Jurisdictional Scan of Initiatives between Primary Health Care and Mental Health/Addictions Services in Nova Scotia

Discussion Paper

Capital Health Mental Health and Addictions Program

March 2013
1. Purpose

The purpose of this document is to present findings of a condensed jurisdictional scan of collaborative initiatives between Primary Health Care and Mental Health and Addictions services in Nova Scotia. This scan was conducted to inform the Working Group created from leaders in Primary Health Care, Mental Health and Addictions services (the latter presently known as Capital Health Mental Health and Addictions Program) on past and existing initiatives around the province of Nova Scotia to better understand existing nature of collaborative initiatives.

The goal of the collaboration is to build better relationships and referrals to our respective services and increase capacity and competencies among primary health providers that often deal with addiction and mental health issues in their practice.

This discussion paper summarizes the information gathered from various agencies in each district of the province of Nova Scotia. It supplements the literature review of existing frameworks of collaboration between Primary Health Care and Mental Health and Addictions. Please refer to a separate document titled “Literature Review: Mental Health and Addictions in a Primary Health Care setting” to find the review of research literature.

2. Background

To move forward the agenda of collaborative mental health care, it is important to have an understanding of the prevalence of mental illness and substance use/misuse as well as related service utilization. Existing research on prevalence of mental health and addictions in general population indicates that in industrialized countries such as Canada, one in five individuals are affected by mental disorders, mainly suffering from anxiety, depression or substance abuse disorders (Centre for Addiction and Mental Health, 2012). Twenty percent (20%) of those with mental health issues also suffer from a substance abuse problem (Centre for Addiction and Mental Health & Canadian Centre on Substance Abuse, 2009). At the same time, less than half of people with mental disorders seek help for their mental health (Lesage et al. 2006 & Clatney, MacDonald, & Shah, 2008). Approximately one third of all family practice patients have identifiable mental health problems and up to 25% of patients who visit their family physician have a diagnosable mental disorder (Collaborative Working Group on Shared Mental Health Care, Canadian Psychiatric Association, College of Family Physicians of Canada, 2000).

The Canadian Community Health Surveys completed by Statistics Canada serve to inform on general health status, health determinants, and health service utilization in the Canadian population. With this data, it is possible to conduct provincial comparisons. The 2006 prevalence rate of any mental health disorders in the 1-year period prior to completing the survey for Nova Scotia was 11.6%, a comparable rate to the Canadian average, 10.6% (Lesage et al., 2006). Eight percent of Nova Scotians age 12 and over reported being depressed which was significantly higher than the national average of 5.2% (Nova Scotia Department of Health, 2007).

When looking at substance abuse, 20% of Nova Scotians aged 12 and over are heavy drinkers (consumed five or more drinks, per occasion, at least once a month during the past year), which is significantly higher than the
Canadian average of 17%, p<0.0001 (Statistics Canada, 2012). When comparing CDHA with the rest of Nova Scotia, the rates for CDHA were at 23% vs. 20% for Nova Scotia; statistically significant difference, p<0.0001 (Statistics Canada, 2012). These figures have remained much the same since 2007 (Graham, 2007). Research examining the utilization of health services indicates that for Nova Scotia, in the last 12 months preceding the survey, 7.6% of individuals sought help for their mental health reasons from their general practitioner. This number is statistically higher than the Canadian average of 5.4% (Lesage et al., 2006).

When looking at the most acutely ill suffering from mental health issues, the data on general hospital admissions in 1999 indicated that nearly 4% of all admissions were due to mental health issues; such as anxiety disorders, bipolar disorders, schizophrenia, major depression, eating disorders, personality disorders and suicidal behaviors (Mental Health Foundation of Nova Scotia, 2011).

According to published literature only 60% of community-residing individuals who suffer from mental health issues seek professional assistance, with 76% of these consulting only their family physician (Nova Scotia Department of Health, 2004; Vasiliadis, Lesage, Adair, Wang, & Kessler, 2007). When looking at the utilization of different providers of mental health services, clients seeking help for their mental health concerns were most often seeking help from their general practitioner, followed by other professionals (nurses, social-workers, psychotherapists, religious advisors, etc), followed by mental health specialists (i.e. psychiatrists and psychologists) and the voluntary sector – self-help groups, telephone help-lines, etc. (Alain et al. & Nova Scotia Department of Health, 2004).

Research argues that the family physician is in an ideal position to identify and treat mental health problems at an early stage: 97% of Canadians have a family physician (Collaborative Working Group on Shared Mental Health Care et al., 2000) More than 80% visit their family physician in the course of the year (Statistics Canada, 2012). Moreover, the family physician is usually the first, and may be the only contact, with a health care provider for individuals with mental health problems (Collaborative Working Group on Shared Mental Health Care et al., 2000).

