All Party Committee on Mental Health, Substance Use, and Addictions
Meeting Minutes

Date: October 28, 2024

Time: 9:30 a.m. – 4:00 p.m.

Attendees:
Committee Members: John Abbott, Perry Trimper, Sherry Gambin-Walsh, Joedy Wall, Jim McKenna, Jordan Brown, Lucy Stoyles

Officials: John McGrath, Gillian Sweeney, Niki Legge, Tara Power, David Coffin, Bradley George

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1. Presentation # 1 – Michel Rodrigue, President and CEO of Mental Health Commission of Canada (MHCC), with Colton Profitt

   Michel provided an introduction and noted that he was generally impressed with the Province's common sense approach to addressing mental health and substance use; leveraging the knowledge and expertise from other provinces; and making collective efforts to come together. He lauded the Province's efforts to evaluate Towards Recovery.

   Key successes for the Province since Towards Recovery include:
   - implementation of the Stepped-Care Model;
   - meaningful engagement and co-design with individuals with lived and living experience and expertise into the development of mental health and substance use health programming;
   - implementation of additional ACT and FACT teams to support community treatment, treatment where and when people need it (e.g. through Doorways' services), and
   - involvement of families (e.g., Mental Health and Addictions Advisory Council, Provincial Recovery Council on Mental Health and Addictions, LifeWise).

   Areas of improvement/gaps included:
   - dealing with mental health stigma as this remains a barrier as people may not be seeking help because of the fear of being labelled;
   - Intersectional and intergovernmental collaboration was also identified as an area for improvement (e.g., need to work across departments and address key areas such as housing, food security, agriculture, economic development, and immigration).

   Recommendations to the Committee:
   - Consider investment in additional ways of accessing mental health services, such as through e-mental health services (e.g., via web/mobile based apps). There was a recognition that digital services may not be for everyone, however, and there will still be a need for physical services; the key is that there is direct care available that is time sensitive.

    - 73 per cent said e-mental health had helped in a moment that resulted in crisis; and
    - 63 per cent said they would not have sought care if there was no e-mental health option.
- Building on existing successful efforts to reduce stigma, consider opportunities to address structural stigma in healthcare. The Commission advised it is available to support NL in reducing stigma. There needs to be investments in mental health literacy programs in schools, post-secondary settings and workplaces.

Also noted: People are affected by fires, floods, issues happening around the province; with the risk of Post Traumatic Stress Disorder (feelings of frustration that need to be acknowledged). It is therefore important to also focus on individuals' physical safety and security.

Further discussion on the Alberta Model of Care

- Adopted a recovery-oriented approach; everyone has a right to live in recovery;
- Some practitioners feel that recovery cannot exist with consumption; and
- Treatment needs to be evidence-informed based upon best practices and research and in consideration of individual's rights and use of safeguards. There needs to be legal requirements/structure/safeguards in place to protect rights.

2. Presentation – Chris Kamel, Director, Canada's Drug Agency, with Sudha Kutty, Executive VP

Chris provided an overview of the work that Canada's Drug Agency (CDA-AMC) does: deliver evidence, advice and recommendations through their core business of conducting health technology assessments (HTA) on (1) pharmaceuticals, (2) medical devices, and (3) clinical interventions.

CDA-AMC reviewed the literature and summarized information related to the ethics considerations, clinical effectiveness, and patient perspectives and experiences on involuntary withdrawal management in secure settings:

- Literature published in the past 11 years (Jan 2013 to May 2024);
- Focused on the health care context (i.e., not punitive or criminal context); and
- No restrictions based on age or other demographics information.

CDA-AMC did not:

- Conduct any direct engagement with Indigenous peoples or people who use drugs or their caregivers; or
- Make a recommendation for or against implementing involuntary treatment.

Ethical Considerations

- The review of ethical considerations identified twelve publications.
- Key themes:
    - The role of individual autonomy;

    - The harms and benefits of these programs understood in broad social context;
    - The resulting potential for loss of trust in caregivers, providers, and health systems; and
    - inequitable impacts.
- Structurally marginalized and equity-deserving groups experience the worst outcomes.
- Those most at risk of experiencing harm are likely to include Indigenous youth, racialized youth, 2SLGBTQ+ youth, and those with a history of involvement with the child welfare system.

