Pilot Site Report: Province of New Brunswick

Development of a Needs-Based Planning Model for Mental Health and Substance Use Services and Supports across Canada

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Background to the National NBP Project

1.1 Background and Need Addressed

Mental health services and supports have traditionally been funded without a comprehensive planning model to help allocate resources equitably and according to population needs (1). There is ample evidence in the Canadian context that this has contributed to a significant “treatment gap”, such that the current capacity of mental health services falls far short of meeting the needs of the population (2, 3). Further, the planning and funding of mental health and substance use services remains quite siloed and hindered by the lack of a planning and resource allocation model that includes both these service delivery sectors. To support the allocation of resources, as well as future population-based performance indicators, work was needed at the national level on practical, evidence-based tools for mental health and substance use/addiction system planning.

A project aimed at improving the planning and allocation of resources for substance use and concurrent disorders services has been underway with Health Canada support from Drug Treatment Funding Program (2010-14) and Substance Use and Addictions Program (2016-18); the project being led by Drs. Jürgen Rehm and Brian Rush at the Centre for Addiction and Mental Health, with Co-Investigators Drs. Joel Tremblay and Daniel Vigo. Feedback during pilot work across Canadian jurisdictions as well as the project’s summary evaluation report confirmed the high interest among the members of the National Advisory Committee, as well as important policy makers and planners in several Canadian jurisdictions, in expanding the work to better represent mental health services and develop a fully integrated, national mental health and substance use Needs-Based Planning model.

Importantly, during roughly the same time, a highly complementary project was funded by the BC Ministry of Health for the development of a comprehensive planning model for that province. While the goals of the two projects were very similar, different although complementary methodologies were utilized, and a collaborative process ensued between the investigators on the CAMH-led project and Dr. Daniel Vigo and his team at the University of British Columbia, supporting the respective projects through consultation and sharing of information.

This project was a continuation of this collaboration and aimed at ***the development of a national, mental health and substance use planning model that would support the development of more integrated, accessible, and effective services for all Canadians.*** The aim was to draw upon the strengths of each project through methodological and data source triangulation, as well as scale-up of the work to a national mental health and substance use planning model that would support the development of more integrated, accessible, and effective services for all Canadians.

The overall goal of the Needs-Based Planning project was to develop a quantitative model that key decision-makers in health planning jurisdictions across Canada can use to estimate the resources required to address the needs for services and supports relating to Mental Health and substance use problems in their population.

What is Need-Based Planning?

Needs-Based Planning (NBP) uses a systematic quantitative approach to planning mental health and substance use treatment and support systems. NBP estimates the required capacity of services and supports, based on needs of the whole population, and all levels of severity and complexity of those needs. A critical ingredient for NBP is an agreed upon set of "core" mental health and substance use services and supports that should be available and accessible to all those in need. The evidence-based foundation of NBP is rooted in systematic design and planning and includes these key principles[1]:

- a broad systems approach to address the full spectrum of issues
- accessibility and effectiveness through collaboration across stakeholders
- a range of system supports.

This evidence-based approach advances local planning and creates a more equitable balance of resources. It provides direction to decision-makers on their investment decisions and, when fully implemented, can reduce costs and improve access to services and client and family outcomes. It is the optimal way to use resources wisely, and to fit services to the dynamic, evolving needs of a population.

What promise does it hold?

Immediate

- increased understanding of population needs and the advantage of NBP over alternative existing approaches
- increased use of evidence-informed practices for planning and delivering services and supports
- improved decisions for optimal resource allocation for mental health and substance use/addiction services and systems

Medium to Longer term

- strengthened, evidence-informed treatment, support services and systems
- increased access to services and coverage of population needs
- improved client, family and population health outcomes

The Research

Canada has played a significant role in developing NBP models, first for substance use and addiction, and now also including a broader focus on mental health. The Canadian work has included model development and implementation for both adult[2] and youth[3] substance use services, as well as work based in British Columbia for (adult) mental health and substance use services. This work has built upon, and benefited significantly, from close communication with colleagues in the United Kingdom, Australia and elsewhere. Although there are differences in scope and methodology across countries, all NBP models have the same essential purpose, namely to bring a population health perspective to a quantitative, evidence-based approach to planning and resource allocation. To date the adult and youth substance use NBP models have been the most widely implemented in Canada.

Benefits of the model

The model is an overarching tool to assist in decision making and planning, prediction of resources that leads to an increase in appetite for increasing treatment resources in underfunded jurisdictions and parts of the treatment and support continuum. Embedding the tool in a National Framework encourages its use nationally.
The model is an aspirational goal. It leads to appreciation of unmet needs and highlights different elements across the continuum of care. Hence, it is not just the finished product but the process of development of the model itself that is also very helpful as it brings to light evidence- based practices and difference in opinions among planners and service providers. While the gap analysis provides an "outcome", the real value is that it provides funders with a powerful planning and prioritization tool that allows funding decisions to be made based on the evidence. The model yields examples of inequitable resource distribution, provides a common language, raises questions and issues for discussion regarding an evidence-based system and services.

Challenges of the model

Not everyone is represented in the population health data, for example, people who are homeless or institutionalized at the time of the key surveys, and a large percentage of Indigenous people. Other information must be incorporated to adjust for these data gaps.

There is no one simple formula for treatment system planning, but rather a collection of tools that can be used together to inform treatment gaps and resource allocation. A needs-based planning model is one tool that should be complemented with other information and methods.

1.2. Overview of the National NBP Project

The project involved five overlapping phases of work:

Phase I: Literature Reviews, and Establishing of the National Advisory Committee

- Re-instated and bolstered the mental health expertise of the National Advisory Committee, including a new cadre of research collaborators drawn from mental health services research groups across Canada.
- Established the workgroups of the National Advisory Committee.
- Updated literature on needs-based planning models, conceptual frameworks, comorbidity, and help-seeking for substance use/addiction to include mental health problems and illnesses.
- Undertook a national environmental scan of provincial/territorial strategic plans for mental health and addictions focusing on the status of mental health and substance use/addiction services integration, including opioid treatment services; the use of tiered service frameworks and identification of core services; and system-level, population-based performance indicators (e.g., help-seeking or level of coverage of need by existing treatment and support services).

- Developed the project performance measurement plan.

Phase II: Methods triangulation

- Reviewed, synthesized, and triangulated the methodologies and data sources used in the BC and previous national Needs-Based Planning projects.
- Derived robust population-based estimates of the numbers of people requiring mental health and substance use/addiction services in each planning region across Canada according to level of severity and need.
- Conducted a comparative analysis of prevalence and need estimates derived from the severity tiers approach based on complexity in the national project and the diagnostic-based approach in the BC project, including opioid use disorders and other 12 substance and mental disorders.
- Investigator team reviewed methodology and potential re-analysis of data, and assessment of the comorbidity and help-seeking literature covering both mental health and substance use/addiction.
- The sub-group of the National Advisory Committee focused on methodology was engaged in the review, assessment, and validation of the approach to reconcile the methodologies and results of the two approaches.

Phase III: Core services and full system modeling

- Translated the learnings from the Phase II work on the triangulation of the jointly held data with respect to substance use/addiction, to the various mental disorders covered by the BC project and the mental health-related data derived in the recently completed national SUAP- funded project.
- Developed a national consensus–based set of core mental health and substance use/addiction services (built upon the previous work of the BC and national projects).
- Drew upon extant literature and international experience with system design frameworks and evidence-based pathways for specific diagnosis and comorbidity. This involved ful engagement of the project's National Advisory Committee to ensure the outputs of the resulting planning model align well with current funding processes and national/provincial/territorial reporting requirements (e.g., functional centres and core services defined by CIHI and in provincial/territorial strategic plans).
- Integrated the information gathered in Phase I (i.e., needs-based planning, conceptual frameworks, comorbidity and help-seeking literature, evidence-based service pathways); Phase II (i.e., methods triangulation) and the above work on core service and conceptual framework to yield the full integrated mental health and substance use/addiction Needs-Based Planning model and which provides estimation of service capacity requirements (e.g., annual caseload across core services as well as capacity requirements expressed, for example, in FTEs within inter-disciplinary roles and treatment beds).

- At this stage the draft model was developed with significant input from the Working Group on Core Services and vetted through the full National Advisory Committee prior to pilot testing in the next phase of work.

Phase IV: Pilot testing and calibration

- Developed the criteria for selection of pilot sites, confirmation through the Advisory Committee and design of the pilot site protocol including local/regional context analysis and data requirements for gap analysis.
- Engaged the pilot sites, developed the required Memoranda of Understanding (MOU), and held the initial on-site meeting with key decision-makers and information specialists, followed by a period of data collection and analysis.
- Iterative pilot testing and calibration of the model from Phase III, with three pilot jurisdictions in Year Two of the project and three pilot jurisdictions in Year 3.
- Ongoing meetings with the pilot sites for discussion and interpretation of results followed by preparation of a case study report.

Phase V: Reporting and knowledge exchange (KE)

- Project reports and other KE activities.
- In addition to the Health Canada reporting requirements, other reporting includes:
  - Project Technical report with sustainability plan
  - Project Evaluation report
  - Final Case Study reports
  - Implementation manual with required statistical tool

1.3. Pilot sites involved in the project

There were a total of six pilot sites in the project:

- Prairie Mountain Health Authority in Manitoba
- North Bay-Nipissing in Ontario
- Province of New Brunswick
- Niagara Region in Ontario
- Province of Nova Scotia
- North Zone in Alberta

2.0 Province of New Brunswick Pilot Project

The Needs-based Planning model is comprised of the following elements and steps for implementation:

Table 1: Steps involved in implementation of the NBP model

Step 1	**Engagement** - With funders and other key stakeholders
Step 2	**Establishing the geographic boundaries, social indicators and community nuances** - Gathering population data and context description of local nuances.
Step 3:	**Estimating population level of need by severity**
Step 4:	**Mapping the system by core services** – Who is currently doing what and for whom?
Step 5	**Sizing:** Estimating level of need for core services
Step 6:	**Estimating current core service supply and utilization** - (number of individuals, FTE's, beds)
Step 7:	**Gap analysis** - by core service category (number of individuals, FTE's, beds)
Step 8:	**Interpretation** - Implications for the gap analysis

Step 1 – Engagement

Requirements of a pilot site/clarification of roles and responsibilities

- Attend project meetings/presentations, and contribute to the group discussions
- Update the working group of the ongoing activities
- Complete the baseline evaluation survey
- Provide input into project materials
- Provide any relevant documents about their services and/or evolving community context
- Provide feedback on areas of the NBP model that may require adaptations or flexibility depending on local/regional context
- Contribute to the system mapping process for their organization
- Provide required information for gap analyses according to the core services (individuals served, FTEs by categories, # beds etc.)
- Assist in interpretation of the gap analyses and implications for the treatment and support system
- Provide feedback on strengths and limitations of the Needs-based Planning process, including participation in the follow-up evaluation

Working group engagement:
Members:

- Bernard Goguen, Health Consultant, Addiction & Mental Health Services, Government of New Brunswick
- Karen McAleenan, Business Analyst, Addiction & Mental Health Services, Government of New Brunswick
- Annie Pellerin, Executive Director, Addiction and Mental Health Services, Government of New Brunswick

Initial meetings were to provide orientation to the history of the model, learnings from the past projects and orientation to the National Core Service Framework. Follow-up meetings included establishing the

geographic boundaries; gathering population data and context description; mapping the system by core services – who is doing what and for whom; estimating current core service supply and utilization - (number of individuals, FTE's, beds); and processing the results of the gap analysis (comparing the current core service supply against the estimates projected by the model by core service category (number of individuals, FTE's, beds)

Limitations of the work

It was made clear to the pilot site representatives that the model had the following limitations regarding what it can or not project:

- Services targeted towards youth - model can't project needs for sub-15 aged population
- MH/SU diagnoses that were not included the 2012 Canadian Community Health Survey (CCHS) Mental Health (e.g., gambling, forensic populations)
- Core Service Platforms that fall outside of the model's scope or where there was no available data to compute a projection (e.g., Crisis Lines, Safe consumption sites)
- Collaborating Partner services that are serviced by other ministries/departments (e.g., schools, justice)
- Exclusions within the population health information – not everyone included in the underlying population health data – homeless, (process must be supplemented with other community needs assessment information homeless) First Nations on reserve, institutionalized populations
- Drilling down e.g., newcomers/refugees; rural/ remote, individual community level.
- Not a dynamic model, so it is not able to reflect individual, often complex treatment trajectories over time (e.g., natural recovery, recovery/ relapse).
- Not all local context can be taken into account

Step 2 - Establishing the geographic boundaries, population, and community nuances