A study assessing family physicians’ interactions with mental health professionals in Saskatchewan found that nearly half of responding GPs reported seeing 11 or more patients with mental health problems per week (Clatney et al., 2008). The same study found that while more than 80% of responding GPs were willing to identify and/or treat mental health problems, fewer than half reported being satisfied with the mental health care they were able to deliver. At the same time, studies argue that one of the most common strengths identified by family doctors in the provision of mental health care was having access to psychiatrists, community mental health nurses, and other Mental Health Professionals (Clatney et al., 2008; Pauzé & Gagné, 2005).

Studies suggest that the collaboration is essential in providing the support to primary care providers (Collaborative Working Group on Shared Mental Health Care et al., 2000; George et al., 2006; Kates et al., 2011). At the same time, within the provincial context, there is recognition by the Nova Scotia Government that family practitioners need support and in order to improve mental health and addictions in Nova Scotia,
Working Together Model: Mental Health & Addictions in Primary Health Care
Nova Scotia Jurisdictional Scan

collaboration must occur – between the primary care providers and those working in mental health and addiction services (Government of Nova Scotia, March 2012 and May 2012).

The review of literature component (mentioned earlier) provides an overview of existing models of collaboration found in research. At present, the Mental Health Commission of Canada is completing a national review of existing models of collaboration of mental health/addictions services with primary health care. This jurisdictional scan aims to fill in the gap and examine collaborative approaches in Nova Scotia.

3. Methods

To obtain information on past and existing initiatives, information was retrieved from publicly available websites of each district, published reports from various organizations, Government of Nova Scotia, and through follow-up with stakeholders in each district. The Research and Statistical Officer at Capital Health Addiction Services contacted his counterparts in each district. These individuals in turn either collated information on all the initiatives in Mental Health and Addictions with Primary Health Care in their districts, or provided contacts for the RSO in CDHA, who followed-up with each of the contacts provided. The Research Assistant with Primary Health Care had obtained information on unique initiatives of Primary Health Care with Mental Health/Addictions in the districts. The collected information was sent back to stakeholders for verification and accuracy. We also sought permission from each district to disseminate our findings to all districts. The list of participants is provided in the Appendix A.

4. Models of collaboration in each District Health Authority of Nova Scotia

Summary of historical and current initiatives is available below. Detailed description is on the next page.

