Mental Health and Addictions Strategy Development

A Submission From the BC College of Family Physicians

August 21, 2018

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The British Columbia College of Family Physicians (BCCFP) is the professional home of family medicine in BC, providing leadership, support, advocacy and continuing professional development (CPD) for more than 5700 members from across the province.

We are committed to working with you to strengthen BC's mental health and addictions system and the delivery of quality care to foster healthy British Columbians and healthy communities across the province.

With 1 in 5 Canadians experiencing mental illness at any given time, family physicians and other health professionals in BC spend a significant amount of time dealing with mental health issues while some patients are still unable to access the care they need.

On behalf of our family physician members and their patients, the BCCFP offers these recommendations for consideration in the development of BC's mental health and addiction strategy:

- Focus on, and fund, equitable access. Mental health and addictions services must be covered and accessible as core health services available to all British Columbians.
- Incorporate and support the treatment of mental health and addictions in primary and community care, particularly as BC develops a Patient's Medical Home /Primary Care Network strategy. This is especially important for rural and remote communities where mental health and addictions supports can be difficult to access.
- Reorient mental health and addictions services to better respond to the social determinants of health (SDH). This includes material determinants, such as housing and income, as well as non-material determinants such as respect and inclusion in decision making across a spectrum of gender, racial and ethnic backgrounds, sexual orientation, age, ability and income.
- Engage meaningfully with those impacted by mental health and substance use in service development, implementation and evaluation.
- Address and mitigate stigma through adoption of evidence-based harm reduction principles, trauma and violence informed care, and cultural safety training.
- Include legislated goals, targets, data and reporting systems, accountability structures and feedback/ learning loops to ensure continued commitment and action.
- Ensure an all-of-government (all sectors, all levels) approach. All ministries must actively participate in decreasing the burden of mental illness and addictions in BC.

We appreciate your commitment to working collaboratively to transform the mental health and addictions landscape in BC.

Sincerely,

Jeanette Boyd, BSc, MD, CCFP
President

The BCCFP's submission for consideration in the development of BC's mental health and addiction strategy focuses on three key areas: access to integrated health care, childhood mental wellness and poverty reduction/ societal resilience.

ACCESS TO INTEGRATED HEALTH CARE

BC's mental health and addictions strategy should minimize barriers to access by integrating high quality mental health care into primary care services for all British Columbians. The treatment of mental health and addictions should be incorporated into primary and community care, particularly as BC develops its Patient's Medical Home/ Primary Care Network strategy. This is especially important for rural and remote communities where mental health and addictions supports can be difficult to access.

- **Support community-based primary health care reform**
  The primary care system should be transformed to provide comprehensive and integrated primary care services including prevention, acute and chronic clinical care, mental health and addictions services, home care, and long-term, palliative and end-of-life care, all delivered by appropriate teams of health professionals. Mental health and addictions services should be integrated into Patient Medical Home-like practices, community health centres and primary care networks.

- **Support innovation in addressing the social determinants of health in clinical settings**
  People with mental illness are more likely to be affected by the social determinants of health (SDH), such as poverty, homelessness, and stigmatization. The Connect for Health program developed in Vancouver brings a SDH approach to primary care. Clients are checked for SDH needs (e.g. housing, income security, food security, health services, and child care) by peer navigators and then connected with appropriate resources. Programs like this should be expanded (*Appendix A*).

- **Expand peer navigator positions**
  Peer navigators help people through the complexities of the mental health and social system. They help individuals access services for housing, income assistance, legal aid, health, and more. Peer navigator programs exist in the Lower Mainland, but should be established province wide, especially for youth.

- **Prioritize trauma-informed care across the health and social service system**
  Research shows that the majority of people who experience opioid addictions have experienced trauma and violence. Trauma-informed practice is an approach to care that integrates an understanding of trauma into all levels of care. The goal of trauma-informed systems is to avoid re-traumatization and support safety, choice, and control in order to promote healing. Health and social services that adopt this approach are more effective and better utilized.