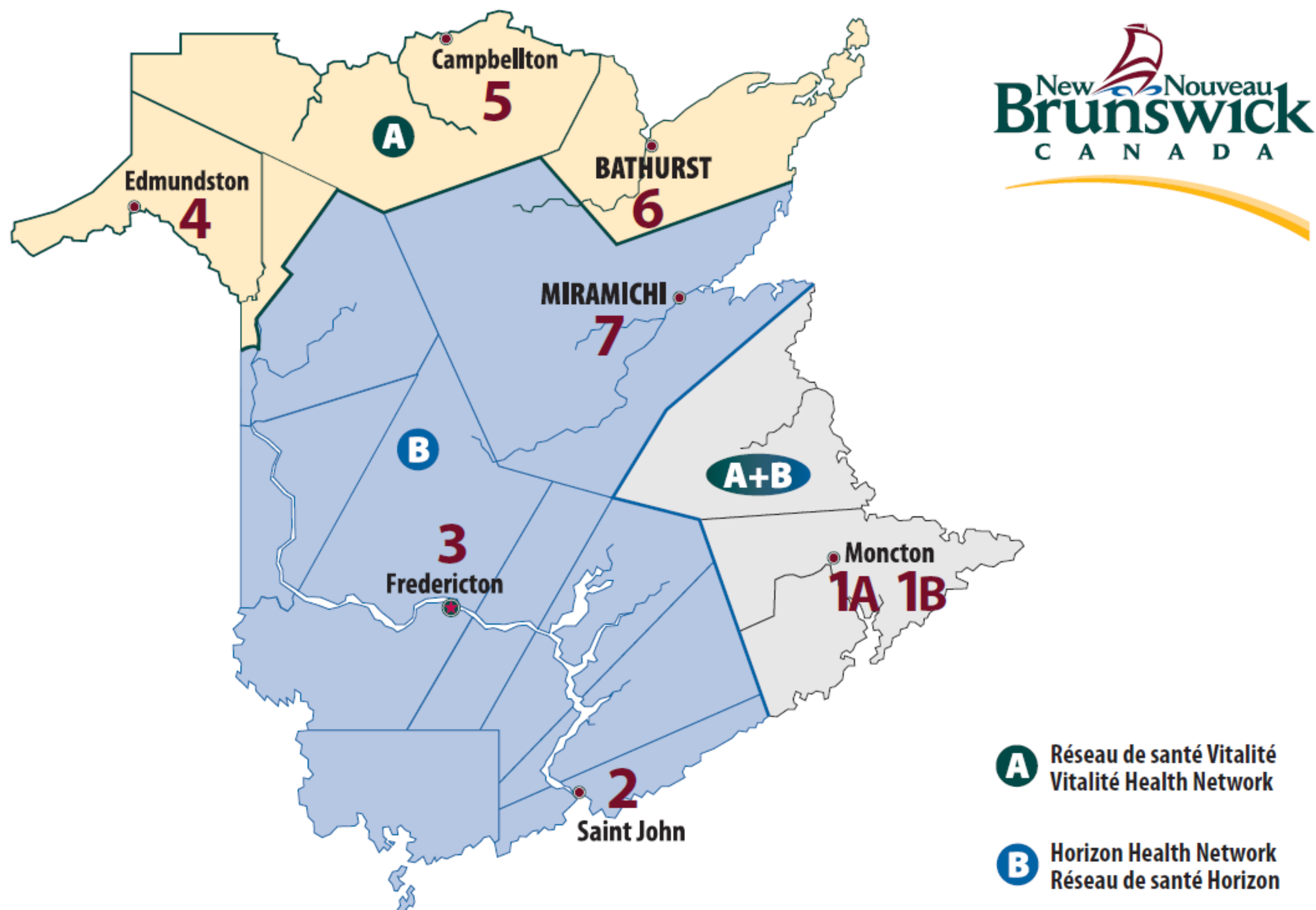
Geographic Boundaries: Selection of the geographic boundaries for developing the mental health and substance use service capacity requirements, which were essentially the health planning regions across the country (typically regional health authorities or planning zones of a provincial health authority or Ministry of Health).

In this case, the planning area was the province of New Brunswick. There are two Regional Health Authorities (RHAs) within the province for delivering health services - Vitalité Health Network and Horizon Health Network.

Horizon Health Network includes the following communities: Fredericton, Miramichi, Moncton, Saint John, Upper River Valley

Vitalité Health Network includes Acadie-Bathurst Zone (region of Bathurst and vicinity and the Acadian Peninsula), Beauséjour Zone (region of Moncton and vicinity), Northwest Zone (region of Edmundston and vicinity), and Restigouche Zone (region of Campbellton and vicinity).

Figure 1: Geographic boundaries for implementation of the NBP model



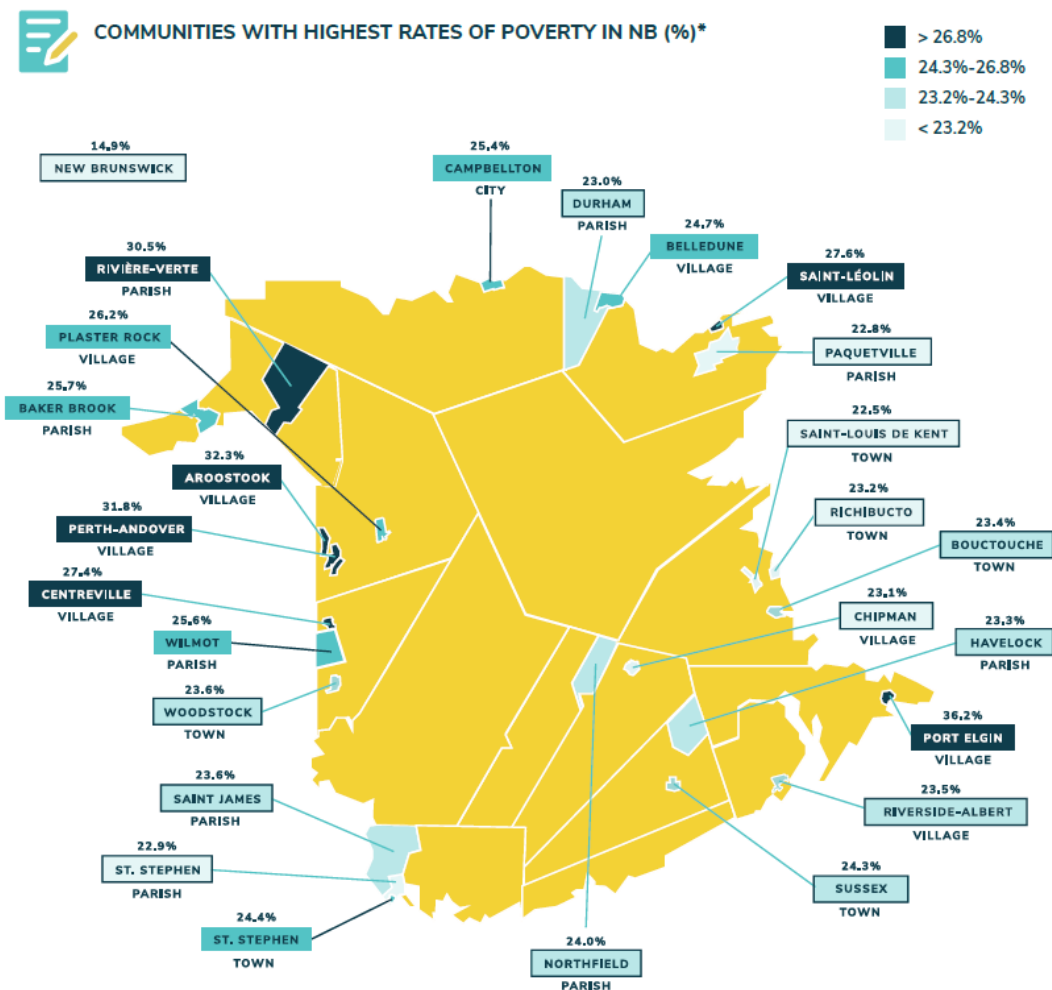
Population:

- As of July 1, 2019, New Brunswick's population was estimated to be approximately 776,827, up 0.8% yearover-year, and up 2.4% since 2015.[4]
- Between 1979 and 2019, the percentage of New Brunswick's population that was under the age of 15 fell by nearly half (from 26.5% to 14.4%), while the percentage of the population aged 55 years or older more than doubled (from 17.9% to 37.3%). These trends are expected continue going forward. Based on Statistics Canada population projections, the number of individuals aged 55 years or older in New Brunswick is expected to exceed the number of individuals aged 15 to 54 by the early-to-mid 2040s.

Income

- Based on the 2016 Census, 14.9% of New Brunswick residents are living below poverty line[5].
- The figure 2 below shows communities with highest rates of poverty in New Brunswick[6]

Figure 2: Communities with highest rates of poverty in New Brunswick



Education

- Based on 2016 Census data, 84.2% of people aged 25 to 64 in New Brunswick had a high school diploma or equivalency certificate, compared with 86.3% in Canada.[7]
- 20.2% of people aged 25 to 64 had a bachelor's degree or higher in 2016, while 26.1% had a college, CEGEP or other non-university certificate or diploma as their highest level of education, and 4.4% had an apprenticeship certificate as their highest.

Prevalence of mental health and substance use problems

- There has been a 16% increase in demand for addiction and mental health services in past 5 years (nine per cent for adults and 33% for youth).[8]
- Wait times for new high priority addiction and mental health referrals are on the rise, with less than 50% of high priority cases receiving treatment within national benchmarks.
- Some of the key highlights included in a 2016 Government of New Brunswick report are[9]:
    - Nearly one in 10 New Brunswickers uses health services for a mood or anxiety disorder each year
    - One in eight New Brunswickers experiences depression in his or her lifetime
    - One in 35 New Brunswickers experiences bipolar mood disorder in his or her lifetime
    - One in 10 experiences generalized anxiety disorder
    - Use of psychoactive and addictive substances is widespread -

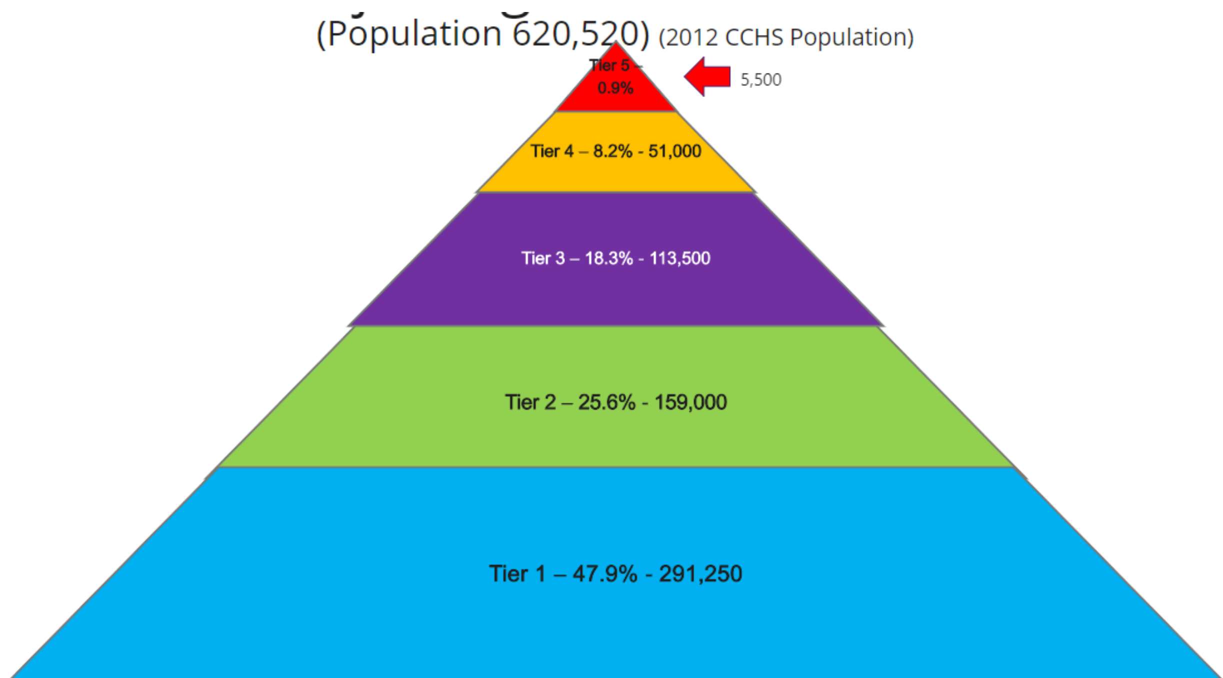
Step 3: Estimating level of need

Figure 3 shows the results of the analysis of the mental health and substance use severity population pyramid for the province of New Brunswick.

Combining tiers 2-5 (Tier 2 – 25.6%, Tier 3 – 18.3%, Tier 4 – 8.2% and Tier 5 – 0.9%), a total of 53% of the population are at some level of risk and need for mental health and substance use services – a large majority in Tier 2 where these needs can perhaps be met with relatively brief and low intensity advice and consultation. While a comparatively small percentage of the area's population are classified in the upper Tiers 4 and 5 (8.2% and 0.9 % respectively), together they represent a considerably large number of people with significant and complex needs, including the need for integrated/collaborative mental health and/or primary health services for those with concurrent mental illnesses and other health issues.

It is important to keep in mind that these data will under-represent the overall level of need for mental health and substance use services, given the exclusion criteria for the Canadian Community Mental Health population survey (e.g., Indigenous populations on reserve, homeless, institutionalized). Although excluded from the survey population, they are somewhat represented in the population pyramid below since they are included in the region's population statistics. Although represented in absolute numbers, their level of need will, however, be under-estimated because the unique population pyramids for these populations could not be estimated with existing data.

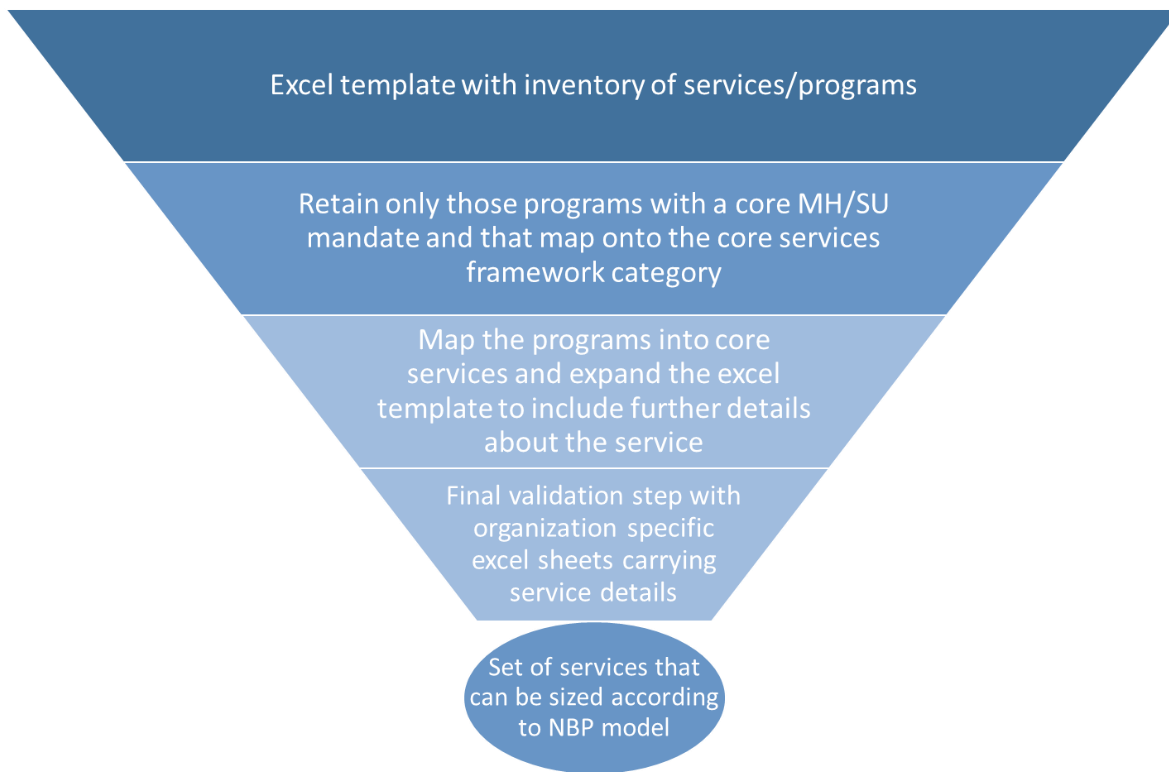
Figure 3 : CCHS Severity Tiers



Step 4: Mapping the system

Figure 4 summarizes the system mapping methodology that was used to create an inventory of services that can be sized according to the NBP model.