<table>
<thead>
<tr>
<th>District</th>
<th>Models of collaboration of Mental Health/Addictions with Primary Health Care</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. South Shore</td>
<td>No initiative identified</td>
<td></td>
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<tr>
<td>2. Southwest</td>
<td>Training PHC staff</td>
<td>training on Mental Health/Substance Abuse provided to screening tools to GPs</td>
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<tr>
<td>3. Annapolis Valley</td>
<td>Consult-liaison</td>
<td>Annapolis Valley Addictions clinicians providing consult in 4 clinics</td>
</tr>
<tr>
<td>4. Colchester East Hants</td>
<td>No initiative identified</td>
<td></td>
</tr>
<tr>
<td>5. Cumberland</td>
<td>Training PHC staff</td>
<td>Training on screening tools to medical residents</td>
</tr>
<tr>
<td>6. Pictou</td>
<td>Consult-liaison</td>
<td>Collaborative Care Clinics</td>
</tr>
<tr>
<td>7. Guysborough Antigonish</td>
<td>Co-location</td>
<td>Mulgrave Medical Centre</td>
</tr>
<tr>
<td>8. Cape Breton</td>
<td>Training/Consult-liaison</td>
<td>Mental Health Collaborative in Glace Bay clinic</td>
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<tr>
<td>9. CDHA</td>
<td>Training/Consult-liaison</td>
<td>“Corridor consultations”</td>
</tr>
<tr>
<td>10. IWK</td>
<td>Training</td>
<td>Training to staff on Mental Health and Addictions issues</td>
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</tbody>
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Prepared by: Patryk Simon
Last update: March 14, 2013
<table>
<thead>
<tr>
<th>District</th>
<th>Service Area</th>
<th>Name &amp; Description of the Initiative</th>
<th>Objective of the initiative</th>
<th>Comments/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. South Shore</td>
<td>Addictions &amp; Mental health</td>
<td>No initiative identified</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td></td>
<td>-</td>
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<tr>
<td>2. Southwest</td>
<td>Addictions &amp; Mental health</td>
<td>Early stages: Provided education</td>
<td>Building capacity for screening among NPs and provide screening tool so know when to refer</td>
<td>In planning/development stage Efforts will be made to integrate self-management</td>
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<tr>
<td></td>
<td></td>
<td>training on GAIN SS screening tool</td>
<td></td>
<td>to MH/AS</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td>Mental Health is being included in</td>
<td>To enhance integration and coordination of chronic disease management programs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>a chronic disease management working</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>group</td>
<td></td>
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<tr>
<td>3. Annapolis</td>
<td>Addictions</td>
<td>At 4 PHC sites:</td>
<td>Building capacity for brief intervention, screening, referrals and consultation</td>
<td>Step 1. Physician -&gt; client No formal screening tool used. GP asks questions</td>
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<tr>
<td>Valley</td>
<td></td>
<td>• Middleton Collaborative Practice</td>
<td></td>
<td>about substance abuse “Do you drink?” and “Are you concerned about it?” and</td>
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<td></td>
<td></td>
<td>• Kentville Family Practice</td>
<td></td>
<td>using MI lens with the client, determines next steps</td>
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<td></td>
<td></td>
<td>• Red Door Youth Health and Support</td>
<td></td>
<td>If the client agrees, follow-up visit scheduled to see GP and CT.</td>
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<tr>
<td></td>
<td></td>
<td>Centre in Kentville</td>
<td></td>
<td>Step 2. CHW/CT follow-up</td>
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<tr>
<td></td>
<td></td>
<td>• Mud Creek Medical Co-op in Wolfville</td>
<td></td>
<td>Brief intervention with client</td>
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<tr>
<td></td>
<td></td>
<td>• Started as a 6 month pilot with</td>
<td></td>
<td>File in Addictions not created unless client continued treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>GPs that were already referring to</td>
<td></td>
<td>Charting in the system of respective site (electronic/paper)</td>
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<tr>
<td></td>
<td></td>
<td>Addictions</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Addictions offered district-wide</td>
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<tr>
<td></td>
<td></td>
<td>MI training, all GPs were invited</td>
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<td></td>
<td></td>
<td>• Clinical Therapist placed in the 4</td>
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<td></td>
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<td>sites for 0.5 day/week</td>
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<tr>
<td></td>
<td></td>
<td>Compensation:</td>
<td></td>
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<td></td>
<td>Mental Health</td>
<td>Planning Phase: currently working on</td>
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<tr>
<td></td>
<td></td>
<td>a similar initiative to Addictions</td>
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</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td>No initiative identified</td>
<td></td>
<td></td>
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</tbody>
</table>
## Detailed Jurisdictional Scan of PHC initiatives by District and Service Area

<table>
<thead>
<tr>
<th>District</th>
<th>Service Area</th>
<th>Name &amp; Description of the Initiative</th>
<th>Objective of the initiative</th>
<th>Comments/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4. Colchester</strong></td>
<td><strong>East Hants</strong></td>
<td>Addictions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>No initiative identified</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td>No initiative identified</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
| **5. Cumberland** | Addictions   | 1. Presentations on addiction services to new docs and medical residents in Cumberland  
2. Early Conversations – provide training to GPs to raise issue of alcohol use and overconsumption with patients  
3. Placing CTs into Collaborative practice – talking phase with VP | 1. To increase awareness of addictions services available in the community that GPs can refer to  
2. To raise awareness of the substance abuse problem clients that GPs can come across in their practice | 1. Presentations delivered by addictions staff to GPs and medical residents |
|                   | Mental Health | Unknown – no response received       | -                          | -                |
|                   | Primary Health Care | No initiative identified | -                          | -                |
| **6. Pictou**     | Addictions   | 1. Referral to Addictions from GPs  
Other initiatives (non-PHC):  
1. Police Liaison Committee  
2. Knowledge Exchange Facilitator on Police Education Sub-Committee | 1. Streamline the referrals to addiction services  
Other initiatives (non-PHC):  
1. Develop client service level improvements for the shared clients between ER, law enforcement, addictions and mental health  
2. Training re: addictions to police | 1. Paper referral form to addictions is available to family physicians  
Other initiatives (non-PHC):  
1. Representatives of Addictions sit in on the committee  
2. Addictions KEF sits in on the sub-committee |

