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DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

Roundtable with Health Leaders

Mental Health and Substance Use Care in Canada

July 2023

Purpose of the Note

The MacEachen Institute for Public Policy and Governance (MIPP) and Dalhousie University Faculty of Medicine hosted a roundtable on June 9, 2023 with invited participants immediately following the closing ceremony of the Fear Memorial Conference on Catalyzing Health Systems Change. The MIPP serves as a forum for vibrant public policy discussion and analysis. The Faculty of Medicine has a strategic goal to catalyze systems change to improve health outcomes.

This roundtable session was an opportunity for system partners and academics to discuss goals for and challenges with mental health and substance use care in Nova Scotia. The 20 participants included professionals in the fields of public health, family medicine, social work, psychiatry and psychology, and government officials.

The roundtable was facilitated by Dr. Lara Hazelton. She is a professor and Director of Education in the Dalhousie Department of Psychiatry and practices community psychiatry at the Cobequid Community Health Centre. A note-taker, Kaitlynne Lowe, summarized the discussion and produced this briefing note.

Facilitator

Lara Hazelton, MD, FRCPC. Professor and Director of Education, Dalhousie Dept. of Psychiatry, and Attending Physician, Cobequid Community Health Centre

Author and Notetaker

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Selected Observations and Key Messages

- There are many cultural barriers to accessing mental health and addictions care. Social and structural determinants of health are important to understand and address.
- Helping patients reach the appropriate level of service is important. We need to use our healthcare professionals better.
- We need to understand how people access the mental health system. There is a difference between help-seeking and need.
- While working to improve clinical settings is important, we also need to de-professionalize mental health care and expand community services. We also need to move away from a focus on illness to focus on health. There needs to be a shift in culture to give people the tools and power to help each other. We should look to factors that make communities resilient.
- Some people can be treated at different points of care rather than by specialists. More services for the "working unwell" are needed and more can be done to integrate mental health into primary care.
- Some patients need more specialized care but are unable to access those services. How do we help the people with the greatest need and the least access?
- Equity-deserving populations have specific needs.
- Trauma-informed and harm-reduction practices are vital.
- Most psychological services are privately funded; they could be more accessible.
- Stigma towards mental health and substance use is often treated as an issue external to the health care system rather than an ongoing challenge in the system. Attitudes within and outside the system need to change.
- Mental health and addictions care needs an "all hands on deck" approach. Circumstances are currently dictating response, but we need to be more agile and creative.

What We Discussed

Conversations and social perceptions about mental health, addictions, and resilience have changed over the past 20 years, as evidenced by the increased media coverage about mental health impacts during COVID-19 and the Opioid Crisis. Human suffering is human suffering regardless of the cause and everyone deserves support. There are many challenges people face, such as finances, family dynamics, and everything in between. Lack of access to affordable housing is a key issue. Communities have often been a source of connection and resiliency, but their role has changed over the years.

There are three levels of health care: acute care, population health, and the social determinants of health. Efforts are underway to move past the disease care model (i.e., disease management) in mental health and addictions care and look more to the pursuit of meaning. Meaning and values are key factors in addition to pathology. We should examine how we talk about happiness in the context of mental health and substance use care. It is important to ask people what they want and what really matters to them, then provide access to relevant resources. The sense of belonging is also a key factor. There is a difference between normalizing the processing of typical human emotions and the agenda to increase wellbeing and resilience for those suffering with mental health and addictions issues. More health care professions need to be integrated into these discussions, however there are clinician concerns about losing their autonomy when working in teams.

We need to do more to have Indigenous voices in health care, but specifically in mental health and substance use care. There needs to be a two-eyed seeing approach to build in ways of knowing and living. Two-eyed seeing refers to "learning to see from one eye with the strengths of Indigenous ways of knowing and from the other eye with the strengths of Western ways of knowing and to using both of these eyes together" (Bartlett C., Marshall M., Marshall A. 2012). Trust is key and takes time to establish. Work has been done to revitalize land- based healing and ceremony practices. Many people only use services in their communities and these services must be culturally responsive. Changing the assessment system to be culturally safe is vital. Interdisciplinary teams are needed. Patients should not necessarily have to ask to receive services; they should be offered them when necessary (e.g., child welfare). Co-creation of programs is important, especially when working with Indigenous, equity-deserving, and rural communities.

A more concerted effort toward a shared care model is necessary, including looking to co-location, care pathways, hiring needs, mapping the continuum of care, ensuring professionals are working to the full scope of their practice, and using mental health and addictions leaders as consultants to primary care. Many people with issues are seen by family doctors because they cannot access other services. Family physicians have limited capacity to manage this, including the necessary time and resources to support each patient. Having dedicated psychological resources in health care clinics can provide support.

Privately funded mental health care adds complexity. It is important to have psychological lenses in health care settings, as it makes a difference in care. The public should be given access to private health care settings, but there are challenges with over-medicalizing cases, treating cases as sociological, as well as tensions for the private system about moving towards more public service delivery. There are different models to enable access to the private mental health care system (e.g., offering 3 free sessions), but more should be done to ensure the most vulnerable have access to resources.