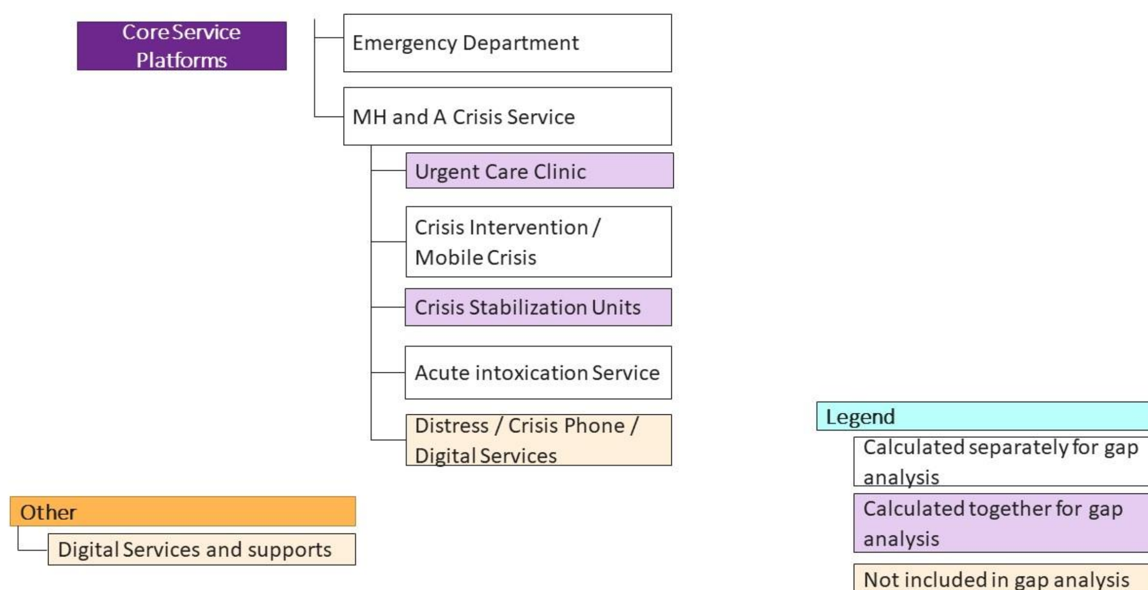
Figure 4: Graphic representation of the system mapping methodology



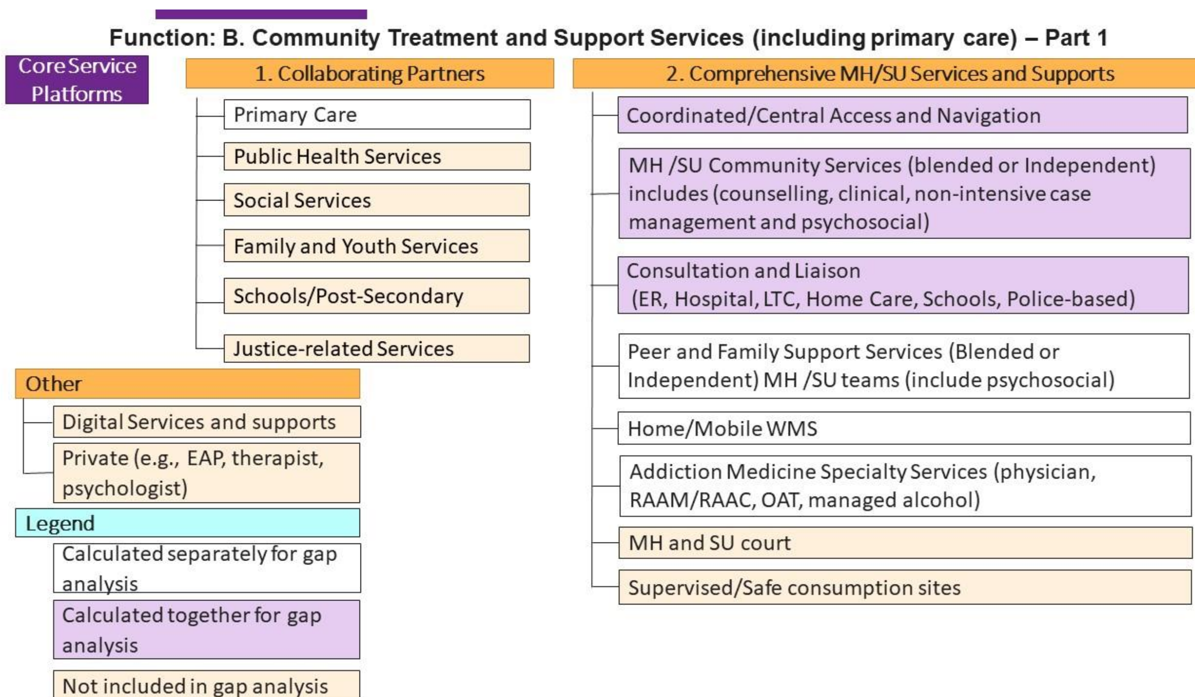
Step 5: Sizing

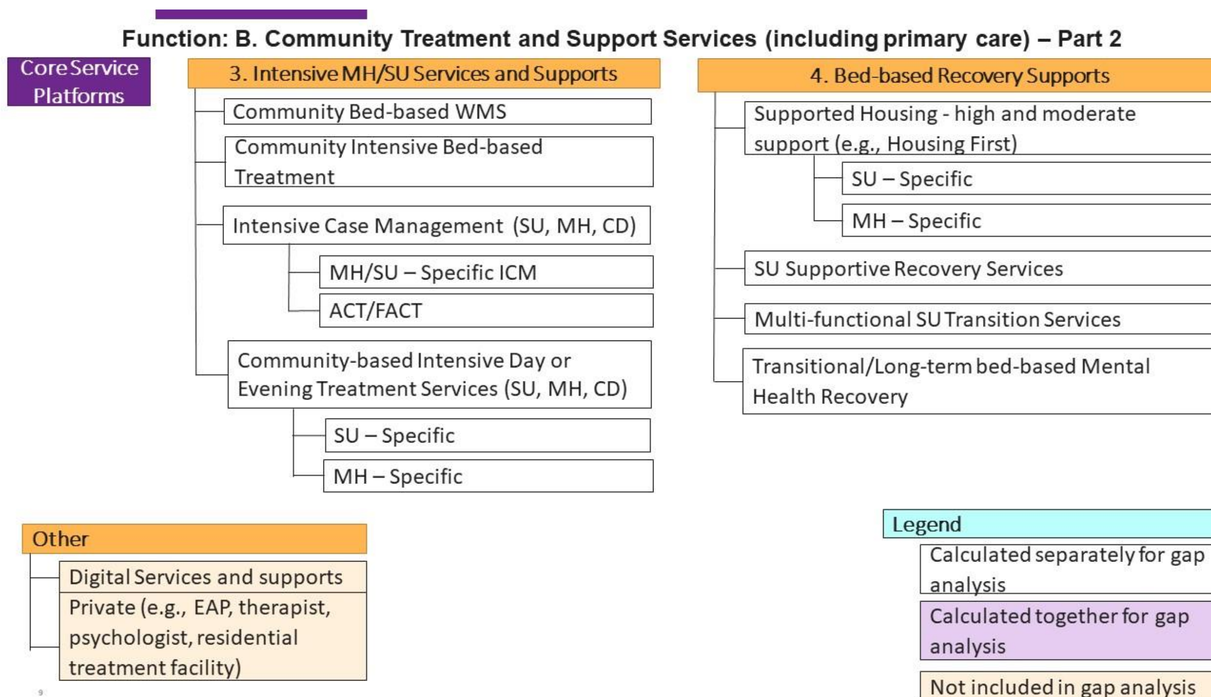
The charts below graphically depict the core service categories that were mapped on to the services available in the province of New Brunswick. A brief description of these categories is included in the sections below.

Emergency and Crisis Response

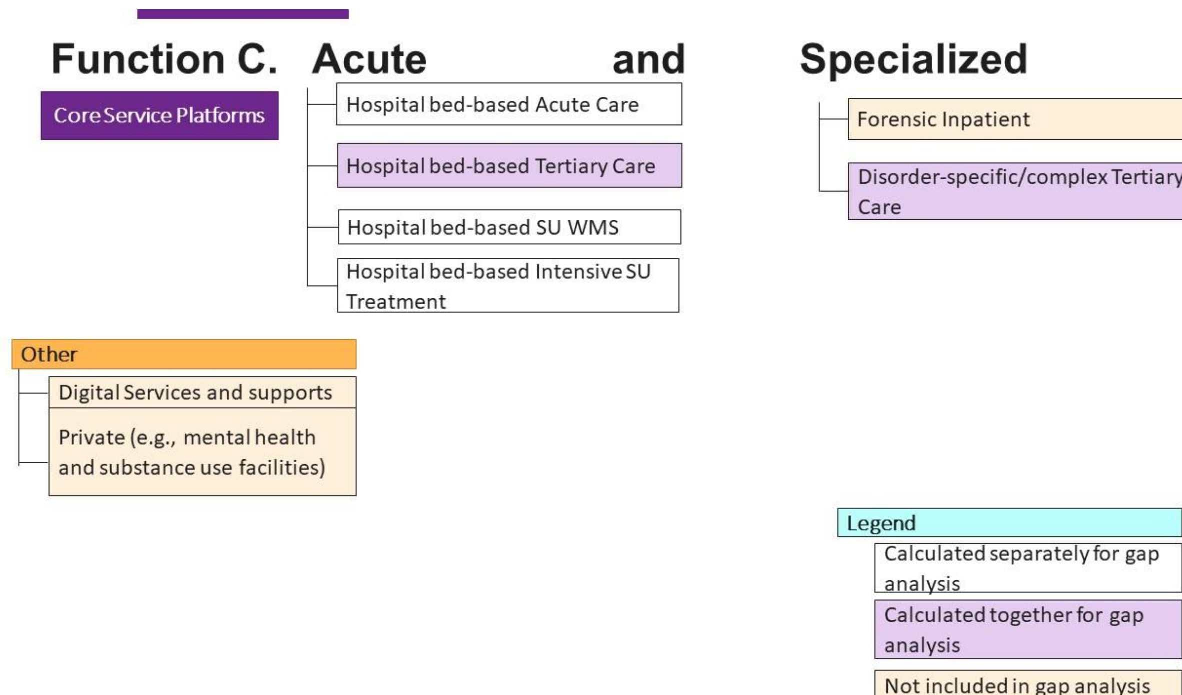


Overview of Community Treatment and Support Services





Overview of Acute and Specialized Services



Step 6: Estimating current core services supply and utilization

In this step, the NBP team worked to estimate the current core services supply and utilization by identifying where there are gaps (and potential surpluses) in each of the Core Services.

Step 7: Gap Analysis – by Core Service Category (number of individuals, FTE's or Beds)

In this step, several meetings were organized with a focus on validating the initial findings. It included:

- identifying areas that the working group found to be inaccurate or odd,
- following up with contributing stakeholders to review data submissions,
- re-examining the excel spreadsheets for errors or omissions, and
- presenting data findings to the working group, responding to questions and verifying the data.

Step 8: Interpretation - Implications of the Gap Analysis

In this step, NBP team worked closely with the working group to review the executive summary document and the key findings document. The team received and incorporated feedback on these documents, and provided additional details where requested.

When reviewing the following information, it will be important to keep the following points in mind:

1. The term core service typically implies "universal" **access** within a given geographic jurisdiction, including concrete provision, and accountability for ensuring that access is possible in another

jurisdiction if not available geographically (e.g., given economies of scale some specialized services cannot realistically be available in all local areas). Core services should also be **available** to all residents – that is, that the funder should ensure there is adequate capacity of services for individuals who need this type and level of support, while also maintaining service quality.

2. The results of Needs-Based Planning are intended to complement other information at hand and the experience of the members of the Working Group. It will, however, bring an evidence-based approach to the decision-making process that others have found helpful.
3. Some of the gaps that may be identified may well be best filled through resources dedicated to larger regions or even the province as a whole. Examples would include some intensive bed-based services such as hospital-based medical withdrawal management, or specialized mental health tertiary care.
4. For people with mild to moderate Mental Health and Addiction challenges (E.g., Tier 2 and part of Tier 3) the model estimates the need for primary care and some other services such as peer and family support. This is important because of the significant size of the population at that level of severity and highlights the important role of these services.
5. The estimated need is based on 100% help seeking, meaning that we are estimating that 100% of people that need help will actually seek the help they require. Based on this assumption the resulting gap is often quite large, and unrealistic to fully address in the immediate term, but it does show the overall level of population need as well as the importance of sequencing system enhancements through careful planning.
6. The population survey data upon which the community needs are estimated typically exclude certain groups. For example, people who are homeless or institutionalized (e.g., hospital or correctional facility) are not represented in underlying survey data. In addition, First Nations people living on-reserve are typically involved in other surveys. Further, problem gambling is not represented in the needs-based planning model as this is also not included in the population survey data. To compensate for some of these omissions, administrative health data have been used to supplement the community survey data.
7. Given the changes in service delivery and the manner in which individuals have sought service during the pandemic, pre-COVID service numbers were utilized for this pilot site.
8. When the Needs-based Planning process identifies a gap in a particular core service category there will still be work needed to identify the specific ways, means and service pathways to deliver that core service in the New Brunswick regional context. Further, it will be important to ensure that identified service delivery models will be planned and implemented according to accepted standards. In short, this is where Need-Based Planning ends and implementation of evidence-based and high-quality service improvements begins.
9. FTE estimates reflects the number of staff required to carry out the clinical work. Estimates have not been made for administrative FTEs that may be required to support clinical work.