- **Incorporate a culturally safe approach to care for Indigenous people**
  Cultural safety training should be mandatory for health care providers. In addition, inclusion of Indigenous Elders and culture into health care has been shown to decrease depressive and suicidal symptoms and substance use and increase social connections in this group.

- **Encourage social prescribing to help alleviate depression and social isolation**
  Social prescribing has been used for people with mild to moderate mental health problems, and has shown positive outcomes, including emotional, cognitive and social benefits. In BC, social prescribing research by Raising the Profile, mainly focused on seniors care, should be expanded across the province (*Appendix B*).

- **Advocate for a national pharmacare strategy that includes mental health treatments**
  We support the Canadian Mental Health Association's position that mental health services and medications be included in the development of a national pharmacare program. Many who struggle with mental illness go without food and other necessities in order to pay for medication; some may skip doses, dose incorrectly, or fail to fill prescriptions because they are too costly. Many cannot access counselling or therapy. The federal government must be encouraged to consider these realities when developing a pharmacare plan.

- **Establish a robust home care program** to adequately support people with physical and mental disabilities, frailty, dementia and those discharged from hospital to recover at home.

- **Expand harm reduction programs for opioid users**
  The government should increase funding to rapidly scale up medically supervised prescription opioid sites across the province and ensure a supply of safe injectable pharmaceutical opioids for users. Enhanced funding for community centres and community outreach teams led by peers with lived experience (for example, the Vancouver Area Network of Drug Users) is required.

CHILDHOOD MENTAL WELLNESS

Trauma in childhood without early intervention, can lead to pervasive behavioral health problems, academic failure, mental illness, and drug addiction later in life. Research has also shown the detrimental effects of childhood trauma on "neuroinflammation" and immunity, in turn, increasing risk for chronic disease such as diabetes, obesity, heart disease and even cancer later in life.

- **Incorporate adverse childhood experience (ACEs) screening into primary care**
  ACEs occur when children are exposed to trauma. Research has shown that it is feasible to screen for adverse childhood events in primary care, but this may add some time to physician visits. A review of ways to address ACEs in care shows that incorporating team-based care in the Patient's Medical Home model and including nurses and/or social workers in care can help facilitate ACEs screening. Appropriate remuneration should be introduced to account for time taken for ACEs screening and addressing identified needs.

- **Prioritize efforts to stabilize families**
  Parental figures are stabilizing factors in a child's life, even under trying circumstances exacerbated by poverty. A stable home environment, including supportive parenting, helps children develop a network of biological and psychological functions that enable them to learn, self-regulate behavior and emotion, establish healthy relationships, and interact appropriately in their social environments. Separation from parents can result in damage to the development and function of children's brains and bodies. Therefore, when appropriate, child services in BC should make every attempt to keep children with immediate or extended family and to provide the necessary resources to support these caregivers in their parenting roles.

- **Implement a Live in Family Enhancement program**
  The number of Indigenous youth taken into care in BC is a humanitarian crisis. In a Manitoba-based program, parents are removed from the home for short periods of time after an adverse episode. During this time the children are cared for at home by a respite worker. This minimizes the childhood trauma of being removed from the home. This program is augmented by a program called LIFE - Live in Family Enhancement - where families are placed together under the care of a LIFE parent/mentor, to model positive parenting skills and behaviours. Such a program is being piloted in the Yukon and should be piloted in BC.

- **Implement the recommendations from the Final Report of Special Advisor Grand Chief Ed John on Indigenous Child Welfare in British Columbia.**

- **Implement Early Childhood Development (ECD) programs**
  ECD programs should be developed and implemented collaboratively with school districts and Indigenous communities and be accompanied by adequate, indexed funding along with guidelines, targets and timelines.