Challenges and tensions also arise in public health and mental health care. Fifteen years ago in New Brunswick, some top concerns about health were mental health, diabetes, and respiratory therapy. A psychologist was hired and shared among six communities. A main challenge to overcome was geographic narcissism, meaning specific communities believe they are more important than others and compete for resources.

Childhood trauma and adverse childhood events have significant impacts on physical and mental health. A focus should be to improve screening for these experiences in clinical environments and population health surveillance. How do we ensure trauma-informed care? There currently is an overuse of buzzwords for "trauma-informed care" but no true change in many clinical settings; however, work to advance these practices in education has been ongoing. At the same time, more needs to be done to understand harm reduction and its role.

Nova Scotia has successful programs in place to observe. For example, the Best Start program that works with families who have children under 3 years old and need support was highlighted as a possible model on which to expand. Health care at home is another example of a program currently underway in Nova Scotia. It establishes collaborative practice teams and interdisciplinary health clinics in communities.

We need to ensure there are resources to support complex cases while balancing resources to treat more general cases (e.g., anxiety). Trauma-informed and harm-reduction approaches are also important. Some cases can be hard to diagnose. There needs to be a balance of wellness, access, and supports for severe mental illness. Resources need to be appropriately allocated to treat causes like anxiety, as well as more complex cases (e.g., psychosis). There are times when specialization is needed in physical and mental health. Currently, physical and mental health are treated separately, but a holistic model is necessary. Other departments and fields need to be involved in mental health care; we cannot only rely on social workers and psychiatrists. We do not have enough of these professionals in Nova Scotia to meet demand. Virtual care and resources (e.g., Tranquility, online Cognitive Behavioural Therapy tool) has created some possibilities but often does not reach the most vulnerable. We can look to other jurisdictions to identify what is working for them to modify and apply here.

We need to look at new ways to achieve positive mental health outcomes. The current focus is Psychiatry. There is also a focus on prescription-based interventions when we should also look to other interventions. Some professionals are using social prescriptions (e.g., time in nature) as interventions. While social prescribing for a healthy lifestyle and stress reduction can be a preventative measure, there is a caution about the individualization of this approach and turning various ways of being into prescriptions. Lifestyle, built environments, and how our communities are designed (e.g., active transportation access) are important factors and often can work against a healthy lifestyle. Legalization of cannabis also has implications for mental health and substance use care.

Prevention needs to be more of a focus in mental health and substance use care. Prevention areas for mental health care include cannabis, equitable access to nature, and more advocacy work to reduce root causes. Health care professionals should look to ways to prevent and reduce potential harm.

Youth are talking about mental health more. Although there are benefits to this, there is also a tendency to pathologize experience and seek validation through the health care system. The responses to help-seeking people tend to define public perceptions of the mental health care system. When individuals do not meet criteria for treatments, they think the system isn't meeting their needs.

Decision-makers need to move away from the philosophy that initiatives will save money. Some initiatives may save money for the system in the long-term and be good value for money, but we need to move beyond merely framing the discussion as one of efficiency and cost-savings when in fact we should have been spending more on these areas all along. Decision-makers also need to get more comfortable with stopping programs that aren't working. Some solutions have unintended consequences; it is important to identify who is impacted by these decisions and mitigate impacts. There are tensions with the political sphere, between the needs of patients and communities and the needs of elected officials (e.g., immediate and measurable results).

Method

We invited leaders and decision-makers from the public health, healthcare systems, policy, as well as leaders in mental health and substance use care in Nova Scotia. The discussion took place in-person over two sessions on June 9, 2023, each one hour long with approximately 20 total participants between the two sessions. The majority of participants selected their top two choices of three possible roundtable topics and were assigned to those roundtables accordingly. Some participants were assigned to roundtables based on availability of seats and their expertise.

This note does not attribute comments to individuals during the discussion; it merely summarizes the comments. Participants shared their observations and experiences; we did not confirm the accuracy of their comments.

Participants were asked to discuss the following questions and encouraged to speak freely during discussion:

- What are the medium-term goals (3–5 years) we are trying to achieve?
- What near-term steps must be taken to set us in the right direction? What untapped opportunities exist? What barriers prevent us from achieving our goals and how do we overcome them?
- What research do we need that we don't yet have access to? How do we access this information?
- What behaviours do we have to motivate in the profession to achieve these changes? How do we motivate these changes?
- What behaviours do we have to motivate in the public to achieve these changes? How do we motivate these changes?
- If we were to reconvene in a year's time, how would we know that we are headed in the right direction?

About the MacEachen Institute

The MacEachen Institute for Public Policy and Governance at Dalhousie University is a nationally focused, non-partisan, interdisciplinary institute designed to support the development of progressive public policy and to encourage greater citizen engagement. Constance MacIntosh, of the MacEachen Institute, was a co-organizer of this event.

Contact

For more information, contact mipp@dal.ca

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The Institute is working to create resources and policy discussions. These include briefing notes as well as panel discussions, videos, and media commentary. You can find our research and resources on our website.

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