The following sections of the report are organized around the core services included in the Needs-Based Planning process, and sometimes bundling this together to assist in presenting the gaps and interpretation to date.

For each core service (or sub-group of core services) we summarize things according to four sub-heading

- What do we mean by this core service?
- What did the gap analysis show?
- How should we interpret this result and what are the implications?

Mental Health/Substance Use Community Services

What do we mean by this core service?

This is a broad category of community-based services that provide screening, assessment and implementation of individualized treatment and support plans to people with mental health and/or substance use challenges that do not require the level of treatment and supports provided through bed-based services, including hospital services. Some services in this category may be focused primarily on mental health, others on substance use and, increasingly in many jurisdictions, blended services are offered. While there are many variations within this service category, this typically involves a scheduled course of one – two-hour sessions for mental health, substance use and related problems - in group sessions or individual formats.

One challenging aspect for this community service category concerns case coordination and case management since activities and supports for these important functions vary widely in scope and intensity. Included are case coordination activities as well as case management that is typically provided by individual staff members are included. However, more intensive, team-based case management such as provided through Substance Use or Mental Health Intensive Case Management Teams and inter-disciplinary Assertive Community Treatment (ACT) teams are identified as a separate core service.

Since many hospital-based mental health outpatient services provide services off-site in the community, often with strong collaborative arrangements with community mental health and substance use services, these outpatient services are also included in this category. Some of these outpatient services are population or diagnosis-specific (e.g., PTSD, Borderline Personality Disorders, Mood Disorders; Early Intervention for Psychosis, Community Geriatric Services) although the NBP model does not project capacity requirements for these diagnosis-specific challenges at the present time.

Importantly, in the NBP model, two additional core services fall in this broad category, but which also cannot be separated out for gap analysis. This includes:

- Coordinated/Central Access and Navigation Supports: *Centralized access* typically describes a one-stop shop or a “hub and spoke” model where clients go through a central intake and assessment process after which they are referred to the level of treatment and support that best matches their strengths and challenges. The model offers a single, central point of contact to access services offered by multiple providers. C*oordinated access*, in contrast, focuses on ensuring commonality in key intake, screening and assessment processes across the participating service providers, as well as agreements on pathways and protocols for referral and transitions among the providers and beyond. The general aim of a centralized/coordinated access model is to minimize the barriers people confront in locating and accessing the help they need. Specific features of centralized/coordinated models may include multiple means of access including web-based technology and direct walk-in services; structured, validated screening and assessment tools and processes; clear and consistent processes for referrals or authority for

direct admission into required services; and system navigation supports in making transitions which may include the use of peer-support workers.

- Consultation and Liaison Services which are comprised of professionals designated specifically to work as a liaison between a specialized mental health, substance use or concurrent disorder service and a community or hospital service which is frequently accessed by people with mental health or substance use challenges, including concurrent disorders. This may include consultation to one or more hospital departments, including but not limited to the ED, long-term care homes, housing services and secondary and post-secondary educational institutions.

What did the gap analysis show?

The gap analysis showed a large and significant gap in community mental health and substance use services, particularly with respect to physicians (Level 1), staff complement Level 2 that are trained and certified to deliver evidence-based psychotherapy, and Level 5 workers with lived experience providing peer/family support or healthy living activities. An over supply was identified in staff complement Level 3 professionals providing counselling, case coordination/management, and staff complement Level 4 that provide psychoeducation and psychosocial supports.

How should we interpret this and what are the implications?

- This gap in Level 2 presents significant challenges for supporting people requiring specialized treatment such as Cognitive Behaviour Therapy (CBT); Dialectical Behaviour Therapy (DBT); and/or Mindfulness Cognitive behaviour Therapy (MCBT). However, it is important to note that this gap is based on 100% help seeking, meaning that this gap identifies the number of FTE's at this staffing level required if everyone who required help, presented for help. Also, this level of expertise is available through private thests and non-for-profit organizations.
- Over the past two years, the province of New Brunswick has added approximately 140 clinicians, mostly Level 3 and Level 2. Given the shortfall that remains in Level 2 professionals, and the oversupply in Level 3 professionals there may be an opportunity here to review how these Level 3 professionals can be supported to gain credentialling to move into Level 2 positions where there is a large and significant gap.
- Although the findings suggest an oversupply of Level 4 workers, it is important to note that these workers play a key role within the system as they provide assistance in navigation, case management, supportive counselling and various activities that can improve a person's quality of life.
- Overall, the province is facing recruitment and retention challenges like all other jurisdictions across Canada. As part of the Five-Year Addiction and Mental Health Action Plan, an Education, Training and Knowledge Transfer Framework will be implemented over the next year in order to support professional development, best practices and consistent service delivery in the

Addiction and Mental Health Services Workforce. The system planners are hopeful that this would help with recruitment and retention to fill this gap.

Province of New Brunswick

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**
Level 1 - Physicians (Community Psychiatry)	101 Full Time Equivalents	55 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	94.9 Full Time Equivalents	384 Full Time Equivalents
Level 3 – Clinicians providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	334.4 Full Time Equivalents	Surplus of 43 Full Time Equivalents
Level 4 – Employees providing psychoeducation and psychosocial supports	85.4 Full Time Equivalents	Surplus of 61 Full Time Equivalents
Level 5 – Employees with lived experience providing peer/family support or healthy living activities	3 Full Time Equivalents	203 Full Time Equivalents

Horizon Health Network

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**
Level 1 - Physicians (Community Psychiatry)	67 Full Time Equivalents	40 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	55.15 Full Time Equivalents	274 Full Time Equivalents
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	213.1 Full Time Equivalents	Surplus of 13 Full Time Equivalents
Level 4 – Employees providing psychoeducation and psychosocial supports	50.25 Full Time Equivalents	Surplus 33 Full Time Equivalents

Level 5 - Employees with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents	141 Full Time Equivalents

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Level 1 - Physicians (Community Psychiatry)	16 Full Time Equivalents	11 Full Time Equivalents	25 Full Time Equivalents	10 Full Time Equivalents	22 Full Time Equivalents	14 Full Time Equivalents	4 Full Time Equivalents	5 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	13.65 Full Time Equivalents	69 Full Time Equivalents	13.2 Full Time Equivalents	94 Full Time Equivalents	20.8 Full Time Equivalents	91 Full Time Equivalents	7.5 Full Time Equivalents	20 Full Time Equivalents
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	33.7 Full Time Equivalents	17 Full Time Equivalents	76.8 Full Time Equivalents	Surplus of 12 Full Time Equivalents	73.35 Full Time Equivalents	Surplus of 5 Full Time Equivalents	29.25 Full Time Equivalents	Surplus of 13 Full Time Equivalents
Level 4 - Employees providing psychoeducation and psychosocial supports	11.5 Full-Timell Time Equivalents	Surplus of 7 Full-Time Equivalents	13.8 Full-Time Equivalents	Surplus of 8 Full Time Equivalents	18 Full Time Equivalents	Surplus of 12 Full-Time Equivalents	6.95 Full Time Equivalents	Surplus of 6 Full Time Equivalents
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents *Peer Support Workers	36 Full TiFull-Timeme Equivalents	0 Full Time Equivalents *Peer Support Workers	46 Full Time Full-Time Equivalents	0 Full Time Equivalents *Peer Support Workers	48 Full Time Equivalents	0 Full-Time Equivalents *Peer Support Workers	12 Full-Time Equivalents

	counted in FACT Teams		counted in FACT Teams		counted in FACT Teams		counted in FACT Teams	

Vitalité Health Network

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	Current Capacity	GAP
Level 1 - Physicians (Community Psychiatry)	34 Full Time Equivalent	15 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	39.75 Full Time Equivalents	110 Full Time Equivalents
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	121.3 Full Time Equivalents	Surplus of 30 Full Time Equivalents
Level 4 - Employees providing psychoeducation and psychosocial supports	35.15 Full Time Equivalents	Surplus of 27 Full Time Equivalents
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	3 Full Time Equivalents	61 Full Time Equivalents

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Level 1 - Physicians (Community Psychiatry)	14 Full Time Equivalents	4 Full Time Equivalents	3 Full Time Equivalents	7 Full Time Equivalents	9 Full Time Equivalents	Surplus of 4 Full Time Equivalents	8 Full Time Equivalents	8 Full Time Equivalents
Level 2 - Clinicians with competencies and credentialing for highly specialized assessment and therapy	10.05 Full Time Equivalents	45 Full Time Equivalents	9.9 Full Time Equivalents	20 Full Time Equivalents	5.7 Full Time Equivalents	10 Full Time Equivalents	14.1 Full Time Equivalents	35 Full Time Equivalents
Level 3 - Professionals with providing counselling, case coordination/management, transitional supports, medication supports, and psychosocial rehabilitation	35.5 Full Time Equivalents	Surplus of 2 Full Time Equivalents	30 Full Time Equivalents	Surplus of 12 Full Time Equivalents	15.8 Full Time Equivalents	Surplus of 6 Full Time Equivalents	40 Full Time Equivalents	Surplus of 10 Full Time Equivalents
Level 4 - Employees providing psychoeducation and psychosocial supports	5.75 Full Time Equivalents	Surplus of 3 Full Time Equivalents	10 Full Time Equivalents	Surplus of 8 Full Time Equivalents	12 Full Time Equivalents	Surplus of 11 Full Time Equivalents	7.4 Full Time Equivalents	Surplus of 5 Full Time Equivalents
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	1 Full Time Equivalents	23 Full Time Equivalents	1 Full Time Equivalents	12 Full Time Equivalents	1 Full Time Equivalents	6 Full Time Equivalents	0 Full Time Equivalents	21 Full Time Equivalents

Mental Health and Substance Community Services – Peer Support

What do we mean by this core service?

Peer and family support is a supportive relationship between people who have a lived experience in common. Some peer and family support services are focused on substance use, others on mental health and other in a blended service model. They have in common a shared experience with respect to mental health and/or substance use-related challenges.

Peer and family support is characterized by a set of values and processes of peer support—among them, recovery, empowerment, and hope. The most common form of peer and family support is self-help support groups where peers or family meet regularly to provide mutual support, without the involvement of professionals, and one-to-one peer and family support such as co-counseling, mentoring, or befriending. With increasing levels of recognition and government investment, there are also many types of peer and family support services that are more specialized, many of which are delivered through, or in collaboration, mainstream providers. Examples include support in housing, education, and employment; support in crisis (e.g., emergency department, and crisis services); traditional healing, especially with Indigenous people; system navigation (e.g., case management); and material support (e.g., food, clothing, storage, internet, transportation).

What did the gap analysis show?

The gap analysis showed a large and significant gap with respect to peer and family support services.

How should we interpret this and what are the implications?

- The gap analysis showed a large gap in peer and family support services. However, it is important to note that most of the province's peer support specialists work in FACT services and were not separated out for the gap analysis.
- A cornerstone of the Five Year Interdepartmental Addiction and Mental Health Action Plan is the implementation of a provincial Stepped Care continuum of services. Peer and family support as well as self-help are key elements of lower intensity services along such a continuum. As part of the Stepped Care implementation, the Department of Health and its partners, both within and outside of government, will be working collaboratively to build capacity and pathways in lower intensity services.
- The province is working closely with its partners to increase training capacity for peers and to create new and more positions in areas other than FACT services.

Province of New Brunswick

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	Current Capacity	GAP
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	3 Full Time Equivalents	203 Full Time Equivalents

Horizon Health Network

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	Current Capacity	GAP
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents	141 Full Time Equivalents

Horizon Health Network Zones

	Zone 1 H		**Zone 2**		**Zone 3**		**Zone 7**	
MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	0 Full Time Equivalents	36 Full Time Equivalents	0 Full Time Equivalents	46 Full Time Equivalents	0 Full Time Equivalents	48 Full Time Equivalents	0 Full Time Equivalents	12 Full Time Equivalents

Vitalité Health Network

MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	3 Full Time Equivalents	61 Full Time Equivalents

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
MH/SU Community Services (blended or Independent) includes (counselling, clinical, psychosocial)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Level 5 - Employees with lived experience providing peer/family support or healthy living activities	1 Full Time Equivalents	23 Full Time Equivalents	1 Full Time Equivalents	12 Full Time Equivalents	1 Full Time Equivalents	6 Full Time Equivalents	0 Full Time Equivalents	21 Full Time Equivalents

Intensive Case Management/Assertive Community Treatment Teams

What do we mean by this core service?

There are two important sub-categories in this category. The first category in Intensive Case Management, which can either be focused specifically on substance use or more broadly on mental health, including concurrent disorders. While this case management model is similar in many ways to the Assertive Community Treatment model (see below) clinicians have larger caseloads (20-1 client to staff ratio), frequency of visits is less (1-3 times per week), and the range of services are more frequently provided through a collaborative approach with other community providers rather than through one team.

The integrated team generally includes access to medical and psychiatric supports varies, staffing generally includes case managers, peer support workers, nurses, housing specialist and access to a psychiatrist.

The second model is the well-known Assertive Community Treatment (ACT) team which is distinguished from other models of intensive case management by its focus on adults with serious and persistent mental illness and which challenges the management of many aspects of daily living. Highly integrated interdisciplinary teams provide assertive wraparound coordination, services, and outreach, with low client-to-provider ratio (e.g., 10-1), and high frequency of visits (1-3 times per day).

What did the gap analysis show?

The gap analysis showed a significant gap with respect to intensive case management services for both substance use and mental health.

How should we interpret this and what are the implications?

Case management is delivered along a continuum of low to high intensity, the highest level being Assertive Community Treatment Teams. The gap analysis has identified a significant gap with respect to intensive case management services for substance use and mental health. It is noteworthy that no intensive case management services exist for individuals living with a substance use issues, and that is likely contributing to the pressure on the Emergency Department and Crisis Stabilization Services. Consideration should be given to the development of a FACT or ACT team dedicated to individuals living with Substance use issues.