  Scholarly reviews of ECD programs find significant benefits to mental health and avoidance of substance abuse for participants, in childhood and across adulthood. Children who take part in these programs have fewer anxiety symptoms and more self control than children who did not. By adulthood, they have fewer arrests, as well as fewer symptoms of mental illness. They also had reduced likelihood of using marijuana or heroin later in life. Participants had better educational outcomes and higher incomes than peers. Economic stability is a buffer to stress which can aggravate or initiate mental illness. Expanding programs will lead to future cost savings. Studies show that on average, society sees a return of $7 for every $1 invested in ECD programs.

- **Fund peer support and other mental health programs for youth in schools and communities.** Increasing access to peer support services for youth in schools and communities is critical. Though studies are limited, youth peer support programs are shown to increase youth satisfaction with mental health services, help youth understand their treatment choices, deal with stressors, and make friends. For homeless youth, peer advocates helped navigate services and reduced feelings of stress and alienation.

- **Enhance supports for youth in care and aging out of care**
  Reports from the UK, the US, and Ontario have found that youth in care, or those who age out of the foster care system, tend to have poor mental health outcomes and are at risk of descending into poverty. A report from Aunt Leah's Link program in the Lower Mainland found that approximately 82% of youth in care reported feeling stressed in the past month and 18% reported extreme stress that made it hard to function. Youth in care also reported more extreme despair to the point they could not work or deal with life (21% compared to 6% of children never in care). Funded programs should support family conflict mediation, adult mentoring and continuing education and skills training. A review of best practices can be found in *Appendix C*.

POVERTY REDUCTION/ SOCIAL RESILIENCE

People with mental illness and addictions deserve access to the same high standard of care available to all British Columbians, but they often face barriers. A recent study of patients in the downtown eastside (2017, unpublished) by Dr. Rupinder Brar showed that people who use injection drugs face significant challenges accessing care. In a sample of approximately 1400 patients, drug users dealing with mental illness, particularly women, reported being unable to access health clinics when needed.

- **Poverty reduction**
  Given the known impact of the SDH on mental health and addictions, any plan to deal with mental health and addictions requires additional resources to reduce poverty. This will require a significant upfront investment, but this will be mitigated by overall reductions in mental illness, addictions and poverty and further decrease demand on public services. The urgency of the problems arising from poverty, including

mental health and addictions issues, require implementation of a comprehensive poverty reduction strategy.*(Appendix D).*

- **Housing and homelessness**
  People with mental health problems are at a greater risk of homelessness, as they may be unable to work, and may have limited social and institutional supports. Furthermore, homelessness can lead to stress which worsens mental illnesses such as anxiety, depression, and substance use. Housing First Strategies have shown positive results for people who are mentally ill and homeless.

  We recommend expanding supportive housing and staffed institutional care for people dealing with complex mental illness. Deinstitutionalization, with the intentions of integrating patients into community care, has not adequately addressed the needs of some patients with more complex needs. A mental health and addictions strategy could consider restoration of some facilities, such as Riverview Hospital in Coquitlam, as centres of excellence in mental health which provide long-term care for complex cases and offer transition housing. Further recommendations related to housing can be found in *Appendix E.*

- **Social Isolation**
  Recently England has established a Ministry of Loneliness to investigate the causes of, and find solutions to, loneliness and social isolation. Lack of social connections is linked to poor mental health outcomes and substance abuse. The Chief Medical Health Officer of Canada's 2017 report showed that social isolation is increasing in Canada. This was echoed by the 2017 Vancouver Foundation Report on social connections in Metro Vancouver. BC should create a portfolio within the Ministry of Mental Health and Addictions to conduct research, knowledge translation and mobilization, and establish pilot programs/ grants to combat social isolation. Social isolation research, monitoring, and intervention must be a priority for rural and northern areas.

- **Food Security**
  Food insecurity is also associated mental illness. According to the University of Toronto, hunger during childhood has a serious and lasting impact on mental health, manifesting in greater risks of depression and suicidal ideation in adolescence and early adulthood.

