeholders
3. Wide range of system supports
4. Unique strengths and needs of First Nations, Inuit, Metis Peoples
5. Developmental age, gender, equity and diversity issues
6. The continuum of care
7. Mix of evidence-based psychosocial and clinical interventions

## C. Evidence-Based Review for Smoking Cessation Interventions

This document is a summary of research reviews already conducted of literature in the tobacco control field. Since the findings were being used to help inform provincial service planning and tobacco control policy, only the highest quality evidence regarding intervention effectiveness were used. The review covered peer-reviewed, academic literature and includes many best practice documents available online between 2010 and 2016. Where there were gaps in the literature for certain topic areas, the review was extended to include pre-appraised syntheses published between 2007 and 2016. The review highlights the following key areas:

- Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment<sup>37</sup>;
- Pharmacological quit smoking aids;
- Behavioral interventions;
- Combined behavioral interventions;
- Auricular acupuncture;
- Interventions for specific or at-risk populations;
- Cessation training; and
- Electronic nicotine devices.

## Review of Past Reports and Strategies

There are a number of informative international, national and provincial planning exercises, projects and reports that were of particular relevance to our planning process. The following are some of the more influential reports we have reviewed and provide context for the beginnings of our provincial model and the Action Agenda.

### International and National Reports

- *The Five Year Forward View for Mental Health. A report from the Independent Mental Health Taskforce to the NHS in England, 2013*
- *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy, Canadian Centre on Substance Abuse (CCSA) (2008)*
- *Changing Direction, Changing Lives – The Mental Health Strategy for Canada, Mental Health Commission of Canada (MHCC) (2012)*
- *Advancing the Mental Health Strategy for Canada – A Framework for Action, 2017-2022, MHCC (2016)*
- *Guidelines for Recovery Orientated Practice MHCC (2015)*
- *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada, MHCC (2006)*
- *Collaboration for Addiction and Mental Health Care: Best Advice, CCSA (2015)*
- *A Framework for Support; 3<sup>rd</sup> edition – Canadian Mental Health Association (2004)*
- *The Costs of Substance Abuse in Canada , CCSA (2002)*
- *Toward Recovery and Wellbeing: A Framework for a Mental Health Strategy for Canada, MHCC (2013)*
- *Investing in Mental Health, World Health Organization (WHO) (2003)*
- *Evergreen: A Child and Youth Mental Health Framework for Canada. Prepared for the Child and Youth Advisory Committee, MHCC (2010)*
- *First Nations Mental Wellness Continuum Framework, Health Canada (2015)*
- *Guidelines for Comprehensive Mental Health Services for Older Adults in Canada, MHCC (2011)*
- *National guidelines for medication-assisted treatment of opioid dependence. Commonwealth of Australia (2014)*
- *Guidelines for the Psychosocially-Assisted Pharmacological Treatment of Opioid Dependence. Geneva: WHO (2009)*
- *International Standards for the Treatment of Drug Use Disorders. WHO and United Nations Office on Drugs and Crime (2016)*

- *A Guideline for the Clinical Management of Opioid Addiction*. Vancouver Coastal Health Authority (2015)
- *CAN-ADAPTT. Canadian Smoking Cessation Clinical Practice Guideline*. (2011).
- *Income Gap between Aboriginal Peoples and the Rest of Canada* – Wilson, D. & MacDonald, D. for the Canadian Centre for Policy Alternatives (2010)
- *Vic Health's Strategy and Action Agenda for Health Promotion*, Australia (2016)
- *Fair Foundations: The Vic Health's Framework for Health Equity*, Australia (2015)
- *Victoria's 10 year Mental Health Plan 2016-2025*, Australia (2016)

## Provincial Reports

- Nova Scotia Health Authority Strategic Plan, *Healthier Together*, 2016-2019
- IWK Health Centre Strategic Plan, *Aspire*, 2016-2020
- *Mental Health and Addictions Epidemiological and Demographic Analysis*, Dalhousie University, Dept. of Community Health and Epidemiology (2011)
- *Come Together: Report and Recommendations of the Mental Health and Addictions Strategy Advisory Committee*, (DHW; 2012)
- *Together We Can: The plan to improve mental health and addictions care for Nova Scotians*. (DHW; 2012)
- *Together We Can: Progress Update* (DHW; 2015 & 2016)
- *Mental Health and Addictions Strategic Plan 2011-2016* – IWK Health Centre
- *Geographic Framework for Health Services Planning* (2015)
- *Nova Scotia Health Profile 2015* (DHW; 2015)
- Statistics Canada – Health Profiles (former NS District Health Authorities, 2013)
- *Choice, Equality and Good Lives in Inclusive Communities, A Roadmap for Transforming the Nova Scotia Services to Persons with Disabilities Program* (2013)
- *2015 Report Card on Poverty in Nova Scotia*
- *Comprehensive Tobacco Control Strategy* DHW (2001, renewed in 2011) and 2004 Progress Report
- *Methadone Maintenance Treatment Handbook* – College of Physicians and Surgeons of Nova Scotia (2012)
- Nova Scotia's Community Health Board Plan(s), Three Year Priorities and Recommendations

The collective message from these reports is the need for resource investment and system change in Mental Health and Addictions is long overdue. Structures for surveillance, measurement and reporting are desperately needed to provide critical information for making decisions to improve care, supports and overall positive mental health and recovery outcomes for people, their families and our communities. Further, despite a strong continuum of services and dedicated, competent professionals, there are significant limitations and challenges in Nova Scotia with respect to:

- Population health issues (e.g. housing, poverty, employment, food access, etc.), which increase vulnerability and create health inequities;
- Stigma and discrimination continues to be pervasive, making it extremely difficult for people and their families to seek and/or participate in treatment when they need it;
- Ensuring patients and families are being treated and supported with evidence-based practices, including the ability to access the right information, resources and skills to support their loved ones;
- Major service access challenges, including lack of transportation options in small towns and rural communities;
- Disconnected patient health information systems and the need for better performance measurement strategies, program evaluation and outcome measures;
- Insufficient system capacity, resulting in lengthy wait times and poor patient flow;
- Consistent feedback from stakeholders, including those who work in Mental Health and Addictions, that the system is under-funded, is at capacity, requires improved coordination, and is unevenly accessible/responsive; and <sup>38</sup>
- Limited use and investment in technology (i.e. E-Mental Health Solutions<sup>39</sup>) to detect, screen, consult, support or treat mental health, substance use and/or gambling problems, despite emerging evidence which demonstrates that E-Mental Health can be as effective as face-to-face services for certain groups of people.

# Stakeholder Consultations and System Mapping

## A. NSHA Zone/IWK's Mental Health and Addictions Leadership Teams

Meetings of Mental Health and Addictions Health Services Advisory Committee (the Advisory Committee) commenced in the summer of 2015 to both inform the development of the plan and inform a process for implementation. The group continues to meet regularly. In addition to these planning meetings, the MHA directors, managers and leaders in the psychiatry group within NSHA and IWK participated in three formal consultation sessions (winter of 2016, early spring of 2016 and late spring/summer 2016). The consultations included a series of presentations which outlined the purpose, objectives and models being used for the planning process. Further, the groups engaged in a series of structured discussions to elicit feedback on principles of design, the provincial model, the Action Agenda, and they also informed the environmental scan of current state initiatives, programs, services and needs.

Sample discussion questions:

1. What would you identify as the major strengths of the current system of services?
2. What would you consider the major challenges or areas for improvement in the current system?
3. There are a set of core functions<sup>40</sup> of a mental health and addiction system (\*functions were provided). Please provide some feedback on the strengths and challenges related to these core functions.
4. There are a number of system features<sup>41</sup> that have been identified as important in supporting a comprehensive, evidence-based mental health and addiction system. Please reflect on each of these, identify strengths and areas for improvement/challenges.
5. If you could wave a magic wand and adapt, add, or remove something from your program area, what would that be?



Directors, managers and key representatives from each management zone in NSHA and IWK also completed a template that detailed community level and zone level program/service descriptions. This information was also used to inform the environmental scan of the current state of mental health and addictions programs and services in Nova Scotia. The template included a section for participants to reflect on key system/service supports that were currently in place and those that may be lacking (e.g. planning, policy, information systems and performance measurement).

## **B. NSHA Zone/IWK Town Halls, Site Visits and Team Consultations: Mental Health and Addictions Teams**

In the spring of 2016, teams working in MHA across the province were invited to participate in a series of in-person information sessions. An online option was made available for people who were unable to join the session in person. The three-hour sessions focused on sharing information about health services planning, the planning models used for MHA, project milestones and proposed core components of a provincial model for MHA in Nova Scotia. There were some opportunities for participants to ask questions and provide feedback to inform the next phase of work (i.e. model refinement, establishing recommendations and defining provincial priorities). The presentation utilized in the information sessions was shared among internal MHA teams.