New Brunswick has FACT teams throughout the province that are now well established with an evidence-based client/FTE ratio. FACT services admission criteria require diagnosis of a severe and persistent mental illness. That being the case, many individuals who have serious substance use issues and other mental health challenges that could benefit from a more intensive case management/wrap around service such as FACT are currently not able to access such a service. While the current 5-year Interdepartmental Addictions and Mental health Action plan does not include the creation of such a service, it does include the creation of a clinical consultation model for individuals with complex needs which may include a dedicated provincial team that would provide guidance, advice, navigation, and ongoing support to clinicians working with more complex cases.

Province of New Brunswick

Intensive Case Management Services (ICM)	**Current Capacity**	**GAP**
ICM, FACT & ACT for Mental Health	106.5 Full Time Equivalents	28 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Services not offered at present	149 Full Time Equivalents (Projected Need, NOT gap)

Horizon Health Network

Intensive Case Management Services (ICM)	**Current Capacity**	**GAP**
ICM, FACT & ACT for Mental Health	58.5 Full Time Equivalents	34 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Services not offered at present	102 Full Time Equivalents (Projected Need, NOT gap)

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
Intensive Case Management Services (ICM)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
ICM, FACT & ACT for Mental Health	9.75 Full Time Equivalents	13 Full Time Equivalents	21.5 Full Time Equivalents	9 Full Time Equivalents	18.5 Full Time Equivalents	13 Full Time Equivalents	8.75 Full Time Equivalents	Surplus of 1 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Services not offered at present	26 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	33 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	35 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	9 Full Time Equivalents (Projected Need, NOT gap)

Vitalité Health Network

Intensive Case Management Services (ICM)	Current Capacity	GAP
ICM, FACT & ACT for Mental Health	48 Full Time Equivalents	Surplus of 6 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Services not offered at present	46 Full Time Equivalents (Projected Need, NOT gap)

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
Intensive Case Management Services (ICM)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
ICM, FACT & ACT for Mental Health	20.5 Full Time Equivalents	Surplus of 5 Full Time Equivalents	8.75 Full Time Equivalents	0 Full Time Equivalents	8.75 Full Time Equivalents	Surplus of 4 Full Time Equivalents	10 Full Time Equivalents	4 Full Time Equivalents
ICM, FACT & ACT for Substance Use	Services not offered at present	17 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	9 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	5 Full Time Equivalents (Projected Need, NOT gap)	Services not offered at present	15 Full Time Equivalents (Projected Need, NOT gap)

Community-based Intensive Day or Evening Treatment Services

What do we mean by this core service?

Day/Evening treatment may be focused on either substance use or mental health challenges, the latter sometimes very specific to a grouping of diagnoses, such as PTSD, Mood Disorders, Borderline Personality Disorder or Eating Disorders.

Day evening treatment is sometimes referred to as "partial hospitalization" or "day hospital" and is an intensive type of non-bed-based services for individuals whose substance use or mental health-related needs are more complex than can be managed through standard outpatient services but yet do not require an inpatient stay. A structured, scheduled program of treatment and support activities is provided for a certain number of days or evenings per week (typically 4-5 days per week), and a certain number of hours per day/evening (typically 3-4 hours per day) while the client resides at home or in another setting such as a multi-functional bed-based service. There is variability in total number of hours of service per week. The distinguishing feature, however, is that there is no live-in component, although arrangements may be made with other services for accommodation while the person participates in the day/evening treatment services and supports.

As with Community Mental Health and Substance Use Services, and depending on organizational size and community context, many hospital-based mental health or substance use services deliver treatment on a day/evening basis off-site from the hospital, perhaps in collaboration with community mental health and/or substance use service, and, therefore, these services are also included in this category. These day or evening programs may be specialized in concurrent disorders.

What did the gap analysis show?

The gap analysis showed a significant gap with respect to Day/Evening treatment services for Substance Use Services and the ability for the current Mental Health Day/Evening Treatment Team to serve the number of individuals that require this service.

How should we interpret this and what are the implications?

- The province currently has only one Intensive Day Treatment Service located in the Moncton Area. It provides a Concurrent Capable approach. This service has been in operation for just over a year and preliminary results are promising. The province is considering to expand this model to other parts of the province. The service delivery design is very similar to the Live-in Concurrent Disorder Treatment Service in Campbelltown. Providing these services in other parts of the province may be a viable option for individuals who are waiting for Live-in treatment or who require intensive services but do not require live in treatment or are unable to leave their home for live-in treatment.
- Should the Intensive Day Treatment service be expanded beyond Moncton, consideration could be given to a "hub and spoke model", utilizing virtual technology to connect the hub site with the spoke sites for the group-based component of the treatment.

Province of New Brunswick

Day/Evening (Day Hospital, Partial Hospitalization)	**Current Capacity**	**GAP**
Substance Use & Mental Health	35 persons served (4 Full Time Equivalents)	6,358 persons in need

Horizon Health Network

Day/Evening (Day Hospital, Partial Hospitalization)	**Current Capacity**	**GAP**
Substance Use & Mental Health	35 persons served (4 Full Time Equivalents)	4,358 persons in need

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
Day/Evening (Day Hospital, Partial Hospitalization)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Substance Use & Mental Health	35 persons served (4 Full Time Equivalents)	1,068 persons in need	Services not offered at present	1,427 persons in need (projected need, Not gap)	Services not offered at present	1,496 persons in need (projected need, Not gap)	Services not offered at present	366 persons in need (projected need, Not gap)

Vitalité Health Network

Day/Evening (Day Hospital, Partial Hospitalization)	Current Capacity	GAP
Substance Use & Mental Health	Services not offered at present	2,000 persons in need

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
Day/Evening (Day Hospital, Partial Hospitalization)	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Substance Use & Mental Health	Service offered by Horizon Health Network accessible to Zone 1 V	735 persons in need (projected need, Not gap)	Services not offered at present	397 persons in need (projected need, Not gap)	Services not offered at present	213 persons in need (projected need, Not gap)	Services not offered at present	654 persons in need (projected need, Not gap)

Addiction Medicine Specialty Services

What do we mean by this core service?

Addiction medicine is a medical sub-specialty that deals with the diagnosis, prevention, evaluation, treatment, and recovery of persons with substance use disorders, and of people who otherwise show unhealthy use of substances including alcohol, nicotine, prescription medicine and other illicit and licit drugs. Addiction specialists may work independently or be part of another core service such as Rapid Access to Addictions Medicine (RAAM) or an Opioid Agonist Treatment (OAT) program.

What did the gap analysis show?

The gap analysis showed a large gap in the category of specialized Addiction Medicine.

How should we interpret this and what are the implications?

- While significant, the gap may be smaller than the results indicate due to the exclusion of private Opioid Agonist Treatment programs (e.g., OATC) from the analysis.
- It is also important to note that New Brunswick has Opioid Agonist Treatment (OAT) programs throughout the province, but they vary in operational procedures and staff complements. While most have some form of psychosocial supports available, the identified gap indicates there is a need for review.
- The biggest gap is in the area of physicians/prescribers. Recruitment efforts continue and likely need to include Nurse Practitioners as well as to explore the role Licenced Practical Nurses can play in Addiction Medicine Services.

Province of New Brunswick

Addiction Medicine	Current Capacity	GAP
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	21.68 Full Time Equivalents	34 Full Time Equivalents

Horizon Health Network

Addiction Medicine	Current Capacity	GAP
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	19.98 Full Time Equivalents	18 Full Time Equivalents

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
Addiction Medicine	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	6 Full Time Equivalents	4 Full Time Equivalents	6 Full Time Equivalents	6 Full Time Equivalents	6.15 Full Time Equivalents	7 Full Time Equivalents	1.83 Full Time Equivalents	1 Full Time Equivalents

Vitalité Health Network

Addiction Medicine	Current Capacity	GAP
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	1.7 Full Time Equivalents	16 Full Time Equivalents

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
Addiction Medicine	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Addiction Medicine Specialty Services (Physician, RAAM/RAAC, OAT, Managed Alcohol)	Services offered by Horizon Health Network accessible to Zone 1 V	6 Full Time Equivalents (Projected need, NOT gap)	Services not offered at present	3 Full Time Equivalents	0.95 Full Time Equivalents	1 Full Time Equivalents	0.75 Full Time Equivalents	5 Full Time Equivalents

Continuum of Withdrawal Management Services (WMS)

What do we mean by this core service?

This broad service category is comprised of:

- Acute Intoxication Services, sometimes referred to as "sobering centres", "brief detox" or "acute sobering unit" provide safe, short-term monitoring and management of symptoms of an episode of heavy alcohol and/or other drug use that cannot be managed at home. A core objective is to minimize ED presentations related to acute intoxication. There are two models of acute intoxication services – one community-based and other hospital based, the latter typically connected to the ED itself. These two models exist along a continuum of what could be described as "medically monitored" to "medically managed". Length of stay is brief, typically less than 24 hours although this will be somewhat longer in hospital-based models for medical management.
- Community home or mobile WMS provide supports in the person's home or other safe accommodation via on-site visits or via Internet-based supports. It may also involve visits to a central location (e.g., community addictions program, or a "safe home" in the community) during the day, while returning home at night. This is sometimes referred to as "daytox". Length of services depends on the range of supports offered, included access to low intensity case management after the immediate needs for safe withdrawal have been met.
- Community Bed-based WMS involves withdrawal management supports in a non-hospital, bed-based setting, and although "community-based", these services are often sponsored or otherwise administratively linked to a hospital to ensure quick access on an as-needed basis for medical emergencies. These community-based services may, however, provide some medical management and include a medical assessment and regular supports during the withdrawal process by physician, nurse practitioner, other nursing and/or other health care worker. The intensity of the medical management and monitoring varies by setting, and withdrawal may be supported with or without medication management. Length of stay is typically 8 days.
- Hospital Bed-based WMS involves withdrawal management supports in a health care setting for stabilization, withdrawal management and medical and psychosocial supports. While many community bed-based WMS services also offer medical supports, the hospital-based services in this category provide access to a significantly higher level of individualized medical and mental health treatment and support. This may include medication management such as tapering from opioids with a goal being to transition to in-house or externally offered Opioid Agonist Treatment, or other treatment and support depending on client choice for that option. Length of stay is typically less than 7 days but this can be quite variable depending on individual strengths and needs.

What did the gap analysis show?
The gap analysis showed a large gap in the area of acute intoxication services, in-home/mobile WMS and hospital bed based WMS as these services are not offered in the province at present.

How should we interpret this and what are the implications?

- The gap suggests a significant gap in the treatment continuum with respect to acute intoxication services, in-home/mobile WMS, and hospital bed based WMS. As with other service continuums, when some parts are missing, the parts that are available will become overburdened; people will not seek treatment; and/or people will not receive the level of treatment they require.
- With respect to a specialized Acute Intoxication Service, there may value in exploring how a more formalized organized model for provision of acute intoxication services in the Emergency Department could streamline current activities and better meet the needs of people presenting with the full range of acute intoxication challenges, including addressing the concurrent mental health issues.
- With respect to hospital bed-based, this may speak to a need for larger provincial capacity in this category.
- The results have indicated a surplus of community bed-based WMS, however, the Department of Health is not prepared to remove treatment beds from the continuum of care. The Department of Health will continue to monitor Withdrawal Management bed-based services and consider repurposing some of these beds to a more multipurpose function that includes services such as Supportive Recovery Beds (for longer-term stabilisation) or Multi-Functional Beds (for transition planning).
- Over the next year (2023-2024), NB will be implementing outpatient withdrawal management services as part of an overall Addiction Medicine framework. This will broaden the continuum of care, align with best practice and support population needs.
- Currently there is no formal mechanism to monitor, track and report on the need and utilisation of acute withdrawal management service in Hospital Emergency Departments. This should be a first step in better understanding this component of the continuum of substance use and mental health services.

Province of New Brunswick

Continuum of WMS	**Current Capacity**	**GAP**
Acute Intoxication Service	Service not offered at present	5.18 Beds (projected need, NOT gap)
In Home/Mobile WMS	Service not offered at present	35 Full Time Equivalents (projected need, NOT gap)
Community Bed Based WMS	85 Beds	Surplus of 50 Beds

Hospital Bed Based WMS	Service not offered at present	8.36 Beds (projected need, NOT gap)

Horizon Health Network

Continuum of WMS	**Current Capacity**	**GAP**
Acute Intoxication Service	Service not offered at present	3.56 Beds (projected need, NOT gap)
In Home/Mobile WMS	Service not offered at present	24 Full Time Equivalents (projected need, NOT gap)
Community Bed Based WMS	60 beds	Surplus of 36 Beds
Hospital Bed Based WMS	Service not offered at present	5.74 Beds (projected need, NOT gap)

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
Continuum of WMS	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Acute Intoxication Service	Service not offered at present	0.89 Beds (projected need, NOT gap)	Service not offered at present	1.16 Beds (projected need, NOT gap)	Service not offered at present	1.21 Beds (projected need, NOT gap)	Service not offered at present	0.30 Beds (projected need, NOT gap)
In Home/Mobile WMS	Service not offered at present	6 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	8 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	8 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	2 Full Time Equivalents (projected need, NOT gap)
Community Bed Based	20 Beds	Surplus of 14 Beds	20 Beds	Surplus of 12 Beds	10 Beds	Surplus of 2 Beds	10 Beds	Surplus of 8 Beds
Hospital Bed Based WMS	Service not offered at present	1.44 Beds (projected need, NOT gap)	Service not offered at present	1.87 Beds (projected need, NOT gap)	Service not offered at present	1.96 Beds (projected need, NOT gap)	Service not offered at present	0.48 Beds (projected need, NOT gap)

Vitalité Health Network

Continuum of WMS	Current Capacity	GAP
Acute Intoxication Service	Service not offered at present	1.62 Beds (projected need, NOT gap)
In Home/Mobile WMS	Service not offered at present	11 Full Time Equivalents
Community Bed Based WMS	25 Beds	Surplus 14 Beds
Hospital Bed Based WMS	Service not offered at present	2.61 Beds (projected need, NOT gap)

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
Continuum of WMS	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Acute Intoxication Service	Service not offered at present	0.60 Beds (projected need, NOT gap)	Service not offered at present	0.32 Beds (projected need, NOT gap)	Service not offered at present	0.17 Beds (projected need, NOT gap)	Service not offered at present	0.53 Beds (projected need, NOT gap)
In Home/Mobile WMS	Service not offered at present	4 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	2 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	1 Full Time Equivalents (projected need, NOT gap)	Service not offered at present	4 Full Time Equivalents (projected need, NOT gap)
Community Bed Based	Service not offered at present	4 Beds (projected need, NOT gap)	10 Beds	Surplus of 8 Beds	6 Beds	Surplus of 5 Beds	9 Beds	Surplus of 5Beds
Hospital Bed Based WMS	Service not offered at present	0.96 Beds (projected need, NOT gap)	Service not offered at present	0.52 Beds (projected need, NOT gap)	Service not offered at present	0.28 Beds (projected need, NOT gap)	Service not offered at present	0.85 Beds (projected need, NOT gap)

Substance Use Bed-based Treatment Continuum

What do we mean by this core service?