  A BC-wide school meal program should be implemented to ensure that all children receive adequate nutrition. Programs such as Farm to School, which brings healthy, local and sustainable food to schools and provides students with hands-on learning opportunities to foster food literacy should be expanded as part of a broader BC Food Security Strategy, which pays particular attention to Northern and Indigenous communities (*Appendix F)*.

- **Healthy Built and Natural Environments**
  The BC College of Family Physicians recognizes that a healthy environment is critical for healthy populations. People living in poverty should not be further penalized by having to live in an unsupportive or toxic environment. A comprehensive physical, mental, and social determinants of health impact assessment should be completed on government and industrial development projects along with environmental, equity and human rights impact assessments.
  The BC government should ensure that all communities have access to clean water and sewage disposal; green spaces, parks and recreation facilities. Healthy built and natural environments should include features promoting community and social cohesion. The BC government must plan for mitigating and adapting to the effects of climate change.

Appendices

Appendix A: Diagnosing the Social Determinants of Health: Connect for Health Program

One in five Canadian adults live with chronic pain. The needs of people who live with chronic pain go beyond those addressed in the doctor's office. Pain impacts almost every aspect of a person's life, including their professional and social life.

The Connect for Health program, developed by Basics for Health Society, takes an SDH approach to addressing chronic pain. Its aim is to empower people living with pain by helping them access programs and services that they need to improve their health and well-being.

Trained volunteers conduct telephone-based intake interviews of clients using a SDH framework (e.g. housing, income security, food security, health services, child care). Based on the client's needs and their location, the volunteers find resources that could help the client, such as food banks, and help filling out medical or benefit-related forms. Further, volunteers create longitudinal relationships with clients, providing needed social support, and recognizes the complexity of dealing with chronic pain beyond the physical pain itself.

Access to health care is only one of the requirements for living a healthy life. The experiences of Connect for Health's clients clearly demonstrate the role that SDH such as housing, income security, child care, and social support play in health and well-being. Single issues such as chronic pain can quickly affect someone's life conditions if SDH are not addressed. This innovative program is currently under evaluation but could act as a model for future programs.

Appendix B: Social Prescribing

Primary care is not always equipped to address the social factors that can put seniors at risk, including social isolation, loneliness and reduced mobility. Isolated seniors are at increased risk for depression, Alzheimer's, sleep disturbances, and high stress, among other physical symptoms. Social prescribing addresses SDH by linking patients with non-medical services such as meals on wheels, seniors' centres, courses, opportunities for interaction, civic engagement and/or volunteering. Social prescribing is usually delivered through primary care; however, there are different models, some involving a linkage worker, who facilitates connections to services.

In a review of effectiveness, Care Services Improvement Partnership found that social prescribing can lead to:

- increased awareness of skills, activities and behaviours that improve and protect mental wellbeing;
- increased uptake of arts, leisure, education, volunteering, sporting and other activities by vulnerable and at-risk groups, including people using mental health services;
- increased levels of social contact and support among marginalized and isolated groups;
- reduced levels of inappropriate prescribing of antidepressants for mild to moderate depression,
- reduced waiting lists for counsellors and psychological services; and reduced frequency of attendance (defined as more than 12 visits to family physician per year).

Appendix C: Children Aging out of Care

Children aging out of care in BC often finding themselves alone and without supports. They often have less educational attainment, have fewer social supports and experience difficulties finding employment and stable housing compared to peers. From a purely financial view, a report from the Provincial Advocate of the Province of Ontario has shown that investing in services for youth transitioning from care improves their lives in the long-term, and also yields significant savings to the system, with $1.36 in benefits per $1 invested.

A review of best practice has highlighted that more research is needed on the most effective support systems for children aging out of care; however, the researchers recommend the following:

- Ensuring that youth have strong relationship with families who are committed to them. To facilitate this, the government can provide support and funding for youth development organizations for programs such as family conflict mediation and providing adult role models outside of families in order to facilitate relationship-building.
- Programs must also be available to support education and post-secondary education for youth in care, including extending the length of time they are eligible to stay in foster care to pursue education. Programs for mentoring, registration, and career planning should also be coordinated in partnerships between universities, colleges, vocational schools and government.
- Adequate housing and financial assistance are also important as youth in care transition to adulthood, as it is difficult to maintain a job or education if one lives in precarious housing.