Site visits were also conducted with various programs and services across the four management zones in NSHA and IWK. There were over 20 different outpatient and inpatient services toured, in both rural and urban communities. Visits were also done with some local community-based harm reduction organizations. This created another opportunity to speak with service providers and see firsthand the current state of operations of the system. It also offered greater insight into the distance between and within the geographical boundaries of NSHA and IWK.

Between January and June 2016, a series of strategic consultations were held with 12 NSHA and IWK health promotion practitioners working in MHA – forming the Health Promotion Planning Team. The team met 10 times as a collective over the course of seven months. Two of these meetings were face-to-face consultations; and the remainder where by teleconference. Team members also engaged in one-to-one interviews to allow for a better understanding of the work and to start the conceptualization of the current state of health promotion practice within MHA (e.g. staff, resources, programming, projects, functions, job descriptions, etc.).

An environmental scan and a SWOTT Analysis (Strengths, Weaknesses, Opportunities, Threats, and Trends) were completed. An online survey was sent to the other health promotion practitioners working within MHA, with an additional 18 practitioners and managers completing the online survey. Further data and evidence were collected from local, provincial, national and international sources to inform the environmental scan.

In the spring of 2016, health promotion practitioners were invited to attend a planning primer via Lync online meeting to inform them on the progress of the planning. In May 2016, many health promotion practitioners working in MHA from across the province came together for an all-day visioning and strategic planning session. The final step of this consultation process involved the planning team being divided into the following four task groups: Logic Model Task Group, Equity Task Group, Health Promotion Resource Library Task Group, and Accountability Framework Task Group. The task groups were designed to address and inform specific gaps and needs in health promotion practice that were identified in the environmental scan.

## SWOTT Analysis Framework

- What are the strengths of the current system?
- What areas need to be improved?
- What new possibilities are available for health promotion in Nova Scotia?
- What challenges might come our way?
- What would it take to create change on this issue?



Halifax Harbour by Jason Jackson

Between June and July 2017, Mental Health and Addictions teams across Nova Scotia participated in a series of engagement sessions to:

- discuss the overall health services planning process for MHA to date;
- share learnings, findings and initial recommendations from the Advisory Committee with the intent of eliciting feedback from MHA team members; and
- talk in a strategic way about the vision, model and future state of Mental Health and Addictions in Nova Scotia.

Initially all MHA team members were invited to attend an online presentation hosted by NSHA's Senior Director for Mental Health and Addictions (Dr. Linda Courey). This presentation was designed to provide context around our evolution as a provincial program of care in Nova Scotia, and to highlight some of the challenges the MHA system in Nova Scotia has historically encountered as well as the service and system improvement opportunities that can make a difference in the lives of people and families living with mental health disorders and/ or are experiencing harmful substance use/ gambling.

MHA teams were also invited to attend in-person consultations. This created another opportunity to share information and collect feedback from approximately 400 MHA team members. Site consultations were held in: Truro, Digby, Kentville, Sydney, Antigonish, and Halifax (Central Zone and IWK). An online option was made available through Skype/ Lync, and presentations were recorded to allow for further sharing of information.

## What We Heard

- A deep commitment to the people and families we serve, and to ensuring the needs of our patients, clients and their families are met either by us or other appropriate care/ service providers;
- Acknowledgement of the significant scope of work that is being proposed and the need to take some time to reflect and better understand the details (e.g., specific objectives, timelines, leads and progress reporting);
- Thoughtful questions regarding the planning process and supports that will be utilized to support the implementation of this massive undertaking as we work together to improve mental health and addictions care to Nova Scotians;
- Concern and frustration regarding the lack of communication and delay in formal engagement with the MHA teams and managers in the planning process to date;
- The need to incorporate the perspective of patients, clients and their families in the planning process if we are to truly achieve patient-centred care as an outcome;
- Insight from our MHA teams regarding challenges in other parts of the healthcare system or other departments over which they have no control and which impact patient and family care ;
- Overwhelming enthusiasm for a plan to share and celebrate examples of the successes experienced by clients and families;
- Confirmation that the proposed model will bring us closer to helping people and their families be successful in recovery.

As a result of what we heard from MHA teams during the consultation sessions, we have made the following commitments:

- Involvement of patients, clients and their families will continue to be a priority;
- MHA teams will play a critical role in planning and implementing all improvement initiatives; and
- Communication with MHA team members will be regular, clear and designed to engage as many as possible in all aspects of the work ahead.

## C. Provincial, National and International Key Informants

Health sector consultations, presentations, engagement sessions and one-on-one meetings were held to gain expert opinions, build on best practice, and determine opportunities for synergy and collaboration with planning and implementation. These key informants were identified as having made significant contributions to the mental health and addiction sector or health promotion practice in the areas of academic research, clinical practice, community leadership, and government leadership:

- NSHA epidemiologists and data analysts from Primary Care, Public Health and Mental Health and Addictions;
- Department of Psychiatry (NSHA);
- Department of Psychiatry (Dalhousie University);
- Academic leads for the various Specialty Services (e.g. Geriatric, Mood, Personality Disorders, Community Mental Health)
- IWK/NSHA CAPA Leads;
- NSHA Zone Directors and Program Leads; IWK Director and Program Manager(s);
- NSHA/IWK Department Heads for Mental Health and Addictions;
- NSHA Public Health;
- NSHA Primary Care;
- Mental Health Drug Court;
- Provincial Forensic Services;
- Nova Scotia researchers in the mental health field;
- Disabled Persons Commission – Government of Nova Scotia;
- Nova Scotia Department of Health & Wellness – Risk Management – Health Promotion;
- Nova Scotia Department of Health & Wellness – Investment & Decision Support;
- Nova Scotia Fountain of Health;
- Nova Scotia Department of Community Services;
- Dalhousie University – Health & Human Performance;
- Nova Scotia Mental Health Foundation;
- VicHealth (Victoria, Australia);
- Victoria Health, Australia (Public Health & Mental Health Division);
- Smoke Free Nova Scotia and Injury Free Nova Scotia;
- Mental Health Commission of Canada;
- Canadian Centre on Substance Abuse; and
- Nova Scotia Department of Seniors.

# National and Provincial Strategies Alignment and Public Consultations

## A. Mental Health Commission of Canada - Mental Health Strategy: *Changing Directions, Changing Lives*

In the next section of the Milestones Report, reference is made to the work of the Mental Health Commission of Canada (the Commission). Documents such as the 2012 *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, the 2016 *Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)* and the 2015 *Guidelines for Recovery-Oriented Practice: Hope, Dignity, and Inclusion*, were strategically used by the Advisory Committee to connect Nova Scotia's model and action agenda to the national recommendations to bring about the changes needed to improve systems and outcomes for people, their families and our communities.

In 2012, our friends and colleagues at the Commission released Canada's first Mental Health Strategy: *Changing Directions, Changing Lives*<sup>42</sup>. The Commission is an independent, arms-length organization that was established by the federal government in 2007 in response to a key recommendation in the report *Out of the Shadows at Last – Transforming Mental Health, Mental Illness and Addiction in Canada*<sup>43</sup>. This report was a milestone in Canada, as it created greater awareness and accountability that Canada needed a plan to address a system that was not working well.

The Commission's Strategy was developed in two phases. Phase 1 included the development and release of a report in 2009, *Toward Recovery and Well-being: A Framework for a Mental Health Strategy for Canada*. The Framework included a vision and a set of broad goals for the type of mental health system needed in Canada. Phase 2 involved planning, engagement and review of work completed to inform the development of the Strategy.

The goal of the Commission's strategy is to improve mental health and well-being for everyone and to influence the creation of mental health systems that can truly meet the needs of people of all ages living with mental health problems and illnesses, and their families. The Strategy was informed by evidence, extensive consultations and input from thousands of people across the country, including people living with mental health problems and illnesses, families, stakeholder organizations, governments, policy makers and field experts. The scope of *Changing Directions, Changing Lives* is broad and its recommendations are grouped into six key Strategic Directions, with a total of 119 recommendations. Each strategic direction focuses on a critical dimension, and when combined together they provide a comprehensive blueprint for change.

The six strategic directions are as follows:

1. Promote mental health across the lifespan in homes, schools and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
5. Work with First Nations, Inuit and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge and foster collaboration at all levels.

In 2013, the Commission established a Youth Council, with the aim of translating the *Changing Directions, Changing Lives Strategy* into a youth perspective. They used the same six directions from the 2012 strategy, but highlighted the experiences and visions of young people working towards

system change for children and youth. The strategy was released in 2015 and is titled *The Mental Health Strategy for Canada: A Youth Perspective*<sup>44</sup>.