This broad service category is comprised of:

- Community Intensive Substance Use Bed-based Treatment whereby clients reside on-site and participate in a structured, scheduled program of interventions and activities with access to 24-hour support. While considerable variability exists within and across jurisdictions in program structure and activities a harm reduction approach is recommended which, among other things, means meeting people where they are at in their recovery journey; accepting people into treatment who are being treated with opioid agonist treatment and acceptance of relapse as part of the recovery journey. Quality of life and well-being are among the criteria for successful outcomes, which may or may not also include complete abstinence, depending on the individual's treatment goals. Programs generally range from 30-90 days with a variable length of stay recommended based on client strengths and needs.

- Supportive Recovery Services which provide temporary accommodation in a safe supportive, recovery-oriented environment often as a step down from intensive bed-based substance use treatment. These services may also be accessed when there is a high risk of relapse and individuals may simultaneously access outpatient and other community treatment services and supports. Programs generally range from 30-90 days but may be six months or even longer depending on program structure and target populations served.

- Multi-functional Substance Use Transition Services offer a variable length stay up to a maximum of 30 days of support (as a guideline) for physical, social, and psychological stabilization for people with moderate to severe substance use disorders. A key distinguishing characteristic is that there is minimal in-house programming given the focus on rest and stabilization. A focus on rest and stabilization, with minimal in-house programming, allows the individual to plan for entering a residential or non-residential treatment service (e.g., while on a wait list after withdrawal management). These transition beds may also be used to help the person make the transition from a residential service to a community non-residential service, for example after housing in the community has stabilized. In some cases, these beds can be part of a mobile withdrawal management program. (e.g., STAR beds in BC or Manitoba).

- Hospital Bed-based Substance Use Treatment, commonly referred to as "inpatient substance use treatment" or perhaps a "concurrent disorders unit" this involves a number of designated beds for stabilization, assessment, treatment and psychosocial supports for people with severe substance use disorders. This may be preceded by a period of medically supported withdrawal management. The distinguishing characteristic of these bed-based substance use treatment services is their capacity to offer in-house treatment of significant health, mental health, and other complex conditions. A variable length of stay is recommended but is typically over 21 days or longer based on clinical presentation. This core service also includes specialized beds for people with opioid use disorder (typically a 4-5 month stays) who have a high level of mental health and other co-morbidities .

What did the gap analysis show?

The gap analysis showed a significant gap across all components of this continuum for bed-based substance use treatment and support.

How should we interpret this and what are the implications?

- The bed-based services currently in place are provincial in nature and individuals from any part of the province can be admitted. At this point, looking at needs from a regional or zone perspective can help in identifying overall need but not necessarily treatment bed placement.
- There is a lack of diversity across the continuum of bed-based services, missing the key components of Multi-Functional beds, and Hospital Beds Based Substance use services. Increasing the diversity amongst this continuum would assist in meeting the varying needs of individuals along this continuum.
- The Live in Concurrent Disorder Treatment Service in Campbelltown is in the process of being expanded from 18 to 24 beds. The buildings housing the 12-bed treatment service in Saint John will be undergoing significant renovations over the next 8-12 months. Architects and Space Planners are exploring the possibilities of adding 6-8 beds within the existing building footprints.
- As investments in bed-based services can be considerable, the Department of Health will need to consider the NBP results carefully and ensure long term planning in this area meets the needs of the population and contributes to an effective and comprehensive continuum of stepped care.

Province of New Brunswick

Continuum of Bed Based Substance Use Services	Current Capacity	GAP
Multi-functional Bed Based Substance Use Services	Service not offered at present	132 Beds (projected need, NOT gap)
Community Bed Based Substance Use Services	52 Beds	119 Beds
Supportive Recovery Bed Based Substance Use Services	30 Beds	263 Beds
Hospital Bed Based Substance Use Services	Service not offered at present	68 Beds

Horizon Health Network

Continuum of Bed Based Substance Use Services	**Current Capacity**	**GAP**
Multi-functional Bed Based Substance Use Services	Service not offered at present	90 Beds (projected need, NOT gap)
Community Bed Based Substance Use Services	52 Beds	65 Beds
Supportive Recovery Bed Based Substance Use Services	30 Beds	171 Beds
Hospital Bed Based Substance Use Services	Service not offered at present	47 Beds (projected need, NOT gap)

Horizon Health Network Zones

	Zone 1H		Zone 2		Zone 3		Zone 7	
Continuum of Bed Based Substance Use Services	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Multi-functional Bed Based Substance Use Services	Service not offered at present	23 Beds (projected need, NOT gap)	Service not offered at present	29 Beds (projected need, NOT gap)	Service not offered at present	31 Beds (projected need, NOT gap)	Service not offered at present	8 Beds (projected need, NOT gap)
Community Bed Based Substance Use Services	Provincial access is available	29 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available	52 Beds (provincial beds)	Surplus of 14 Beds* *Provincial beds have been counted	Provincial access is available	40 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available	Provincial access is available	10 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available
Supportive Recovery Bed Based Substance Use Services	Service not offered at present	51 Beds (projected need, NOT gap)	30 Beds	35 Beds	Service not offered at present	69 Beds (projected need, NOT gap)	Service not offered at present	17 Beds (projected need, NOT gap)
Hospital Bed Based Substance Use Services	Service not offered at present	12 Beds (projected need, NOT gap)	Service not offered at present	15 Beds (projected need, NOT gap)	Service not offered at present	16 Beds (projected need, NOT gap)	Service not offered at present	4 Beds (projected need, NOT gap)

Vitalité Health Network

Continuum of Bed Based Substance Use Services	**Current Capacity**	**GAP**
Multi-functional Bed Based Substance Use Services	Service not offered at present	41 Beds (projected need, NOT gap)
Community Bed Based Substance Use Services	Service not offered at present	53 Beds (projected need, NOT gap)
Supportive Recovery Bed Based Substance Use Services	Service not offered at present	92 Beds (projected need, NOT gap)
Hospital Bed Based Substance Use Services	12 Beds	21 Beds (projected need, NOT gap)

Vitalité Health Network Zones

	Zone 1V		Zone 4		Zone 5		Zone 6	
Continuum of Bed Based Substance Use Services	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Multi-functional Bed Based Substance Use Services	Service not offered at present	15 Beds (projected need, NOT gap)	Service not offered at present	8 Beds (projected need, NOT gap)	Service not offered at present	4 Beds (projected need, NOT gap)	Service not offered at present	13 Beds (projected need, NOT gap)
Community Bed Based Substance Use Services	Service not offered at present	20 Beds (projected need, NOT gap)	Service not offered at present	11 Beds (projected need, NOT gap)	Service not offered at present	6 Beds (projected need, NOT gap)	Service not offered at present	17 Beds (projected need, NOT gap)
Supportive Recovery Bed Based Substance Use Services	Service not offered at present	34 Beds (projected need, NOT gap)	Service not offered at present	18 Beds (projected need, NOT gap)	Service not offered at present	10 Beds (projected need, NOT gap)	Service not offered at present	30 Beds (projected need, NOT gap)
Hospital Bed Based Substance Use Services	Provincial access is available	8 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available	Provincial access is available	4 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available	12 Beds	Surplus of 10 Beds * This would be the gap if provincial beds were not available	Provincial access is available	7 Beds (projected need, NOT gap) * This would be the gap if provincial beds were not available

Primary Care

What do we mean by this core service?

People commonly receive primary care services from physicians (general practitioner or family physician) or a nurse practitioner and this can be in solo or group practices or other service delivery models such as a family health team. Such primary care services are critical components of the overall community treatment and support services with mental health and substance use challenges; what are termed *core collaborating service providers* in the national core services framework.

For people with mild to moderate mental health and/or substance use challenges the primary care service may provide structured screening and brief intervention and referral to specialized services if needed. Primary care practitioners may also provide counselling, and medication management for people across a wide spectrum of severity living in the community.

What did the gap analysis show?

The gap/surplus for Primary Care is unknown as this information was unavailable, though it is projected that almost 335,176 people in the province could benefit from this support from their Primary Care Provider for a mental health or substance use related challenges.

How should we interpret this and what are the implications?

There are challenges interpreting this gap analysis for primary care for two important reasons. The first is that current data were not available on the number of people currently accessing these services and secondly, it would be rare indeed for a primary care professional to dedicate all their time to this important population. Without a quantitative estimate of the size of the gap the information is still important and shows:

- the importance of including primary care in the planning process (e.g., discussions about coordinated access);
- identifying the role of primary care in specific service pathways, and for specific populations (e.g., medication management for substance use or specific mental health challenges after specialized stabilization and treatment);
- advocating for continuing and perhaps enhanced training for primary care professionals in mental health and substance use, especially in the areas of screening and brief intervention;
- support for primary care professionals to be a part of a team that are able to support those individuals with complex needs, those who are marginalized and/or those who experience homelessness;
- the need for primary care providers to be attached to community mental health and addiction programs (e.g., ACTT); and
- the need for primary care providers to be involved with those individuals who are experiencing less severe symptoms, but where consultation would prove beneficial.

Given the large number of individuals requiring some form of mental health and/or addiction support from their primary care providers, it is imperative that as future system planning is conducted, primary

care providers must be active partners and collaborators in the co-design of the Mental Health and Addiction System.

Province of New Brunswick

Primary Care	Current Capacity	Projected Need
Physicians & Nurse Practitioners	Data not available at this time	314,954 people in need

Horizon Health Network

Primary Care	Current Capacity	Projected Need
Physicians & Nurse Practitioners	Data not available at this time	214,360 people in need

Horizon Health Network Zones

	Zone IH		Zone 2		Zone 3		Zone 7	
Primary Care	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**
Physicians & Nurse Practitioners	Not available at this time	53,835 people in need	Not available at this time	69,646 people in need	Not available at this time	72,994 people in need	Not available at this time	17,885 people in need

Vitalité Health Network

Primary Care	Current Capacity	Projected Need
Physicians & Nurse Practitioners	Data not available at this time	97,594 people in need

Vitalité Health Network Zones

	Zone IV		Zone 4		Zone 5		Zone 6	
Primary Care	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**

Physicians & Nurse Practitioners	Data not available at this time	35,890 people in need	Data not available at this time	19,387 people in need	Data not available at this time	10,410 people in need	Data not available at this time	31,907 people in need

Emergency and crisis

What do we mean by this core service?

This broad service category is comprised of:

- Emergency Departments (ED), including those that are specialized in mental health and substance use and which may be affiliated with a specialized mental health facility.
- Urgent Care Clinics, including those specialized in mental health and substance use, and which offer walk-in support to those with less urgent needs than typically requiring support in an ED.
- Crisis Stabilization Units which are 24/7 bed-based services that offer a short-term alternative to acute hospital-based care, providing crisis response and assessment and short-term interventions.
- Crisis Intervention Services which may be delivered through a mix of options including a mobile crisis team, distinguished for its outreach capacity, and sometimes including police officers, and/or located on site at a hospital for walk-in support as well as via telephone and/or Internet-based contact.

The focus of all these options is to support the management of an acute situation with the goal being to transition the individual to the next appropriate level of treatment and support based on individual strengths and needs, for example, inpatient services in the hospital or follow-up and continuing treatment and support in community-based services.

What did the gap analysis show?

The gap analysis showed that a large and important gap exists in regional ED capacity to support people with mental health and addictions. The current capacity for bed-based crisis stabilization and mobile crisis services is over the required capacity, but it is important to highlight that this over capacity reflects a situation where the current gap in community mental health and substance use services were filled.

How should we interpret this and what are the implications?

- The estimate of required ED beds for mental health and substance use, like the estimate for primary care, is based on assumption that these beds would need to be dedicated 100% time to these individuals in need.
- With respect to Crisis Stabilization, the information suggesting that current capacity may be larger than actually required no doubt reflects the significant gap in community mental health and substance use services which, if new investments brought it much closer to the required capacity, would reduce the need for crisis intervention as well as ED utilization.
- Given that local stakeholders report very heavy use of the existing crisis services, and the number of people in receipt of Crisis services is more than four times that of the projected need,

should NOT signal a need to reduce current capacity. Rather the data illustrates the inter-connectedness of all the components of a mental health and substance use treatment and support system and signal the need to invest in those community-based resources.

- In May of 2021, the Department of Health, Vitalité and Horizon Health Networks created a report containing 21 recommendations aimed at improving the crisis response within the Addiction and Mental Health Service and particularly within Emergency Departments. This included creating dedicated mental health workers within the Emergency Department along with dedicated space for individuals experience mental health issues as they are triaged and assessed. One site is now operational and over 2022/2023 other Emergency Departments will follow.