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<tbody>
<tr>
<td>6. Pictou</td>
<td>Mental Health</td>
<td>1. Two Shared Care Collaborative Clinics • Salaried adult psychiatrist and a child adolescent psychiatrist provide a one hour consultation in each of two collaborative practice clinics 2. Child psychiatrist provides direct visits/consults to Pictou Landing First Nations community 3. Mental health clinician in First Nations communities (Pictou Landing and Paqtnkek) – planning phase</td>
<td>1. To support GPs in practice when dealing with clients with MH issues 2. To provide psychiatric services to First Nations communities 3. Biggest gap in FN community was MH and addictions; to provide support to the community</td>
<td>1. Open grand rounds, GPs do a case presentation and psychiatrists provide consultation on medication management, DDx, and when to refer adolescents to MH services • Psychiatrists don’t see the clients</td>
</tr>
<tr>
<td>7. Guysborough Antigonish</td>
<td>Addictions/ Mental Health</td>
<td>1. One clinician (COW/CHW) from Addictions and one from Mental Health present in health centres (Lindsay’s Health Centre for women and Men’s Health Centre) 2. Mental Health Clinician co-located in Mulgrave medical Centre</td>
<td>1. Work with primary care providers (physician, nurse practitioner) to provide easy access, quick referrals, and improve consultation/collaboration among team members 2. Increase communication with other providers based in the centre 3. Support practitioners at schools</td>
<td>1. Presence in the offices for one day/week • The referral can be from the client themselves, or any clinician at these centres Challenges: - different electronic records systems/filing systems - different accountabilities amongst team members 2. Clinician is co-located, but does not function as a member of the primary care team 3. providers at schools with varied frequency as needed (from once/week to once/month)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In progress:</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>3. Addictions/MH working with GPs and NPs working with schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td>Mental health is involved in a chronic disease management strategy</td>
<td>• To promote coordination and integration between programs</td>
<td>• Planning and development stage</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>8. Cape Breton</td>
<td>Addictions</td>
<td>1. Continue Methadone Stabilization in the community</td>
<td>• Increasing capacity in the program&lt;br&gt;• Working on transitioning stable clients to GPs in the community</td>
<td>• Arrangements with GPs to continue to prescribe methadone in the community under the methadone program, similar to the MTT in the Annapolis Valley&lt;br&gt;• In the process of trying to engage a physician leader who would support working with other GPs to transition clients to community&lt;br&gt;• Double entry into ASsist and Meditech</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
<td>In addition to the Mental Health Collaborative in Glace Bay clinic, Child and Adolescent Mental Health and Addiction Services provides psychiatry consultations to GPs</td>
<td>• Provide consultations to GPs</td>
<td>• Requests for medication reviews/consults from GPs are fast-tracked to psychiatry</td>
</tr>
<tr>
<td></td>
<td>Primary Health Care</td>
<td>Mental Health Collaborative in Glace Bay clinic - case conferencing and consultation (3 GPs and 2 NPs)</td>
<td>• To improve coordination and communication between family physicians, Nurse practitioners, and psychiatrists and social worker (MSW)&lt;br&gt;• To increase use of the PHQ9 to improve capacity to diagnose depression and monitor treatment response</td>
<td>• Psychiatrist and MSW social worker (case manager) meet every 2 weeks for lunch to discuss cases; if no cases, it is a teaching opportunity&lt;br&gt;• Built-in into role, no compensation&lt;br&gt;• Psychiatrists provide advice to family physicians for more complex cases&lt;br&gt;• Psychiatrist or social worker may see the client on site as well if client agrees&lt;br&gt;• Outcomes pending; generally positive reception thus far</td>
</tr>
<tr>
<td>District</td>
<td>Service Area</td>
<td>Name &amp; Description of the Initiative</td>
<td>Objective of the initiative</td>
<td>Comments/Details</td>
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</tbody>
</table>
| 9. CDHA  | Mental Health                       | 1. Corridor consultations by Dr. Risk Kronfli i  
2. Psych. consultations with 3 FP clinics – RN and psychiatrist for half day/week:  
• Albro Lake Medical Clinic  
• Dartmouth Medical Centre  
• Pleasant St. Medical Group | 1. Providing expertise to PCP and practical approach to the case  
2. Same as above, but also would see the clients for assessment if need be. | 1. Consultations to PCPs via fax/email on short description of cases. Majority of cases from CDHA but also receiving from NS. Usually responded to in 48hrs  
2. Provided advice on management, if not beneficial to client, would see client |
|          | Primary Health Care                 | • Behaviour Change Institute  
• Increase provider capacity to provide self-management support |  | Behaviour Change Institute staff provide training to providers to increase their ability to provide self-management skills |
| 10. IWK  | Addictions & Mental Health          | 1. CHOICES works with Homebridge and Phoenix House  
2. Health promotion support and outreach to schools and Youth Health Centres in CDHA  
3. Community Outreach worker support to First Nations communities across Nova Scotia | 1 & 2. Increase capacity among staff around MH & Addictions issues and conduct outreach  
2. Provide support to guidance to counselors, administrators and YHCs to enhance capacity and provide evidence-based health promotion programs | 1. Offer training to staff around Mental Health and Addictions issues to enhance self-management skills  
2. CTs provides outreach to schools when required  
3. HPRO specialist provides training for teachers, guidance counselors, administrators re: MH & A issues (including policies). |
5. References


Canadian Centre on Substance Abuse. (2009). *Substance abuse in Canada: concurrent disorders.* Ottawa, ON: Canadian Centre on Substance Abuse.