In an effort to mobilize the uptake of the 119 recommendations in the national strategy, the Commission established and released a Framework for Action (2017-2022), *Advancing the Mental Health Strategy for Canada* (the Framework)<sup>45</sup>. The Framework was informed by an extensive engagement process, which resulted in the identification of four key pillars and the prioritization of a number of actions that are likely to have the greatest impact in achieving the Strategy's vision over the next five years. The four key pillars are as follows:

1. Leadership and Funding
2. Promotion and Prevention
3. Access and Services
4. Data and Research

Our Advisory Committee in Nova Scotia decided we would utilize the Framework and the key recommendations outlined in the Commissions' Strategy as the blueprint for our Action Agenda and our related priorities.



North Sydney by Jason Jackson



## B. Nova Scotia's Mental Health and Addictions Strategy – *Together We Can*

In March 2010, Nova Scotia Government announced its commitment to develop Nova Scotia's first Mental Health and Addictions Strategy<sup>46</sup>, *Together We Can* (the Strategy) to improve services and supports for people living with mental health problems and/or addictions.

In the fall of 2010, the Nova Scotia Government appointed an Advisory Committee for the Strategy comprised of representative stakeholders with personal and professional experiences in mental health and addictions. They were given the task of engaging in a consultative process to develop recommendations to help inform the Strategy. The Nova Scotia Health Research Foundation (NSHRF) was engaged to gather the data required for the Advisory Committee's work and to facilitate and oversee the consultative and planning processes.

Over 1,200 Nova Scotians engaged in the consultative process. Participants included health professionals, Mental Health and Addictions clinicians, psychiatrists, individuals who live with mental health problems and/or addictions, others affected by mental health and addictions problems, non-governmental organizations (NGOs), First Nations, African Nova Scotians, Francophone/Acadian communities, former District Health Authorities (DHAs), IWK, allied communities groups, forensic service providers, chiefs of police, and military families. Further, public education and information gathering sessions were held, along with consultations with key experts in the mental health and addictions field. The public also had an opportunity to provide written submissions online or through mail-in questionnaires<sup>47</sup>.

One of the strongest recommendations from the Strategy's Advisory Committee was to invest in the system. Specifically, committee members noted a strong case can be made for investment in mental health and addictions and further actions and recommendations which would subsequently resonate in the provincial strategy would require additional resource investments. They noted the need is particularly evident for preventive measures, health promotion, early intervention and treatment, as this will reduce the overall social and economic costs the province currently bears from untreated and under-treated people who are living with mental health problems and addictions.

The five strategic directions identified in the Strategy are as follows:

1. Intervening and Treating Early For Better Results – With A Strong Focus On Children and Youth
2. Shorter Wait Times, Better Care
3. Aboriginal and Diverse Communities
4. Working Together Differently
5. Reducing Stigma

Each of these five broad strategic directions has specific goal areas, sub-populations, and some proposed initiatives. A key companion report, titled *Summary of the Current State of Mental Health and Addictions Services in Nova Scotia* provided the foundation for the five strategic directions. A one-year update<sup>48</sup> was provided for the Strategy, as well as a Progress Report, in 2016<sup>49</sup>.

Throughout MHA's current health services planning process, the Advisory Committee paid close attention to the earlier work of the Strategy, specifically the themes from the public and stakeholder consultations. Many of the findings in the reports and the public consultations/engagement sessions were still relevant to our current situation. Attention was paid to potential gaps in the previous engagement processes and included stakeholders who did not participate in the 2011-12 engagement process. For example, this was one of the reasons extensive engagement was done with provincial, national and international health promotion experts throughout 2015 and 2016. This approach was used to ensure appropriate opportunities for garnering expert information into the development of the priorities for health promotion, the strategic framework strategies, shorter-term targets, and long-term outcomes.



Blomidon by Bruce Dienes

## C. NSHA's Public Consultations –Talk About Health (Phase 1)

From October 2015 to April 2016, NSHA implemented a public engagement initiative called Talk About Health<sup>50</sup>. This initiative included 42 face-to-face conversations with almost 1,000 people in communities across Nova Scotia. Furthermore, there were over 9,000 visits to the Talk About Health website, and hundreds of Nova Scotians downloaded information, filled out surveys and posted comments. The intention of this initiative was to engage Nova Scotians in a dialogue about population health status and discuss innovative ways to create a healthier future together. Nova Scotia's Community Health Boards, NSHA's Public Engagement Office and many other community partners, stakeholders and leaders collaborated to make these consultations a success. The feedback received from the engagement sessions painted a picture of what Nova Scotians see as the challenges or barriers for achieving good health, as well as highlighted some opportunities to capitalize on to achieve better health outcomes.

The comments gathered from the consultations were grouped into five main themes:

1. Live Well
2. Cooperate, Coordinate and Collaborate
3. Encourage a Healthy Population
4. Build Supportive Systems
5. Build a Healthy Society



The information gathered from the Talk About Health engagement sessions has and will continue to be used to inform the planning for Mental Health and Addictions in Nova Scotia. Of particular relevance to the planning process were conversations about:

- Access challenges (e.g. food/basic needs, transportation, services);
- Social determinants of health/overall living conditions and their influence on positive mental health and recovery outcomes (e.g. poverty, housing, education, employment, literacy levels, stigma and discrimination, culture, race, etc.);
- Community connectedness and individual/community resiliency;
- Importance of healthy and supportive relationships and networks;
- Exposure to risks, harms and injuries related to substance use; and
- Eating well, being active, managing stress, getting enough sleep and other related health practices.

In the Talk About Health summary report, it was noted that Nova Scotians expressed hope and that reaching out to talk about health was a positive first step towards healthier people and a healthier province. Feeling positive, optimistic or hopeful about the future contributes to everyone's health and well-being.

The expression of hope in particular has great significance for Mental Health and Addictions health services planning process, as hope has deep roots within the sector and for people and their families living with mental health disorders and/or experiencing harmful substance use/gambling. Hope, as described in the provincial consultations, is a starting place, and for people and their families living with a mental health disorder and/or experiencing harmful substance use/gambling it's the starting place for recovery. Hope creates optimism that recovery is possible, for everybody.

Phase 2 of Talk About Health is in the planning stages – NSHA's Public Engagement office continues to consult and plan with partners, including Mental Health and Addictions Advisory Committee and the six other health services planning streams.

Hope has many expressions – there is no standardized path of recovery. For some, it means returning to their previous life. For others, the recovery journey represents new beginnings. The specifics of what one hopes for may vary from person to person. But the need to have hope is common to all<sup>51</sup>.

## D. Community Health Board Plans

In Nova Scotia, Community Health Boards (CHBs) are an important link between citizens and our health care systems. CHBs are legislated by the Health Authorities Act, and are mandated to carry out key functions to ensure our health system is responsive to community health needs. Every three years Community Health Boards are expected to develop a community health plan for their communities. This is done by examining information about overall population health status and consulting with people, families, communities and organizations about their views on how to improve the health of individuals and how to create social and physical environments that promote health. This information is used to develop recommendations for Community Health Board Plans. NSHA and IWK consider these plans as the yearly health services business plans are developed.<sup>52</sup>

As part of the health services planning process, members from the Advisory Committee reviewed Community Health Board plans and the recommendations relevant for mental health and addictions system transformation. The following highlights the main themes and priorities identified for Mental Health and Addictions in Nova Scotia from the CHB planning process.

- Information about available supports and services across the province, especially in rural and underserviced areas;
- Mental health promotion, mental wellness and programs and services for those at-risk;
- Access and navigation related to existing resources and services;
- Supports, knowledge, skills for primary care providers; and
- Supports and initiatives that can be community-led and community-involved that address needs and gaps (e.g. stress, social isolation/loneliness, resiliency, stigma etc.).

# Summary of Findings

## A. Highlights of Population Trends in Nova Scotia

In 2013, Nova Scotia had a population of 942,930, a slight increase of 0.4 per cent (from 939,124) in 2009; Nova Scotia represented 2.7 per cent of Canada's total population (35,158,300)<sup>53</sup>. From 2001 to 2011, population growth across Nova Scotia varied by county<sup>54</sup>. Many communities across Nova Scotia face significant material and psychosocial deprivation<sup>54</sup>. Further, Nova Scotia has one of the highest rates of child poverty in Canada<sup>55</sup>.