Province of New Brunswick

Emergency and Crisis	**Current Capacity**	**GAP**
Emergency Department	Service not available at present	7.36 Beds (Projected need, NOT Gap)
Urgent Care/Stabilization Unit	7 Beds	Surplus 4 Beds
Crisis Intervention/Mobile Crisis	9,023 people being served	2,120 people requiring service (Note: This estimate is provided with the understanding that all other parts of the system would be in place, thereby reducing the reliance on Crisis Services)

Horizon Health Network

Emergency and Crisis	**Current Capacity**	**GAP**
Emergency Department	Service not available at this time	5 Beds (Projected need, NOT Gap)
Urgent Care/Stabilization Unit	2.5 Beds	0 Beds
Crisis Intervention/Mobile Crisis	7,507 people being served	1,457 people requiring service (Note: This estimate is provided with the understanding that all other parts of the system would be in place, thereby reducing the reliance on Crisis Services)

Horizon Health Network Zones

	Zone 1 H		Zone 2		Zone 3		Zone 7	
Emergency and Crisis	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Emergency Department	Service not available at present	1.27 Beds (Projected need, NOT Gap)	Service not available at present	1.64 Beds (Projected need, NOT Gap)	Service not available at present	1.72 Beds (Projected need, NOT Gap)	Service not available at present	0.42 Bed (Projected need, NOT Gap)
Urgent Care/Stabilization Unit	2.5 Beds	Surplus of 2 Bed	Service not available at present	0.76 Beds Projected need, NOT Gap)	Service not available at present	0.8 Beds (Projected need, NOT Gap)	Service not available at present	0.2 Beds (Projected need, NOT Gap)
Crisis Intervention/Mobile Crisis	1,350 people being served	366 people requiring service	2,142 people being served	473 people requiring service	3,989 people being served	496 people requiring service	26 people being served	122 people requiring service

Vitalité Health Network

Emergency and Crisis	**Current Capacity**	**GAP**
Emergency Department	Service not offered at present	2.3 Beds (Projected need, NOT Gap)
Urgent Care/Stabilization Unit	4.5 Beds	Surplus of 3 Beds
Crisis Intervention/Mobile Crisis	1,516 people being served	663 people requiring service (Note: This estimate is provided with the understanding that all other parts of the system would be in place, thereby reducing the reliance on Crisis Services)

Vitalité Health Network Zones

	Zone 1 V		Zone 4		Zone 5		Zone 6	
Emergency and Crisis	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Emergency Department	Service not offered at present	0.85 Beds (Projected need, NOT Gap)	Service not offered at present	0.46 Bed (Projected need, NOT Gap)	Service not offered at present	0.25 Beds (Projected need, NOT Gap)	Service not offered at present	0.75 Bed (Projected need, NOT Gap)
Urgent Care/Stabilization Unit	Data difficult to gather	Surplus of 2 Beds	Data difficult to gather	0.21 Beds Projected need, NOT Gap)	Data difficult to gather	Surplus of 1 Bed	Data difficult to gather	0.35 Beds (Projected need, NOT Gap)
Crisis Intervention/Mobile Crisis	Data difficult to gather	244 people requiring service	364 people being served	132 people requiring service	477 people being served	71 people requiring service	675 people being served	217 people requiring service

Supportive/Supported Housing - High and Moderate Support

This core service category includes a large number and variety of service delivery models.

- In Supportive Housing, housing and support are linked, with staff members providing various levels of support within the residences. This type of housing usually features group home settings but can sometimes include low-support, self-contained apartments.
- In Supported Housing, housing and support are separate functions. There are no staff members on-site. Support services are provided from outside the home, usually in the form of case management. Supported housing usually consists of independent apartments, housing co-operatives or other government-funded social housing for people with low income. Important features included social support, good housing quality, privacy, a small number of residents and resident control.
- Some jurisdictions such as Ontario provide Substance Use-Specific Supported Housing and in others (indeed the majority of Canadian jurisdictions) the housing supports are targeted at needs related to both mental health and substance use.
- The "Housing First" model encompasses both a set of key principles (e.g., housing is a basic human right; the separation of housing and services; personal choice and self-determination, recovery orientation and harm reduction) as well as key features such as scattered-site housing and independent apartments and provision of significant supports for mental health and substance use (e.g., an ACT or ICM team). Importantly, housing is provided first and then supports are provided including physical and mental health,
- Supportive and supported housing are similar in many respects (e.g., provision of housing and supports such a medication management when needed), focusing on community integration). Coupled with case management, persons living in supportive or supported housing can also be linked to a wide variety of social services as job training, life skills training, community support services (e.g., childcare, educational and recreational programs, support groups).
- "Low barrier" housing is another approach to supported housing for individuals with substance use challenges who are continually at risk of being homeless, or who are homeless and require a safe place to live. There is no requirement for the person to be abstinent or involved in treatment to access this housing. However, it is important to note that in some jurisdictions an important distinction is drawn between sober housing and other low-barrier housing.
- Importantly, the capacity requirements for Supportive/Supported Housing also includes estimated level of need for financial supports through rent supplements or other means of financial subsidy. Rent supplements are also often included in Supported Housing models, for example in Ontario. The NBP model can separate out supported or supportive housing, inclusive of rent supplements, from subsidized housing.

What did the gap analysis show?

The current capacity for supportive and subsidized housing was largely unknown in these two categories, therefore the analysis shows the projected need rather than the gap.

How should we interpret this and what are the implications?

Given the large number of individuals who are homeless or precariously housed in some part of the province (Moncton estimates about 400 for example), there is certainly a need for more supported and supportive housing as is also indicated by the NBP findings. Most of the existing supportive housing services tend to focus more on mental health needs and in particular the needs of those with more severe mental health issues. There seems to be few housing units for individuals experiencing substance use issues. It would be helpful for further work to be completed in order to understand the available number of Supportive and Subsidized Housing units and therefore better understand the quantitative gap.

The 5-year Interdepartmental Addiction and Mental Health Action Plan identifies supportive housing an area of focus and priority with expected project start dates in early 2023. At this stage, more work is needed in detailed system mapping to fully understand the current landscape of supportive housing. The Department of Health will work with other key government departments such as Social Development, the Regional Health Networks as well as NGOs to develop a more detailed plan to improve this key component of the continuum of services. The Department of Social Development also has its Housing Strategy, and it will be important to work collaboratively to ensure alignment. The result of NBP will be critical for system planning in this area.

Province of New Brunswick

Supportive Housing	Current Capacity	Projected Need
Mental Health and Substance Use Supportive Housing	Not clearly defined at this time	4,519 persons in need
Subsidized Housing	**Current Capacity**	**Projected Need**
Mental Health & Substance Use Subsidized Housing	14,624 clients* not dedicated to MHSU	8,692 persons in need

Horizon Health Network

Supportive Housing	Current Capacity	Projected Need
Mental Health and Substance Use Supportive Housing	Not clearly defined at this time	3,105 persons in need
Subsidized Housing	**Current Capacity**	**Projected Need**
Mental Health & Substance Use Subsidized Housing	Breakdown not available by zones	5,973 persons in need

Horizon Health Network Zones

	Zone 1H		Zone 2		Zone 3		Zone 7	
Supportive Housing	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**
Mental Health and Substance Use Supportive Housing	Breakdown not available by zones	780 persons in need	Breakdown not available by zones	1,009 persons in need	Breakdown not available by zones	1,057 persons in need	Breakdown not available by zones	259 persons in need
Subsidized Housing								
Mental Health and Substance Use Subsidized Housing	Breakdown not available by zones	1,500 persons in need	Breakdown not available by zones	1,941 persons in need	Breakdown not available by zones	2,034 persons in need	Breakdown not available by zones	498 persons in need

Vitalité Health Network

Supportive Housing	Current Capacity	Projected Need
Mental Health and Substance Use Supportive Housing	Breakdown not available by zones	1,414 people in need
Subsidized Housing	**Current Capacity**	**Projected Need**
Mental Health and Substance Use Subsidized Housing	Breakdown not available by zones	2,719 people in need

Vitalité Health Network Zones

	Zone 1V		Zone 4		Zone 5		Zone 6	
Supportive Housing	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**	**Current Capacity**	**Projected Need**
Mental Health and Substance Use Supportive Housing	Breakdown not available by zones	520 persons in need	Breakdown not available by zones	281 persons in need	Breakdown not available by zones	151 persons in need	Breakdown not available by zones	462 persons in need
Subsidized Housing								
Mental Health and Substance Use Subsidized Housing	Breakdown not available by zones	1,000 persons in need	Breakdown not available by zones	540 persons in need	Breakdown not available by zones	290 persons in need	Breakdown not available by zones	889 persons in need

Mental Health Bed-based Continuum

What do we mean by this core service?

This broad service category is comprised of:

- Hospital Bed-based Acute Care commonly referred to as an Acute Inpatient Psychiatry Unit (AIPU), General Psychiatry Unit (GPU) or Mental Health Unit (MHU) or just under the broad umbrella of "acute care inpatient psychiatry" (this category includes Psychiatric Intensive Care Units/Beds – PICU). This involves a number of designated beds for stabilization, assessment, treatment and support for people experiencing an acute mental health condition and who may need safety monitoring, stabilization, assessment, treatment and support, including but not limited to medication management. Length of stay can be variable but often the anticipated duration is 1-2 weeks, and which may complement additional services provided through longer stay inpatient units. The focus is on support in managing an acute situation with the goal being to transition the individual to the next appropriate level of treatment and support based on individual strengths and needs, for example, longer term inpatient or outpatient, community-based services. As such the focus of these services is two-fold – treatment and support as an inpatient but also discharge planning to other appropriate supports.
- Hospital Bed-based Tertiary Care commonly referred to as "a psychiatric or mental health facility", this involves a number of designated beds for longer-term stays than for the acute care mental health services. That being said, admissions can be quite variable in terms of duration. The focus is on assessment, treatment and support for people experiencing severe and refractory mental illness who have not responded to treatment and/or have difficulty maintaining successful community tenure despite exhausting all available supports and interventions. Where possible, the aim is to transition the individual to outpatient, community-based services for ongoing treatment and psychosocial support. Some of these tertiary care services may have highly specialized units, for example, for people with Acquired Brain Injury, and may be considered in the core service category Disorder-Specific/Complex Tertiary Care (e.g., Psychogeriatrics, Acquired Brain Injury) or Inpatient Forensics.
- Transitional/Long-term Bed-Based Mental Health Recovery, which includes several sub-categories that vary across provinces and territories. In Ontario, the longer-term facilities typically fall under the jurisdiction of Homes for Special Care (HSC), the Ministry of Health and Long-Term Care province-wide residential care program for adults with serious mental illness. The HSC Program offers more than just residential group homes and, depending on location/site, includes a variety of services to assist people to explore and fulfill life expectations beyond psychiatric stabilization and health maintenance.
- Transitional/Long-term Bed-based Mental Health Recovery – (Respite), this Core Service is the same as described above, except that this service is specifically for individuals living with a Developmental Disability.
- Other terms and examples include:

- Licensed Community Residences which provide supervision (24 hours a day, 7 days per week) and with professional staff available to assist residents as needed, including managing the storing and dispensing of patients' medications.
- Supported Living Homes which offer staff support during certain daytime hours and where residents are responsible for taking their own medication.

What did the gap analysis show?
The gap analysis showed that capacity for Hospital-based Acute Care was about right-sized to meet the current needs. A oversupply was identified within the category of Transitional/Long-term Bed-Based Mental Health Recovery services (Special Care Homes), and for Hospital-Based Tertiary Care..

How should we interpret this and what are the implications?

As with supportive housing, more detailed system mapping will be required in the areas of long-term bed based transitional services to fully understand existing capacity. While a surplus of Long-term bed-based Mental Health Recovery/Transitional is shown, the beds are not transitional in nature, rather individuals tend to live in these beds permanently.

The NBP model suggests that current hospital bed based acute care is right sized on a provincial level. However, the population of NB has grown significantly since the census data used in NBP and acute care units are consistently at full or over capacity.

Hospital bed-based Tertiary Care/ Disorder-specific/complex hospital bed-based services are provincial in nature and would be best looked at in that lens. The gap will be considered, however, the system is looking to plan for additional community supports that will reduce the need for tertiary beds.

The Department of Health, along with its partners in Horizon and Vitalité will continue to monitor these service as we expand and broaden the continuum of care through a Stepped Care Model.

Province of New Brunswick

Mental Health Bed Based Continuum	**Current Capacity**	**GAP**
Hospital Based Acute Care	177 Beds	Surplus of 2 Bed
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Capacity unknown at this time	230 Beds (projected need, NOT Gap)
Long-term bed-based Mental Health Recovery/Transitional (Special Care Homes)	654 Beds	Surplus of 501 Beds
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	190 Beds	Surplus of 40 Beds

Horizon Health Network

Mental Health Bed Based Continuum	**Current Capacity**	**GAP**
Hospital Based Acute Care	91 Beds	29 Beds
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Capacity unknown at this time	158 Beds (projected need, NOT Gap)
Long-term bed-based Mental Health Recovery/Transitional – Special Care Homes	Service not available at present	105 Beds (projected need, NOT Gap)
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	50 Beds	53 Beds

Horizon Health Network Zones

	Zone 1H		Zone 2		Zone 3		Zone 7	
Mental Health Bed Based Continuum	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Hospital Based Acute Care	31 beds	Surplus of 1 bed	23 beds	16 beds	25 Beds	16 beds	12 beds	Surplus of 2 beds
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Capacity unknown at this time	40 beds (projected need, NOT Gap)	Capacity unknown at this time	51 beds (projected need, NOT Gap)	Capacity unknown at this time	54 beds (projected need, NOT Gap)	Capacity unknown at this time	13 beds (projected need, NOT Gap)
Long-term bed-based Mental Health Recovery/Transitional –Special Care Homes	Service not available at present	26 beds (projected need, NOT Gap)	Service not available at present	34 beds (projected need, NOT Gap)	Service not available at present	36 beds (projected need, NOT Gap)	Service not available at present	9 beds (projected need, NOT Gap)
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	Provincial access is available	26 beds (projected need, NOT Gap) * This would be the gap if provincial	50 beds (provincial facility)	Surplus of 17 beds * This would be the gap if	Provincial access is available	35 beds (projected need, NOT Gap) * This would be the gap if provincial beds	Provincial access is available	9 beds (projected need, NOT Gap) * This would be the gap if provincial beds

		beds were not available		provincial beds were not available		were not available		were not available

Vitalité Health Network

Mental Health Bed Based Continuum	Current Capacity	GAP
Hospital Based Acute Care	86 Beds	Surplus of 31 Beds
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Capacity unknown at this time	72 Beds (projected need, NOT Gap)
Long-term bed-based Mental Health Recovery/Transitional – Special Care Homes	Service not available at present	48 Beds (projected need, NOT Gap)
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	140 Beds	Surplus of 93 Beds

Vitalité Health Network Zones

	Zone 1V		Zone 4		Zone 5		Zone 6	
Mental Health Bed Based Continuum	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**	**Current Capacity**	**GAP**
Hospital Based Acute Care	24 beds	4 beds	15 beds	4 beds	20 beds	Surplus of 14 beds	27 beds	Surplus of 9 beds
Long-term bed-based Mental Health Recovery/Transitional – Respite Note: This service is only for people living with a Developmental Disability.	Capacity unknown at this time	26 beds (Projected Need not gap)	Capacity unknown at this time	14 beds (Projected Need not gap)	Capacity unknown at this time	8 beds (Projected Need not gap)	Capacity unknown at this time	23 beds (Projected Need not gap)
Long-term bed-based Mental Health Recovery/Transitional – Special Care Homes	Service not available at present	18 beds (Projected Need not gap)	Service not available at present	10 beds (Projected Need not gap)	Service not available at present	5 beds (Projected Need not gap)	Service not available at present	16 beds (Projected Need not gap)
Hospital bed-based Tertiary Care OR Disorder-specific/complex hospital bed-based	Provincial access available	17 beds (Projected Need not gap) * This would be the gap if provincial	Provincial access available	9 beds (Projected Need not gap) * This would be the gap if provincial	140 beds (provincial facility)	Surplus of 135 beds 5 beds* * This would be the gap if provincial	Provincial access available	15 beds (Projected Need not gap) * This would be the gap if provincial

		beds were not available		beds were not available		beds were not available		beds were not available	

3.0 Summary of Highlights

1. Gap in Community Treatment and Support Services: The gap analysis showed a large and significant gap in community mental health and substance use services, particularly with respect to the staff complement (Level 2) that are trained and certified to deliver evidence-based psychotherapy. Given the significant issues with recruitment and retention in rural areas, consideration may be given to innovative practices such as hiring Level 2 clinicians to provide treatment virtually via larger urban centres within New Brunswick, and/or investigating how the new provincial training program could train existing clinicians to a level required to deliver evidence based structured psychotherapy.