Working Together Model: Mental Health & Addictions in Primary Health Care
Nova Scotia Jurisdictional Scan


Appendix A: Contacted key stakeholders listed by district
Working Together Model: Mental Health & Addictions in Primary Health Care

5.1. Appendix A: Key stakeholders contacted listed by district

Please note, this list is by all means not comprehensive, but only provides names for individuals with whom the authors had communicated. In many instances, the individuals listed consulted colleagues in their districts to solicit further information as it relates to Mental Health and Addictions initiatives with Primary Health Care.

South Shore (District 1), Southwest (District 2) and Annapolis Valley (District 3):
- Cathy Smith, MSc, BSc
  Research and Data Analyst
  Addiction Services, DHA 1, 2, and 3
  Kentville, Nova Scotia
- Michele Bullerwell
  Quality Management Coordinator
  Addiction Services
  South West District Health Authority
  Yarmouth, Nova Scotia
- Michele LeBlanc
  Chronic Disease Management Coordinator
  Primary Health Care
  South West District Health Authority
  Yarmouth, Nova Scotia

Colchester/East Hants (District 4):
- Phillip MacLeod MLT, CSMLS, BHSc, BMgmt
  Research & Statistical Officer
  Addiction Services; DHA 4, 5, and 6
  Pictou, Nova Scotia

Cumberland (District 5):
- Phillip MacLeod MLT, CSMLS, BHSc, BMgmt
  Research & Statistical Officer
  Addiction Services; DHA 4, 5, and 6
  Pictou, Nova Scotia
- John Rossong, Clinical Manager
  Addiction Services
  Cumberland Health Authority
  Amherst, Nova Scotia

Pictou Country Health (District 6):
- Janice Fraser, Manager
  Addiction Services
  Pictou Country Health Authority
  New Glasgow, Nova Scotia
- Maureen Jones, Manager
  Mental Health
  Pictou County Health Authority
  New Glasgow, Nova Scotia
- Sheri Cunningham
  Quality Management Coordinator
  Addiction Services
  Pictou County Health Authority
  Pictou, Nova Scotia
- Jayne MacCarthy
  Knowledge Exchange Facilitator
  Addiction Services
  Pictou County Health Authority
  New Glasgow, Nova Scotia

Guysborough Antigonish (District 7):
- Allison L. Stevens, M.Sc.
  Clinical Manager - Community-Based Services, Addiction Services
  Guysborough Antigonish Strait Health Authority
  Antigonish, Nova Scotia
- Michelle MacLean
  Quality Management Coordinator
  Addiction Services
Appendix A: Contacted key stakeholders listed by district

Working Together Model: Mental Health & Addictions in Primary Health Care

Guysborough Antigonish Strait Health Authority
Antigonish, Nova Scotia

- Jane Newlands
  Manager, Primary Health Care and Seniors Health
Guysborough Antigonish Strait Health Authority
Antigonish, Nova Scotia

Cape Breton (District 8)
- Dr. Linda Courey, Director
  Mental Health and Addiction Services
Cape Breton District Health Authority

- Kim Bartholomew-Pushie
  Manager, Primary Health Care
Cape Breton District Health Authority

Capital District Health Authority (District 9)
(continued)
- Dr. David Pilon, Psychologist
  Mental Health Specialty Programs
  Capital Health Addictions and Mental Health Program
  Halifax, Nova Scotia

- Cheryl Billard, Program Leader
  Mental Health Strategy initiative
  Capital Health Addictions and Mental Health Program
  Dartmouth, Nova Scotia

- Mary Pyche, Program Leader
  Acute Care Crisis Support
  Capital Health Addictions and Mental Health Program
  Halifax, Nova Scotia

IWK
- Lewanne Stefishen, Assistant Database Coordinator
  Quality & Decision Support Services
  IWK Health Center, CHOICES program

- Derek Leduc, Manager
  (Derek was the Health Promotion Specialist at IWK prior to coming to CDHA)
  Concurrent Disorders
  Capital Health Addictions and Mental Health Program
  Dartmouth, Nova Scotia

- Susan Hare, Program Leader
  Manager for Community Teams
  Capital Health Addictions and Mental Health Program
  Halifax, Nova Scotia