Nova Scotia has the second oldest population in Canada, and out-migration of youth and younger workers contributes substantially to this trend. Nova Scotia represents one of Canada's most rural provinces, and similar to other Canadian provinces, we are witnessing a shift of population from rural communities to urban communities. Further, from 2010 to 2014, only two counties in Nova Scotia experienced a growth in total population (Halifax and the Hants area). Considering the rural-urban shift as well as the aging trends, Nova Scotia is witnessing an absolute decline in the total population. An aging population and flat population growth rate is not sustainable long-term.

Nova Scotia has low rates of cultural diversity compared to the rest of Canada. Aboriginal people represent 2.7 per cent of the province's total population. Almost 34,000 residents declared Aboriginal identity on the 2011 National Household Survey – First Nation, Métis, or Inuit<sup>56</sup>. According to the 2011 National Household Survey, African Nova Scotians make up the largest racially visible group in Nova Scotia. They represent 44 per cent of the racially visible population, which represents 2.3 per cent of the total Nova Scotian population<sup>57</sup>.

Health and social inequities are prevalent, pervasive and linked to poor mental health and problems with substance use/gambling in Nova Scotia. They tend to disproportionately affect people based on their social position, including educational attainment, occupational status, income, gender, race or ethnicity, and disability. In order to work towards a healthier population in Nova Scotia, we will need to have a stronger focus on inequities related to the social determinants of health to ensure a future where policies, communities, and environments are designed to support all people.

## B. Implications for Adults in Need of Mental Health and Addictions Care and Support

Now is the time to make an investment in care and supports for people and their families living with mental health disorders and/or harmful substance use/gambling – we actually cannot afford to wait any longer! It is well-documented that individual, community, organizational, and societal level costs associated with mental health disorders, and/or harmful substance use/gambling are high. Although the total economic impact is not fully understood in Canada, studies suggest the costs associated with mental health problems amount to approximately \$51 billion per year<sup>58</sup>; substance use costs an additional \$38.9 billion per year<sup>59</sup>. While we know these costs are high, alarmingly, these costs are expected to continue to grow if action is not taken.

There is a need for stronger resource investment to help restore health, well-being and recovery amongst people in need and their families. Further, shoring up resources for those in need helps to minimize societal level impacts; that is, costs associated with healthcare and criminal justice systems, and overall loss of productivity due to premature death and persons ill health.

Nova Scotians report higher rates of depression and anxiety disorders, and lower self-ratings of overall mental health compared to other Canadians<sup>60</sup>. Further, Nova Scotia has higher provincial rates of substance use disorders (especially alcohol, tobacco and cannabis use)<sup>61</sup> and related patterns of use such as heavy drinking<sup>62</sup>. There are high rates of co-occurring disorders and a complex interplay amongst substance use, addiction, mental health problems and physical health<sup>63</sup>. This highlights the need for an integrated mental health and addictions system of supports and care, as well as close collaboration with primary care, emergency services and other health services.

There are many sub-groups in the population with greater vulnerabilities and risks for mental health problems, and/or substance use/gambling related harms. When planning for those in need, attention needs to be paid to gender, age, culture, etc. The relationship between the social determinants of health and achieving positive mental health and recovery outcomes cannot be ignored in Nova Scotia. Efforts should be concentrated, coordinated, and multi-sectoral – a comprehensive response is required, including strategies to address adequate housing, food, transportation, employment, education, income and other social supports.

## C. Implications for Children, Adolescents and their Families in Need of Mental Health and Addictions Care and Support

Depression and anxiety are the most common mental health disorders amongst children and adolescents in Nova Scotia. It is estimated that as many as 12 per cent of children between the ages of four and 17 living in Nova Scotia meet the criteria for a mental health disorder<sup>64</sup>. The use of alcohol and other drugs is also common amongst school-aged children and adolescents<sup>65</sup>. This is a concern for parents, educators, care providers, community members, policy makers and governments, as it has implications for healthy emotional and social development outcomes as people progress from childhood to adulthood in Nova Scotia.

Additional resource investments are needed to enhance the continuum of wellness, treatment, care and community supports for children, adolescents and their families in Nova Scotia. Care, supports and strategies are needed to reduce risks, harms and improve overall quality of life. Intervening as early as possible in a young person's life, when symptoms first emerge, is critical to successful recovery. A key focus must be on building resiliency and attaining the best possible mental health outcomes for children as they grow. The right combination of care, treatment and supports for children and adolescents can be thought of as effective prevention strategies for adults.

Early onset and subsequent trajectory of mental health disorders and/or harmful substance use/gambling among children and adolescents speaks to the need for early identification, intervention and treatment for all children, adolescents and youth in need under age 25. Close engagement and collaboration with primary care providers, pediatricians and other service providers in daycares, family resource settings, and school settings is critical from both a treatment and prevention perspective. For school aged children and their parents/guardians the school environment is a particularly important setting to work within as it creates opportunity to improve student learning, health, well-being and overall achievement.



The close and complex relationship between physical health, mental health and harmful substance use/gambling as people age calls for close collaboration between primary care, pediatrics, and specialists within the mental health and addictions sector. Service planning is also required to facilitate ease in transitions between child service and adult service delivery systems. Attention needs to be paid to the transition years; that is, adolescents in need should be prepared to enter the adult system as they age. Adolescents and their families who disengage from service provision during the transition years are at greater risk for poorer mental health outcomes later in their lives.

## D. MHA System Strengths, Challenges and Opportunities

### System Variation:

We discovered through our environmental scan there are significant differences in the care and supports people who live with mental health disorders and/or harmful substance use/gambling receive in Nova Scotia. This variation exists despite provincial program standards for Mental Health and Addictions, as well as requirements to comply with Accreditation Canada's standards for Mental Health Services. Service variances can be mainly attributed to: the lack of accountability structures; the nine different health organizations/governance structures that previously existed in Nova Scotia (district health authorities); fundamental inconsistencies in priority setting; policy and procedures which have a direct link to inconsistency in operations; and variances in resource allocation across the province. There are some wonderful examples of innovation and best practices in many parts of our MHA system, but, we also found there were some examples of practices and models of service delivery that needed to change, as they were not in keeping with the latest evidence.

Variation was noted in the following areas:

- Models of service delivery (i.e. degree of MHA integration, approach to health promotion practice);
- Degree to which harm reduction is embraced at the policy and practice levels;
- Processes related to referrals, intake, clinical pathways including both in the understanding of and the way in which target populations are identified. This is particularly but not exclusively true for care, treatment and support at the community level (outpatient services);
- Degree of collaboration and capacity within primary health care to support people experiencing mild to moderate mental health and/or substance use/gambling conditions;
- Admitting practices, particularly related to the admission of children and adolescents under the age of 18, to adult mental health units;
- Degree to which recovery oriented practice guidelines, trauma informed practice, and cultural safety approaches to service delivery are understood, and embraced in practice;
- Degree of compliance with the provincial model of care for inpatient withdrawal management;
- Roles and responsibilities of care providers (including psychiatry, clinicians, health promotion specialists), as well as expectations related to qualifications, assessment of competencies, and team functioning;
- Inconsistent implementation and monitoring of provincial initiatives (e.g. CAPA) and health policy; and
- Degree of and approach to stakeholder engagement planning (e.g. patients, families, partner services, communities) in system improvement as well as family involvement in recovery planning.



Caribou Island, Pictou County by Steve Currie

## System Strengths:

The following were some of the strengths observed throughout the health services planning process:

- Our people – the presence of dedicated, experienced and competent care teams and system leaders is core to the success and capability of Mental Health and Addictions in Nova Scotia;
- Collaborative working relationships – the increasing commitment to (and success in) working in inter-professional teams and collaborating more broadly with community partners, and other care/service providers;
- Leadership – the strength and flexibility of managers attributable, at least in part, to the strong leadership in the system; and
- Service delivery – strong examples of innovation and evidence-based care among broad areas of service delivery and specific services across the province. The reach of these examples varied, with some restricted to local communities and others extended across the province. Many MHA services were identified as offering high quality, evidence-based care. We have a lot to build on!