2. Fulsome Continuum for Withdrawal Management Services (WMS): The gap analysis showed a lack of diversity along the continuum of withdrawal management services, with no capacity for Acute Intoxication Services, no capacity for In-Home/Mobile WMS, and no capacity for Hospital Bed-Based WMS. Missing these parts of the WMS continuum means that the part of system that is in place (Community Bed Based WMS) may become overburdened; individuals will not seek treatment as Community Bed Based WMS is the only option; or individuals will not receive the level of treatment they require. As in many other jurisdictions investments have not been made to diversify the continuum of withdrawal management services and diversification of WMS should be considered an area of priority for New Brunswick. It is important to note that as the continuum of WMS expands, there must be a medical component to new services, so that those individuals who choose to withdraw with medical support may do so.

3. Intensive Case Management: The gap analysis showed a large and significant gap with respect to intensive case management services, in particular for those living with substance use issues. Consideration should be given to the development of a FACT or ACT team dedicated to individuals living with Substance use issues.

4. Fulsome Continuum for Bed Based Substance Use Services: Consideration should be given to increasing capacity In New Brunswick in Multi-functional Substance Use Transition Services, and Hospital Bed Based Services where there is currently no capacity in the system. The significant gap in Supportive Recovery Bed Based Substance Use Services is also noteworthy given the important role this service plays in supporting individuals following live-in treatment.
Increasing the diversity amongst this continuum would assist in meeting the varying needs of individuals along this continuum.

5. Supportive Housing: Given that the obtainable information is currently not clearly defined and largely unavailable for Supportive Housing and Subsidized Housing, it would be worthwhile for system planners in New Brunswick to spend the time required to obtain these numbers in order to understand the gap and plan accordingly based on that gap.

6. Community Based Day/Evening Treatment Services (SU, MH, or CD): Given the significant need in New Brunswick for this type of non-bedded intensive service, and given the promising early results of this new service in Moncton, consideration ought to be given to expanding this service for those individuals whose substance use or mental health-related needs are complex in a nature but yet do not require live-in treatment or are unable to leave their home for live-in treatment.

7. Peer Support: The gap analysis showed a large gap in peer and family support services; however, it is important to note that most of the province's peer support specialists work in FACT services and were not separated out for the gap analysis. The benefits of the supportive relationship between people/families who have a lived experience with people who are seeking treatment/in treatment are well known. Consideration ought to be given to understanding how many peer and family support workers are embedded in other complementary services across New Brunswick. This would help to inform where there are opportunities to enhance existing services with peer and family support services.

8. Addiction Medicine: The gap analysis showed a fairly significant gap in this category of specialized Addiction Medicine, presenting an opportunity to develop Rapid Access Addiction Medicine (RAAM) clinics in communities in New Brunswick; develop Addiction Medicine Consult Service (AMCS) to build a continuity of care for individuals who access hospital in crisis as a result of their substance use; and/or develop a managed alcohol program. Given the challenges transitioning individuals back to Primary Care who live with a substance use issue, careful planning and/or innovative models must be considered, including both Nurse Practitioners and Family Physicians in the planning of any new Addiction Medicine services.

9. Emergency and Crisis: It is noteworthy that there are currently no beds in any emergency department in the province that are dedicated to the care of individuals who live with Mental Health and Addiction issues. Consideration for this specialized level of care ought to be considered. With respect to the significant over capacity in Crisis Intervention/Mobile Crisis this overcapacity reflects an ideal state where the necessary investments in community mental Health and substance use services have been made, thereby reducing the need for crisis intervention.

10. Mental Health Bed Based Continuum: While a surplus of Long-term bed-based Mental Health Recovery/Transitional is shown, the beds are not transitional in nature, rather individuals tend to live in these beds permanently. In regard to Respite services, this category is largely unknown outside of British Columbia, and largely only in place for individuals who live with Developmental Disabilities. *Note: More detailed work will be completed on the methodology specific to Long-term bed-based Mental Health Beds with the extension of this pilot project.

11. Primary Care: There is a significant need for primary care providers to be providing mental health and addictions support to their rostered patients, with an estimated need of almost 336, 000 people in the province of New Brunswick. Given the large number of individuals requiring some form of mental health and/or addiction support from their primary care provider, it is imperative that as future system

planning is conducted, primary care providers must be active partners and collaborators in the co-design of the Mental Health and Addiction System.

4.0 Recommendations for Planners and Health Service Providers

The recommendations below reflect both the quantitative analysis and the experience and knowledge of the New Brunswick Working group.

Priority Areas for Investment:

1. Mental Health/Substance Use Community Services: Investment in ***Level 2 clinicians*** who are able to provide specialized treatment.
2. Continuum of Withdrawal Management Services (WMS): Diversify the continuum of WMS services with the development of an ***In-Home/Mobile WMS***, and the development of an ***Acute Intoxication Service*** (within or within close proximity of the Hospital Emergency Department). ***Note:*** There must be a medical component to both of these new services.
3. Substance Use Bed-based Treatment Continuum: Diversify the continuum of Substance Use Bed-Based Treatment starting with the development of a ***Multi-functional Substance Use Transition Service*** and the expansion of the current ***Supportive Recovery Services.***
4. Addiction Medicine Specialty Services: Consideration should be given to investing in additional Addiction Medicine services such as ***Rapid Access Addiction Medicine (RAAM)*** services and/or ***Addiction Medicine Consult (AMCS) services***.
5. Day or Evening Treatment Service: Consideration ought to be given to expanding this new intensive non-bedded service to other jurisdictions in New Brunswick, potentially utilizing virtual technology to link the sites. ***Note:*** There must be a medical component to this service.

Priority areas for System Planning work:

1. Primary Care: As future system planning is conducted ***primary care providers must be active partners and collaborators*** in the co-design of the Mental Health and Addiction System. Given the challenges transitioning individuals back to Primary Care who live with a substance use issues, this is an area of priority.
2. Supportive Housing: Consideration ought to be given for system planners in New Brunswick to spend the time required to obtain the number of Supportive Housing units and Subsidized Housing units available in their region in order to understand the gap and plan accordingly based on that gap.
3. Peer Support: Consideration ought to be given to understanding how many peer and family support workers are embedded in other complementary services across New Brunswick.

Appendices:

Appendix A: CCHS 2012 Tier Severity Criteria

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
Tier 1	No CIDI disorder **-and-** No non-cannabis illicit drug use **-and-** Prescription drug use only as prescribed **-and-** No perceived need for care **-and-** Drinking below **(our approximation to)** the low-risk guidelines: Men: Up to 15 drinks per week; Up to 3 drinks per day most days Women: Up to 10 drinks per week; Up to 2 drinks per day most days **-and-** Cannabis use: never, **-or-** just once (past 12m or lifetime), **-or-** more than once > 12m ago, **-or-** more than once in the past 12m **and** frequency was < once a month.	No CIDI alcohol **-or-** drug disorder **-and-** No non-cannabis illicit drug use **-and-** Prescription drug use only as prescribed **-and-** No perceived need for care **-and-** Drinking below **(our approximation to)** the low-risk guidelines: Men: Up to 15 drinks per week; Up to 3 drinks per day most days Women: Up to 10 drinks per week; Up to 2 drinks per day most days **-and-** Cannabis use: never, **-or-** just once (past 12m or lifetime), **-or-** more than once > 12m ago, **-or-** more than once in the past 12m **and** frequency was < once a month.
Tier 2	One abuse problem (out of 4) related to alcohol **-or-** cannabis **-or-** other drugs excl. cannabis, 12m **OR** Binge drinking (5+ drinks on one occasion), *once a month* **-or-** *2-3 times a month* **-or-** *once a week* **-or-** *more than once a week* **OR** Drinking above the LRDG: Men: **(**> 3 drinks per day on most days **-or-** >15 drinks per week**)** Women: **(**>2 drinks per day on most days **-or-**	One abuse problem (out of 4) related to alcohol **-or-** cannabis **-or-** other drugs excl. cannabis, 12m **OR** Binge drinking (5+ drinks on one occasion), *once a month* **-or-** *2-3 times a month* **-or-** *once a week* **-or-** *more than once a week* **OR** Drinking above the LRDG: Men: (> 3 drinks per day on most days **-or-** >15 drinks per week**)**

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	>10 drinks per week**)** **OR** Any self-reported disorder, current *[schz/psychosis/mood/anxiety/PTSD/learning/ADD/eating]* **-and- (***no perceived need* **-or-** *all needs met***)**. *[PNCDNEED in (1,2)]* **OR** Any drug use, 12m, excl. one-time cannabis use **OR** Any prescription drug use not as prescribed **OR** Cannabis use more than once in the past 12m, **-and-** frequency was once a month or more.	Women: **(**>2 drinks per day on most days **-or-** >10 drinks per week**)** **OR** Any drug use, 12m, excl. one-time cannabis use **OR** Any prescription drug use not as prescribed **OR** Cannabis use more than once in the past 12m, **-and-** frequency was once a month or more.
Tier 3	**(**2–4 abuse problems **-or-** 1–2 dependence problems on any one (or more) of alcohol **-or-** cannabis **-or-** other drugs, 12m**)** **OR** **(<u>One</u>** 12m CIDI disorder that is not alcohol, cannabis, other drugs, and bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale <4. *MHPFINT=2 (not sig. interference)***)** **OR**	**(**2–4 abuse problems **-or-** 1–2 dependence problems on any one (or more) of alcohol **-or-** cannabis **-or-** other drugs, 12m**)** **OR** Perceived need for care *(needs partially met* **-or-** *needs not met).* (*May include some mental health comorbidity*)

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	(Any self-reported disorder, current *[schiz **-or-** psychosis **-or-** mood **-or-** anxiety **-or-** PTSD **-or-** learning **-or-** ADD **-or-** eating]* **-and-** Perceived needs *partially met* **-or-** *not met***)** **OR** Perceived need for care *(needs partially met* **-or-** *needs not met).*	
Tier 4	**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis**)** [AUDDYD or SUDDYCD or SUDDYOD] **OR** **(<u>One</u>** 12m CIDI disorder that is not alcohol, cannabis, other drugs, or bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-** Sheehan >=4. *MHPFINT=1 (significant intf).***)** **OR** **(**2+ CIDI disorders including alcohol **-or-** cannabis **-or-** other drugs, interference not necessary**)** [alcohol abuse or dep. (12m), cannabis abuse or dep. (12m), drug abuse or dep. (12m), major depressive episode (12m), bipolar II (12m), hypomania (12m), GAD (12m)**]**	**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis**)** [AUDDYD or SUDDYCD or SUDDYOD] (*May include some mental health comorbidity, but not meeting criteria for Tier 5*)

Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	OR **(**Self-reported schizophrenia **-or-** self-reported psychosis **-or-** bipolar I**)** **OR** **(**Self-reported mood **-or-** anxiety **-or-** PTSD **-or-** ADD **-or-** learning disability **-or-** eating disorder**)** **-And-** **(**Hospitalized overnight for a mental health, alcohol, or drug problem **-or-** Had suicidal ideation**)** **OR** K6 >=13. *(Serious distress.)*	
Tier 5	**Four stand-alone sets, separated by 'OR':** **(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **-And-** **(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4.**)** *MHPFINT=1 (signif. interference)* **-And-** **(**1+ chronic condition *(out of 7)*	**Dependence and interference is required, and then either one of the two sets after AND, separated by -OR-, is required:** {**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **AND** **(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-**

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<tr><th>Level of Need</th><th>Definitions for
Mental Health and Substance Use</th><th>Definitions for
Substance Use</th></tr>
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Tier 5, contd</td><td>-or-
WHO_DAS=high (90th pctile))]

OR

[(2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD)
-and-
Sheehan Disability Scale >=4]. MHPFINT=1 (signif. interference))
-And-
(1+ chronic condition (out of 7)
-or-
WHO_DAS=high (90th pctile))]

OR

[(Self-reported schizophrenia
-or-
Self-reported psychosis
-or-
CIDI Bipolar I)
-And-
(1+ chronic condition (out of 7)
-or-
WHO_DAS=high (90th pctile))].

OR

(12m alcohol dependence -or- 12m cannabis dependence -or- 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD]
-and-
Sheehan Disability Scale >=4.) (AUDFINT=1
-or- SUDFINT=1 (signif. interference)

-And-</td><td>Sheehan Disability Scale >=4).
MHPFINT=1 (signif. interference)

-And-
(1+ chronic condition (out of 7)
-or-
WHO_DAS=high (90th pctile))

-OR-

[(Self-reported schizophrenia
-or-
Self-reported psychosis
-or-
CIDI Bipolar I)
-And-
(1+ chronic condition (out of 7)
-or-
WHO_DAS=high (90th pctile))]}.</td></tr>
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Level of Need	Definitions for Mental Health and Substance Use	Definitions for Substance Use
	(Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]**	

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