Appendix E: Poverty Reduction Measures

We support the recommendations from the Poverty Reduction Coalition recommending increasing income assistance rates to the Market Basket Measure to ensure that people can live with dignity. Calculated by Statistics Canada, the Market Basket Measure represents a basic standard of living and is based on the actual cost of purchasing shelter (including utilities), a nutritious diet, clothing and footwear, transportation costs, and other necessary goods and services. Currently, this ranges from $1477 to $1669 a month in BC for a single person and from $2953 to $3337 for a family of four depending on the size of their community. Setting welfare rates below this remains a sentence of poverty and is difficult to overcome.

In addition, we support the following recommendations:

- Ensuring adequate assistance in training and education for the unemployed and precariously employed.
- Providing adequate and accessible income support for the non-employed
- Improving the earnings and working conditions of those in the low-wage workforce

Appendix F: Homelessness and Housing

We also support the recommendations of the Poverty Reduction Coalition's Submission by reinforcing that while the Province's recent commitments to housing are a significant move in the right direction, more is needed. 2,500 new units of housing for the homeless over 3 years, in addition to the 2,000 modular units announced in September 2017, will not meet the need. Further, while modular units provide much more security and stability than shelters, they are not designed to be long-term homes.

Long-term housing must be built at the same time as the government provides these modular shelter units. In addition, while extra support is needed for some, many homeless do not want or need the surveillance built in to the supportive housing model. Ensuring the right to housing for all requires grounding the government's approach in respect and dignity for homeless and under-housed people.

Although there have been excellent attempts to address homelessness in Vancouver and more broadly in BC, the number of homeless people continues to rise. The City of Medicine Hat Alberta has had considerable success by taking a systems approach to solving homelessness through Housing First. In this model, housing must be integrated with other services such as health care, mental health and addictions services, psychosocial supports, child care, and job/skills training as well as employment opportunities. Cost benefit analyses of homelessness show that it is far cheaper to provide sustainable social housing (Housing First) than to pay for the police, justice and healthcare costs related to leaving people living on the streets.

We support the Poverty Reduction Coalition's recommendations for ending homelessness and adopting a comprehensive affordable social housing plan:

- Recommit to building thousands of new social and co-op housing units per year. BC should be bringing in 10,000 such units per year.
- Enhance and enforce tenant rights including introduction of rent control on the units.

Appendix G: Food Security

Poverty, which is linked to mental illness, often manifests in a lack of food or nutritious food. A Child Food Strategy will be an important component of both a Mental Health and Addictions Strategy and a Poverty Reduction Strategy. There is ample evidence that an improved diet can positively impact many outcomes, including academic achievement, behavioral issues, and dropout rates. We advocate for a fully funded, BC-wide school meal program much like the Ontario Student Nutrition Program,

As food insecurity rises in Canada, BC needs a Provincial Food Security Strategy. Food insecurity is correlated to unemployment rates, so some emphasis must be put on establishing secure, well-paying jobs. Initiatives to improve access to local food are also essential. Supports should be given to food providers in both rural and urban settings, including policies that would support new farmers entering into farming and fisheries. As the climate changes, BC must be mindful of the impacts that climate change will have on growing conditions and implement a plan to minimize risk to food production. One study has found that mono-crops, such as many staple crops in Canada, are much more vulnerable to climate change than multi-crop systems; therefore, food policy in BC should promote more sustainable production.

Food insecurity is much higher in Northern BC, especially in Aboriginal communities. This is increasing with climate change. The cost of flying-in food is high and traditional harvesting practices can be expensive. Interventions for these communities must be culturally sensitive and must be initiated in partnership with communities.