## System Challenges:

Identifying the current and historical challenges within the Mental Health and Addictions system creates an opportunity. The opportunity is for MHA to close the gaps in services and highlight the areas in need of further investment. Strategically implementing change within the system will create a more equitable, high-performing and accessible system for those people and families who need it. Services will be of the highest quality and impactful in terms of achieving positive mental health and recovery outcomes. The following system challenges were identified through our health services planning process:

- Clinical practices, health promotion initiatives and treatment services offered that are not uniformly evidence-based;
- Gaps in the continuum of care, particularly in the areas of health promotion, early intervention, supportive and transitional housing, services for adults with complex intellectual and/or developmental disabilities;
- Highly restricted and inequitable access to Specialty Services and child psychiatry;
- Limitations of capacity related to poor client flow-through, in particular for specialized inpatient units and programs providing opioid agonist therapy province-wide;
- Disconnected and limited information systems, with restrictions to the EMR, compromising patient safety and evidence-based decision-making;
- Inconsistent approach to and resources assigned for training, continuing education, and supervision;
- Challenges related to service accessibility, often relate to stigma and discrimination, especially for children, youth and marginalized groups;
- Lack of coordination within the system, historically resource strapped (under-funded), and unevenly accessible or responsive; and
- While inpatient care is an important part of the MHA continuum and must be accessible when required, there is a tendency for the public to assume the best treatment is treatment provided on an inpatient unit, when in fact, for many people, hospitalization is not helpful and for some, it may actually be harmful.

# Transforming Mental Health and Addictions in Nova Scotia

## A Provincial Model of Positive Mental Health, Care and Support

### TIERED MODEL, STEPPED CARE, AND SYSTEM SUPPORTS

The proposed model for Nova Scotia Mental Health and Addictions program of care and support has two parts. The first part of the model is **stepped care**. It aims to operationalize a service delivery network to ensure access, transitions and engagement in evidence-based care, treatment and supports for people, their families and our communities experiencing mental health disorders and/or harmful substance use/gambling.

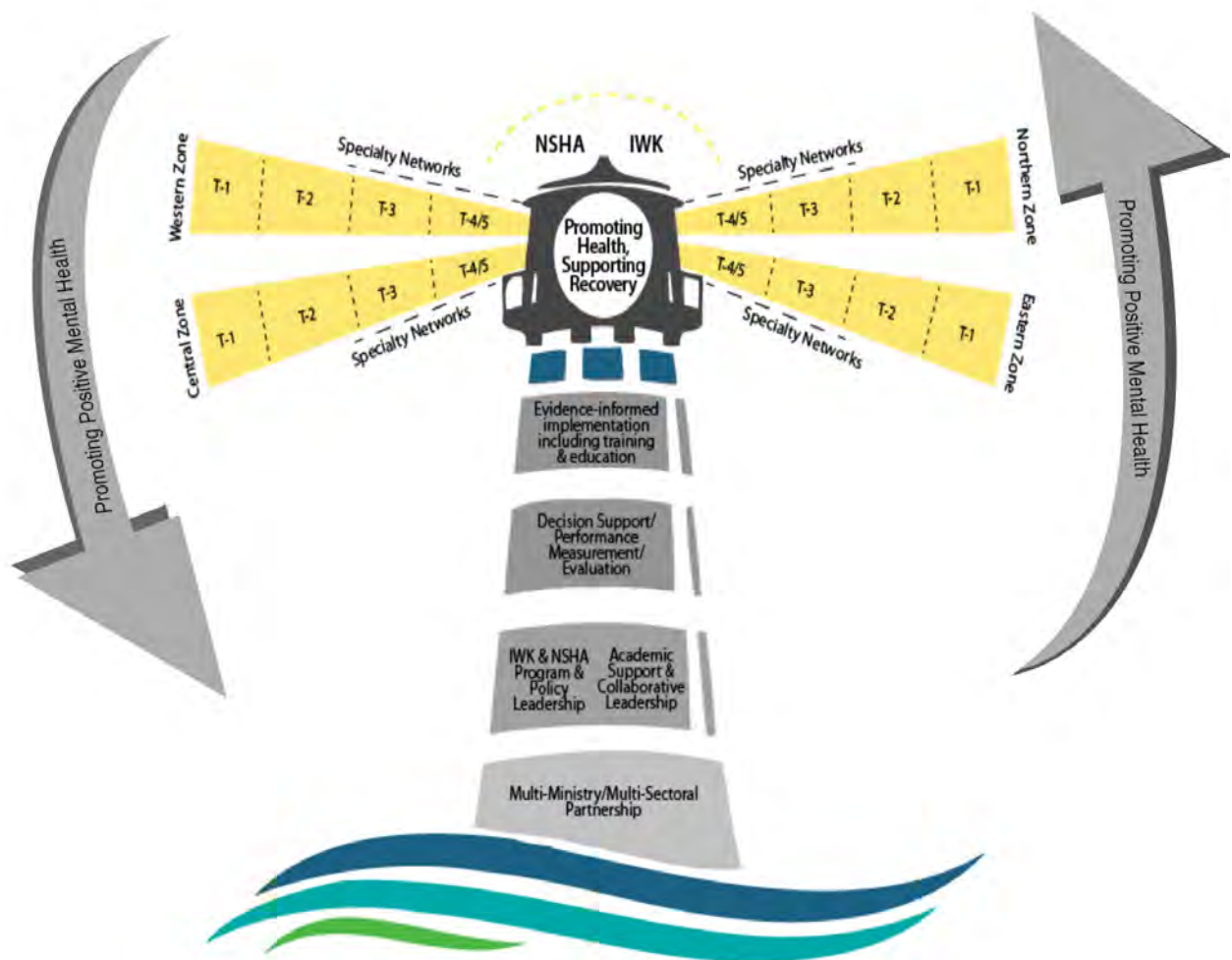
The second part of the model includes the **system supports** necessary for ensuring an efficient, effective, and equitable network of services.

Both components build upon the tiered model of system design discussed earlier and incorporate principles from both population health planning and needs-based planning models. The conceptual model took the shape of a lighthouse, clearly an iconic symbol in Nova Scotia. The components of the model will be discussed in detail on the next few pages.

The statement *Promoting Health and Supporting Recovery* is written in the centre of the model – this represents the mission of the overall system of care and supports for people living with mental health disorders and/or harmful substance use/gambling. NSHA and IWK are depicted together at the top of the model to represent their collective mandate and commitment to working together for the delivery of mental health and addictions services in Nova Scotia. The overall model is wrapped in the words “promoting positive mental health.” This is intended to send the message that health services are one element of our overall strategy; continuous focus on health promotion is needed to improve population mental health outcomes in Nova Scotia.

# Stepped Care:

At the top of the lighthouse there are four rays of light; these represent the systems of care and support within each of the four health service management zones across the province (Eastern Zone, Northern Zone, Central Zone and Western Zone). The model needs to be tailored to the needs, strengths and challenges of each health service management zone, while still maintaining compliance with the provincial model of care and support for MHA. The current service mix in each zone, as well as local context such as rural/urban living and population trends, need to be considered carefully.



Core elements include:

- Tier 1 – Population-based health promotion initiatives/strategies aimed at health improvements among the overall population;
- Tier 2 – Fundamental role of primary health care providers and other potential collaborators such as school and health/service providers in community who are able to support people who are experiencing mild to moderate impairment related to the presence of mental health and/or substance use/gambling problems; and
- Tiers 3-4/5 – Core functions of the formal MHA system in the assessment, care and treatment of people and their families experiencing presence of mental health disorders and/or harmful substance use/gambling; the severity of which results in moderate to severe functional impact on their lives; and whose risk level can be addressed safely at these level(s) of care.

Operationalizing this stepped care approach will result in four interconnected systems of care and support across the province, including the Specialty Services, and the services of IWK. NSHA and Department of Psychiatry at Dalhousie University must work to ensure required Specialty Services are available and connected to each area across the province – this is represented by the dotted line in the model and depicts the requirement to reach out to the rest of the province. Some of the Specialty Services will be connected through a supported network approach that provides consultation appropriate to specific conditions and care pathways. These Specialty Services must also continue to provide training and education, including capacity building within Tier 2.

There is a need to ensure smooth transitions and filters to and from the more intensive services as the needs change of the people requiring care and support. The concept of treatment matching is foundational to the stepped care model. That is, ensuring people's presenting needs are appropriately understood and matched with the right intensity or level of service/care. It is important people and their families are not being over treated or underserved.

## System Supports:

There is recognition that a wide range of system supports are also needed to hold-up and sustain the provision of care and support in the stepped care model. This is represented conceptually by the lower pillar of the lighthouse model and includes:

- Multi-ministry, multi-sectoral partnerships;
- Collaborative program and policy leadership between IWK, NSHA and through the academic mission of Department of Psychiatry, Dalhousie University.
- Strong decision-support, performance measurement and evaluation; and,
- Training and education that includes evidence-based support for scale – up and implementation of evidence-based practices.