Clinical Effectiveness

- Two studies identified reporting clinical outcomes (opioid overdose death and relapse rates).
- Methodological concerns:
    - Risk of bias – there were concerns identified with the methodology and there was a risk of bias because a study was observational in nature;
    - One study did not describe demographic information, the other predominately enrolled white males; and
    - Neither study was focused on subgroups of interest such as children, adolescents, or equity-deserving groups.
- Overall, these studies suggested that involuntary secure withdrawal management is unlikely to provide meaningful, long-term clinical benefit (e.g., risks of drug poisoning death or relapse).

Patient Perspectives

- The review of patient perspectives identified 2 studies describing the perspectives of adults who use drugs and one study described the perspectives of parents of children who use substances.
- Key concepts:
    - Importance of recognizing agency, autonomy, and competencies;
    - Assuming diminished capacity can undermine autonomy and self-determination;
    - Involuntary measures used as coercive tools rather than ‘last resort’ can undermine trust in caregivers and institutions; and
    - Acknowledgement of broader factors influencing substance use enables development of more tailored interventions.
- Parents described involuntary withdrawal management as a last-resort, life-preserving option providing temporary relief. They also recognized that there is an absence of clear evidence demonstrating successful achievement of long-term goals.

Indigenous Perspectives

- The literature review on Indigenous perspectives highlighted that Indigenous Peoples may also be subject to involuntary withdrawal management in Canada.

- Indigenous organizations and programs advocate for harm reduction, cultural revitalization, and holistic wellness approaches that prioritize individual autonomy, cultural safety, and consent.
- Indigenous-led initiatives focus on culture and supporting individual and communities, rather than coercive approaches that enable harm and trauma.
- Indigenous Peoples in Canada are disproportionately experiencing the opioid epidemic, compounding the health care gaps and inequities stemming from colonialism, residential schools, and ongoing systemic racism.

Strengths and Limitations of the Literature Review

- Limitations
    - They did not find any evidence on some relevant clinical outcomes (e.g., non-fatal overdose, hospital admissions, engaging with treatment); and
    - Where described, the population in clinical studies was predominately white males.
- Strengths
    - The was a multidisciplinary review including ethics, clinical and qualitative evidence, which provides a deeper and integrated understanding of key considerations compared with any one element in isolation.

Conclusion

- Limitations of the clinical evidence, together with ethical considerations and patient perspectives underscore the complexity of decisions regarding involuntary withdrawal management.
- Key considerations include autonomy, structural and systemic issues of substance use, lack of information on long-term benefits, and upholding trust in caregivers and health systems.

3. Presentation – Anil Thapliyal, CEO, E-Mental Health International Collaborative

Anil complimented Newfoundland and Labrador (NL) on the recent work done with respect to mental health services, pointing to Bridge the Gapp as a good initiative, as well at the current infrastructure in place. An Atlantic approach to service delivery was suggested as a positive example of good collaboration; it is important to learn from colleagues and peers around the world and determine how other practices can be incorporated.

Anil suggested that digital mental health supports do not need distinction; they can just be considered mental health supports. The level of usage will depend on the individual. He identified that there is room for both e-services and in person services; they should co-exist and could be a valuable combination for many people.

Anil discussed the difference between Digital Commercial Applications (social media, news, email, WhatsApp) versus Digital Therapeutics (developed by scientists, clinically proven as treatment). He spoke further on digital therapies and Indigenous approaches (WISE Practices). Anil highlighted NL's leadership in digital mental health, provincially, within Atlantic Bloc, within Canada; and viewed respectfully by the global Digital Mental Health Community.

Improvement for Newfoundland and Labrador in Digital Mental Health:

- Investment – communication campaign to promote all digital mental health options available to increase awareness and change consumer behaviour (e.g., the National Depression Initiative campaign in NZ).
- Foster Collective Ownership
- Focus on Collaboration:
    - Nationally: Mental Health Commission of Canada; and
    - Internationally: eMHIC, Scottish Government, Australia, NZ.

Recommendations to the Committee

- Invest in digital mental health solutions - A continued investment in digital mental health services, with a particular emphasis on systems navigation as many people simply do not know where to go for services. More specifically, NL should utilize a communications campaign for Bridge the Gapp so that more people know that it exists and what services it can provide. There needs to be more proactive investments in digital mental health, with integration occurring across systems. Such investments should be focused on improving capacity.
- Let's get it right by design – Anchor digital mental health in policy.
- Integration across systems (e.g., primary care).
- Continue to invest in a stepped-care model.
- Invest in digital mental health to build capacity for the Workforce (e.g., digital mental health academy).

4. Action Items
    - Secretariat to provide a copy of requested presentation to members.