## Cross-Cutting Principles for Mental Health and Addictions in Nova Scotia

Mental Health and Addictions in Nova Scotia endorses the following principles in all the work we do:

1. Collaborative leadership (administrative and physician) with NSHA, IWK and academic partners
2. Full continuum of wellness, care, treatment and support across the lifespan for people and their families
3. Promotion of positive mental health for all people, families and communities
4. Actions and decisions informed by research and evidence-based practice
5. Embraces hope, empowerment, responsibility, self-determination and supports the possibility of recovery regardless of diagnosis, situation, or life stage
6. Supports progressive solutions with community and other cross-sectoral partners
7. Inclusion of people and their families with lived experience in service planning, priority setting, and outcome measurement
8. Respects diversity, strengthens responses to address inequities and co-creates culturally safe care
9. Commitment to quality improvement, better use of data and compliance with national standards
10. Champions and seeks opportunities to eliminate stigma and discrimination



# Mental Health and Addictions Action Agenda

## Pillar 1: Mobilizing Leadership and Fostering Collaboration

We are committed to **Mobilizing Leadership and Fostering Collaboration** that supports excellence in service delivery and improved health outcomes for people and their families living with mental health disorders and/or harmful substance use/gambling in Nova Scotia. In keeping with the NSHA's Strategic Plan '*Healthier Together 2016-19*' and IWK's Strategic Plan '*Aspire 2016-2020*', we will ensure the articulated model of co-leadership (administration and physician) is implemented across MHA.

Top priorities for MHA are the integration of our MHA care teams, policy development, and achievement of service and system-wide quality standards for MHA. Strong leadership and capitalizing on strategic opportunities for collaboration with other care and service providers will result in increased system capacity in Nova Scotia to deliver high quality, evidence-based supports, care and initiatives across all five tiers in Nova Scotia. Our MHA system must also focus on achieving parity between physical and mental health care – this requires a commitment to better integration of mental health and physical health, and influencing other sectors to champion mental health and addictions care and support (i.e. health, social, education and justice).

## Pillar 1 Strategic Actions

- 1.1 Continue integrating MHA services across Nova Scotia.
- 1.2 Further cultivate MHA's co-leadership model (administration and physician) in service planning; provision of care and support for people and their families; and developing well-integrated and high-performing teams.
- 1.3 Continue to use needs-based and population health planning models to prioritize and evaluate system improvements.
- 1.4 Enhance collaboration in the delivery of care and supports for people living with mental health disorders and/or harmful substance use/gambling across the continuum and across other service sectors including health, justice, education and community/social services.
- 1.5 Strengthen public knowledge, community engagement and sharing of information to increase awareness of MHA as a provincial program and to improve understanding of its mandate.
- 1.6 Increase collaboration and partnerships with diverse communities such as African Nova Scotians, First Nations people, Acadian Nova Scotians, immigrant communities, LGBT2Q+, to ensure timely and equitable access to a continuum of safe, quality care and supports.



Courtesy of the Town of Antigonish

## Pillar 2: Promoting Positive Mental Health

In order to respond to the needs of Nova Scotians, we are committed to **Promoting Positive Mental Health** which will meet people where they are and influence the socioeconomic, political, and cultural contexts that sustain and perpetuate inequitable conditions. Health promotion practice in MHA focuses on the social determinants of health that influence positive mental health outcomes and health equity, while concentrating on preventing or reducing stigma, risks, harms, and injuries from poor mental health, substance use, and gambling. Our strategic aim is a Nova Scotia where everyone has the opportunity to achieve and maintain mental wellness, communities are free from harms and injuries of substance use and gambling, and people lead flourishing lives free of stigma and discrimination.

## Pillar 2 Strategic Actions

### Cross-cutting action

- 2.1 Adopt the Positive Mental Health Promotion Framework (See Appendix A) and Action Plan as the provincial model for MHA in NS, which includes the following key priority areas:
- Promoting Positive Mental Health and Health Equity;
  - Preventing Inequities, Risks, Injuries and Harms from Alcohol;
  - Preventing Inequities, Risks, Injuries and Harms from Tobacco;
  - Preventing Inequities, Risks, Injuries and Harms from Other Drugs; and
  - Preventing Inequities, Risks, Injuries and Harms from Gambling.

### Building healthy public policy at all levels of government and with our communities

- 2.2 Initiate projects that build equitable healthy public policies and address inequities associated with the social determinants of health that significantly influence mental wellness, substance use and gambling.
- 2.3 Continue to build readiness with decision makers and communities to commit to a population health policy approach to the five key priority areas.
- 2.4 Influence decision makers to consistently apply a health equity lens to decision making related to the five key priority areas.

## **Creating supportive, safer and healthy environments for all Nova Scotians**

- 2.5 Promote positive mental health across the lifespan targeting multiple levels of influence (i.e. individual, family, community and society) in personal, communal, organizational and public policy settings.
- 2.6 Implement initiatives to reduce stigma and discrimination faced by people and their families experiencing mental health disorders and/or harmful substance use/gambling and involve those with lived experience, as appropriate and when possible, in the planning, implementation and evaluation.

## **Strengthening community action to result in social change**

- 2.7 Develop a strategic engagement and public participation plan to increase community capacity (awareness, knowledge and ability to take action).
- 2.8 Establish multi-pronged, comprehensive initiatives to improve population mental health and eliminate or reduce the risks and harms from substance use/gambling.
- 2.9 Work in collaboration with other government departments, services and community organizations to address the multiple and complex needs of people and their families, including those related to safe, affordable, supportive housing as well as employment and education.
- 2.10 Provide resources to support community action (e.g. support local boards and coalitions; support staff in community endeavors).

## **Fostering community and individual resilience**

- 2.11 Foster community and individual resilience by supporting community action on socio-economic and environmental factors that affect individual and community health.
- 2.12 Affirm recovery and wellbeing as foundational principles that drive MHA policies and practices.

### **Re-orienting health services to promote better health and wellness**

- 2.13 Work collaboratively with other parts of the health system to promote positive mental health and reduce health disparities by ensuring equity and fairness of access to community resources and health services that promote positive health and wellbeing.
- 2.14 Ensure MHA policies, programs and services reduce disparities and barriers to services and are responsive to the needs of diverse communities.
- 2.15 Work to build understanding and awareness of mental health disorders, harmful substance use/gambling as a health issues within NSHA and IWK.

### **Investing in population health promotion to enhance quality and accountability**

- 2.16 Provide accountable decision making through the establishment of reporting, monitoring and evaluation processes.
- 2.17 Involve people and their families, living with mental health disorders and/or harmful substance use/gambling, in all initiatives that promote and influence positive mental health.
- 2.18 Align with Accreditation Canada's Population Health and Wellness Standards and Health Promotion Canada's Competencies for Health Promotion.



Eastern Shore by Bruce Dienes

## Pillar 3: Improved Access, Treatment and Coordination

We are committed to **Improving Access, Treatment and Coordination** of mental health and addictions care and support to better meet the needs of individuals and their families. People living with mental health disorders and/or harmful substance use/gambling and their families should have timely access to high quality, evidence-based, integrated, person-centred care and supports across the continuum of care. Special attention is needed to improve transitions across life stages and between services, with the continuum of services anchored in recovery-oriented policies and practices.

### Pillar 3 Strategic Actions

#### Access

- 3.1 Establish a provincial, integrated central intake system that is highly responsive, accessible, seamless, standardized and evidence-based.
- 3.2 Increase access to mental health and addictions care and support within primary care by improving care transitions, coordination and collaboration with primary health care teams.
- 3.3 Improve access to intensive, highly specialized MHA services, treatments and supports across the province by establishing clear pathways to specialized care and building local capacity to provide at least some Specialty Services.
- 3.4 Remove barriers and establish provincial protocols to ensure successful transitions between child and adolescent MHA services and those for adults.
- 3.5 Facilitate successful transitions from intensive, hospital-based services to community MHA services, which includes providing prompt follow-up after discharge from hospital.
- 3.6 Continue to work collaboratively with justice and other key partners to increase the availability and accessibility of programs to divert people living with mental health disorders and/or harmful substance use/gambling from the corrections system, including mental health courts and other services and supports for youth and adults.

### **Shared care and stepped care**

- 3.7 Provide a range of services and supports of differing intensity and complexity to effectively and efficiently respond to the needs of those seeking care and support.
- 3.8 Increase the use of technology and e-mental health solutions to foster collaboration, support, education, increased access to consultative and other services, and engage people and their families.
- 3.9 Reduce inappropriate use of inpatient services by providing timely access to necessary services, treatments and supports in the community.

### **Matching services to address needs**

- 3.10 Improve the meaningful involvement of clients/patients and families in clinical decision making as well as in planning and evaluating initiatives designed to improve MHA.
- 3.11 Continue implementation and evaluation of the Choice and Partnership Approach (CAPA) model to achieve consistent and coordinated care and supports for children, adolescents and their families across NS.
- 3.12 Review the feasibility of service improvement models for adults and their families to improve access, resource efficiency, treatment matching and care pathways — in keeping with core elements of stepped care and CAPA.



Truro by Steve Currie

### **Quality, safe and evidence-based care**

- 3.13 Expand the range of harm reduction initiatives, policies and practices that prevent and reduce health, social and fiscal impacts of harmful drug use.
- 3.14 Strengthen the culture of recovery-oriented practice within MHA and with other care/service providers, building on the belief that recovery is possible.
- 3.15 Work in partnership with diverse communities to improve availability of quality, culturally competent, safe services for Nova Scotia's diverse populations and communities.
- 3.16 In partnership with the Emergency Program of Care and First Responder organizations improve competencies of providers related to mental health disorders and/or harmful substance use/gambling.
- 3.17 Continue to integrate trauma-informed approaches into service delivery to create safety and trustworthiness through our health practices, our physical and emotional environments and social interactions with clients, families, and communities.
- 3.18 Continue to monitor and evaluate compliance with the provincial model of care for inpatient withdrawal management services for all units providing withdrawal management.
- 3.19 Continue to expand, monitor and evaluate community-based withdrawal management models for people who are in need of withdrawal management but do not require inpatient care.



Pictou by Steve Currie



## Pillar 4: Advancing Provincial System Supports

We are committed to a culture of **Accountability, Leadership, Quality and Safety** that promotes learning, evidence-based practice, research and continuous service improvement across the continuum. Data and reports will be used to support decisions, promote transparency and embed accountability across the system. A focus on education, clinical competencies and workforce development will provide a strong foundation for our work.

### Pillar 4 Strategic Actions

#### Quality, research and evaluation

- 4.1 Strengthen MHA quality and safety infrastructure and processes - implement a consistent program-wide framework.
- 4.2 Establish a provincial approach to evidence-based policy development, implementation and evaluation.
- 4.3 Improve routine data collection, analysis, and reporting for MHA.
- 4.4 Develop a provincial evaluation framework which includes targets, milestones and key performance indicators for transforming MHA in NS.
- 4.5 A renewed investment in MHA workforce development strategy to ensure training and competency development is evidence-based, coordinated, in keeping with strategic priorities and addresses the needs of Nova Scotians.
- 4.6 Establish research priorities based on MHA's plan and strategic priorities and promote internal and external research within these areas.
- 4.7 Continue to build relationships and partnerships with the research community to strengthen MHA infrastructure to improve scientific research and knowledge exchange.
- 4.8 Increase involvement of people and their families living with mental health disorders and/or harmful substance use/gambling in accreditation, priority setting, system planning monitoring, and advisory bodies in the MHA system.

# Project Milestones and Dates

## HEALTH SERVICES PLANNING

### SUMMER 15

**June 2015** – Project Management Team (PM) identified; Initial Meeting of MHA's health service planning Advisory Committee.

**July 2015** – Change Management Planning begins with NSHA's Project Management Office (PMO); Draft PM documents: Project Plan, Project Charter, and Stakeholder Registry.

**Aug 2015** – Geographical framework identified and reviewed with seven work streams.

### WINTER 15/16

**Dec 2015** – First engagement session of MHA Leadership Team facilitated by Project Consultant.

**Jan 2016** – Formation of MHA's Health Promotion (HPRO) Planning Team for HSP Project.

**Jan/Feb/Mar/April 2016** – Engagement sessions with MHA Leadership Team, MHA Program Leaders, Psychiatry Group (s), and other key stakeholders.

**Feb 2016** – Integration opportunities identified with all seven work streams.

### SUMMER 16

**May/June 2016** – MHA engagement by way of Town Halls, site visits and stakeholder consultations in NSHA's four zones and IWK; Series of meetings with Primary Care, Emergency Program of Care, Public Health etc. re planning process.

**July 2016** – Siting and sizing criteria established by the PMO and distributed to the seven work streams for planning process; NS evidence-based review for tobacco complete.

**July 2016** – Final meeting (10 in total) of the HPRO Team.

**July/August 2016** – PowerPoint slide deck used in Town Halls shared with MHA teams.

### WINTER/SPRING 2017

**Dec 2016/Jan/Feb/March 2017** – Review, discussion, and prioritization of recommendations by MHA's Advisory Committee.

**Jan/Feb/March 2017** – Development of MHA's health services planning internal engagement approach.

**June 2017** – MHA internal engagement sessions across Nova Scotia.

### FALL 15

**Sept/Oct 2015** – MHA's Project Plan and Project Charter submitted to the PMO for review; Presentation of MHA's project to NSHA's Executive Leadership Team (ELT).

**Nov 2015** – NSHA's PMO Office commence biweekly meetings with the leadership of the seven work streams.

**Nov/Dec 2015** – Formal engagement of MHA's HSP Project Consultants: Dr. Brian Rush (clinical component) and Dr. Paula Hutchinson (health promotion component).

### SPRING 16

**Mar 2016** – Partnership with Smoke Free Nova Scotia and NSHA to complete evidence-based review for tobacco.

**April 2016** – Information Management/Information Technology (IM/IT) resources identified for each of the seven work streams; Begin working on IM/IT implications.

**April/May/June 2016** – Data group created to inform MHA's health services planning process.

**April/May 2016** – Presentation on MHA's milestones/ progress to date to NSHA's HSP Leadership Committee and MHA's Advisory Committee.

### FALL 16

**Oct 2016** – Health Promotion report submitted by Sam Hodder and Dr. Hutchinson for review by MHA's HSP Advisory Committee; Final report (s) submitted by Dr. Brian Rush for review by MHA's Advisory Committee; Summary/key findings to date of MHA's planning process presented by Dr. Linda Courey to NSHA's ELT and MHA's Leadership Team.

**Nov 2016** – Summary/key findings to date of MHA's planning process presented by Dr. Linda Courey to Maternal Newborn HSP Committee, HSP Committee of the Board, Patient Family and Public Advisory Council.

### FALL 2017

**Sept/Oct 2017** – Internal/External engagement sessions across Nova Scotia; Prioritization of strategic actions; Development of clear objectives, timelines, leads and project resources; Establish processes for regular reporting on progress.

# Appendix A:

## Promoting Positive Mental Health Action Plan

### STRATEGIC AIM

A Nova Scotia where everyone has the opportunity to achieve and maintain mental wellness, communities are free from harms and injuries of substance use and gambling, and people lead flourishing lives free of stigma and discrimination.

#### WHO WE ARE

Involve  
Influence  
Innovate  
Integrate

#### INVOLVE & INFLUENCE AT FOUR LEVELS

Individual  
Family  
Community  
Society



Personal  
Communal  
Organizational  
Public Policy

#### INNOVATE & INTEGRATE IN MULTIPLE SETTINGS



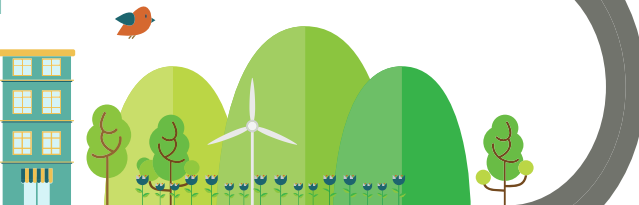
#### WHAT WE DO

Foster Community and Individual Resilience  
Strengthen Community Action  
Create Supportive Environments  
Re-orient Health Services  
Building Equitable Public Policy  
Decision-Making Through Evaluation and Research



#### HOW WE DO IT

Community Engagement  
Evidence Informed Knowledge Translation (KT)  
Cross-Sectoral Collaborations  
Equitable Healthy Public Policy Development  
Accountability & Evaluation



### PRIORITY ISSUES

- Promoting Positive Mental Health and Health Equity
- Preventing Inequities, Risks, Injuries, and Harms from Alcohol
- Preventing Inequities, Risks, Injuries, and Harms from Tobacco
- Preventing Inequities, Risks, Injuries, and Harms from Other Drugs
- Preventing Inequities, Risks, Injuries, and Harms from Gambling

# Endnotes

- 1 Mental Health Commission of Canada. (2015). Guidelines for Recovery-Oriented Practice. Retrieved from: [http://www.mentalhealthcommission.ca/sites/default/files/MHCC\\_RecoveryGuidelines\\_ENG\\_0.pdf](http://www.mentalhealthcommission.ca/sites/default/files/MHCC_RecoveryGuidelines_ENG_0.pdf)
- 2 Mental Health Promotion. (2014). Retrieved from <http://www.phac-aspc.gc.ca/mh-sm/mhp-psm/index-eng.php>
- 3 Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., & Silove, D. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013. *International Journal of Epidemiology*, 43(2), 476–493. <http://doi.org/10.1093/ije/dyu038>
- 4 Statistics Canada. (2013). Canadian Tobacco Alcohol and Drugs Survey. Ottawa, ON. Retrieved from: <https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2013-summary.html>
- 5 Mental Health Commission of Canada. (2010). Making the Case for Investing in Mental Health in Canada. Retrieved from: <http://www.mentalhealthcommission.ca/sites/default/files/2017-03/Making%20the%20Case%20for%20Investing%20in%20Mental%20Health%20in%20Canada.pdf>
- 6 Statistics Canada. (2012). Canadian Community Health Survey: Mental Health. Ottawa, ON. Retrieved from: <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5015#a2>
- 7 Nova Scotia Department of Health and Wellness. (2016). 2013 Nova Scotia Adult Gambling Information Collection Project. Retrieved from: <http://novascotia.ca/dhw/publications/Adult-Gambling-Information-Collection-Project-2013.pdf>.
- 8 Kessler R, Berglund P, Demler O, Jin R, Merikangas K, Walters E (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*, 62, 593-602.
- 9 World Health Organization. (2001) Mental disorders affect one in four people. Retrieved from: [http://www.who.int/whr/2001/media\\_centre/press\\_release/en/](http://www.who.int/whr/2001/media_centre/press_release/en/).
- 10 Nova Scotia Department of Health and Wellness. (2012). System Level Standards for Concurrent Disorders. Retrieved from: <https://novascotia.ca/dhw/addictions/documents/System-Level-Standards-for-Concurrent-Disorders.pdf>
- 11 IWK Health Centre is one of the two health authorities in Nova Scotia. Located in Halifax N.S., the IWK provides services and a research agenda for women, children, youth and families.
- 12 Nova Scotia Health Authority Business Plan. (2015) Retrieved from: [http://www.nshealth.ca/sites/nshealth.ca/files/2015-16\\_nsha\\_business\\_plan\\_-\\_master\\_final\\_2015-06-03.pdf](http://www.nshealth.ca/sites/nshealth.ca/files/2015-16_nsha_business_plan_-_master_final_2015-06-03.pdf)
- 13 Health Service Planning. (2017) Retrieved from: <http://www.nshealth.ca/about-us/plans-and-reports/health-services-planning>
- 14 Nova Scotia Health Authority Strategic Plan. (2016). Retrieved from: <http://www.nshealth.ca/publications/strategic-plan>
- 15 IWK Strategic Plan. (2016). Retrieved from: <http://www.iwk.nshealth.ca/sites/default/files/iwk-strategic-plan-2016.pdf>
- 16 Public Health Agency of Canada. (2011). What Determines Health? Retrieved from: <http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php>
- 17 Canadian Centre on Substance Abuse. (2008). A Systems Approach to Substance Use in Canada. Retrieved from: <http://www.ccsa.ca/Resource%20Library/nts-systems-approach-substance-abuse-canada-2008-en.pdf>
- 18 Victorian Healthcare Association. (2016). Population Health. Retrieved from: <http://www.vha.org.au/policy-publications/population-health>
- 19 The application of the Needs-Based Planning model was modified to reflect Nova Scotia's integrated system of mental health and addictions care. The NBP model was organically developed to plan for substance use services and supports in Canada.
- 20 Strang, J., Babor, T., Caulkins, J., Fischer, B., Foxcroft, D., & Humphreys, K. (2012). Drug policy and the public good: evidence for effective interventions. *The Lancet*, 379(9810), 71-83.
- 21 Statistics Canada. (2011). Census of Canada. Ottawa, ON. Retrieved from: <http://www12.statcan.ca/census-recensement/2011/rt-td/rt-td-eng.cfm>
- 22 Statistics Canada. (2011). National Household Survey Profile, Nova Scotia, 2011. Ottawa, ON. Retrieved from: <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/page.cfm?Lang=E&Geo1=PR&Code1=12&Data=Count&SearchText=nova%20scotia&SearchType=Begin&SearchPR=01&A1=All&B1=All&Custom=&TABID=1>

- 23 Statistics Canada. (2014). Public Use Micro data File 2011/2012. Canadian Community Health Survey - Annual Component. Ottawa, ON. Retrieved from: <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3226>
- 24 Statistics Canada. (2016). Mental Health, Public Use Micro data File 2012. Canadian Community Health Survey - Annual Component. Ottawa, ON. Retrieved from: <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5015#a2>
- 25 Health Canada. (2013). Canadian Tobacco Alcohol and Drugs Survey. Retrieved from: <https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2013-summary.html>
- 26 Nova Scotia Department of Health and Wellness. (2013). 2012 Nova Scotia Student Drug Use Survey. Retrieved from: <http://0-nsleg-edeposit.gov.ns.ca.legcat.gov.ns.ca/deposit/b10659444.pdf>
- Milestones on Our Journey
- 27 Ashbridge, M, Pauley, C., Langille, D., Kisely, S., & Whipp, A. (2011). Mental Health and Addictions Epidemiological and Demographic Analysis. Dalhousie University, Department of Community Health and Epidemiology.
- 28 Statistics Canada. (2013). Canadian Survey on Disability. Retrieved from: <http://www.statcan.gc.ca/daily-quotidien/131203/dq131203a-eng.htm>
- 29 Union of Nova Scotia Indians. (2013). The Health of the Nova Scotia Mi'kmaq Population: Results of the Regional Health Survey for the On-Reserve Population 2008-2010.
- 30 Statistics Canada. (2007) Participation and Activity Limitation Survey 2006: Tables. Retrieved from: <http://www.statcan.gc.ca/pub/89-628-x/89-628-x2010015-eng.htm>
- 31 Nova Scotia Department of Health and Wellness. (2016). 2013 Nova Scotia Adult Gambling Information Collection Project. Retrieved from: <http://novascotia.ca/dhw/publications/Adult-Gambling-Information-Collection-Project-2013.pdf>.
- 32 Health Canada. (2013). Supplementary Tables, Youth Smoking Survey 2012-2013. Retrieved from: <https://www.canada.ca/en/health-canada/services/publications/healthy-living/youth-smoking-survey-2012-2013-supplementary-tables.html?wbdisable=true>
- 33 Nova Scotia Department of Health and Wellness (2016). 2011 Nova Scotia Adolescent Gambling Surveillance - Technical Report. Retrieved from: <https://novascotia.ca/dhw/publications/Adolescent-Gambling-Surveillance-Technical-Report.pdf>
- 34 Tier 4 and 5 combined as not all in-need populations represented in the survey data (homeless, incarcerated, people in hospital, First Nations, etc.)
- 35 The Choice and Partnership Approach (CAPA). (2016). Retrieved from: <http://capa.co.uk/>
- 36 Waddell, C., Shepherd, C., Schwartz, C., & Barican, J. (2014). Child and youth mental disorders: Prevalence and evidence-based interventions. Children's Health Policy Centre, Simon Fraser University, British Columbia.
- 37 The CAN-ADAPPT guideline was based on the evidence and recommendations contained in existing international guidelines (2002-2009)
- 38 Patient flow can be best described as an individual's movement through the health care continuum.
- 39 Christensen H., Griffiths K.M., Evans K. (2002). e-Mental Health in Australia: Implications of the Internet and Related Technologies for Policy. ISC Discussion Paper No 3.
- 40 System Functions: Early Identification and Intervention; Provision of Information, Engagement and Linkage Supports, Outreach; Problem Identification, Assessment of Strengths and Needs, and Individualized Treatment and Support Planning; Delivery of Mental health and Substance Use Specific and Biopsychosocial Interventions and Supports; Continuing Care/ Recovery Monitoring; Delivery of Substance Use, Specific and Highly Integrated Psychosocial, Medical and Psychiatric Interventions and Supports; Prevention and Health Promotion (including addressing stigma and discrimination); Harm Reduction
- 41 System Features – Policy, Leadership; Funding; Performance measurement and accountability; Information management; Research and knowledge exchange
- 42 Mental Health Commission of Canada. (2012). CHANGING DIRECTIONS, CHANGING LIVES: The Mental Health Strategy for Canada. Retrieved from: <http://strategy.mentalhealthcommission.ca/pdf/strategy-summary-en.pdf>
- 43 The Standing Senate Committee on Social Affairs, Science and Technology (2006). OUT OF THE SHADOWS AT LAST: Transforming Mental Health, Mental Illness and Addiction Services in Canada. Retrieved from: [http://www.mentalhealthcommission.ca/sites/default/files/out\\_of\\_the\\_shadows\\_at\\_last\\_-\\_full\\_0\\_0.pdf](http://www.mentalhealthcommission.ca/sites/default/files/out_of_the_shadows_at_last_-_full_0_0.pdf)

