BRITISH COLUMBIA | Ministry of Mental Health and Addictions

What we heard

Roundtable Dialogue with Direct Service Providers

Victoria, May 14, 2018

On May 14, 2018 the Honorable Judy Darcy, British Columbia's Minister of Mental Health and Addictions, met with 20 direct providers of mental health and addictions services from different parts of Vancouver Island.

This dialogue was part of the Ministry's engagement process for developing a strategy for a seamless, coordinated mental health and addiction system that is free of discrimination and stigma, culturally-safe and focused on a path forward. The initial stages of the process include meeting with a broad spectrum of individuals, communities, as well as Indigenous peoples from across the province. In addition, we are encouraging people to share their feedback on mental health and addiction services on the B.C. Government Engage website. What we learn from this engagement process will help inform the mental health and addictions strategy and be incorporated into a final report.

The Ministry recognizes that B.C.'s mental health and addictions system needs reform in spite of the best efforts of service providers who are working hard every day to serve people's needs. Hosted by the Honourable Minister Darcy and facilitated by Simon Fraser University's Morris J. Wosk Centre for Dialogue, the roundtable provided an opportunity to listen and learn from the experiences of those who work in clinical settings as generalists and specialists, as well as people who provide community-based supports in schools and community organizations—so we can build from the strengths and approaches that are successful.

Following opening remarks from Minister Darcy, participants were invited to introduce themselves and to share what brought them to this dialogue. After the opening circle, participants met in small breakout groups supported by a table facilitator to discuss what—based on their experiences or observations—has worked or is currently working in the mental health and addictions system, and what changes would make a difference. To close off the breakout discussion, participants were asked to identify their priorities for action. In a closing circle, participants shared what gives them hope and what more needs to change in the mental health and addictions system.

Participants' experiences and specific suggestions were captured by note-takers and through worksheets.[1] This report summarizes participants' input and suggestions by themes, illustrated with selected individual responses recorded in participants' own words. The themes listed in this report are ideas or suggestions mentioned in at least two participant worksheets. This means that the list does not indicate an order of priority.

[1] The testimonies and suggestions recorded in this report do not necessarily reflect the views of the Ministry of Mental Health and Addictions or its staff. Individual statements reproduced in participants' own words are identified as such through quotation marks.

Increased treatment and recovery options with greater accessibility and reduced wait times was most frequently prioritized by participants. Integration of services and care was the second most frequent identified priority, including easier transitions from one service to another, and improved integration between ministries and professionals that help people find mental health and addictions support. Participants also frequently mentioned increased accessibility of primary care, including family doctors and nurse practitioners with mental health training, as well as free or low-cost mental health care, such as counselling. Support for independent and assisted housing was another commonly prioritized item.

The full list of priorities includes:

- More treatment and recovery options / reduced wait times
- Integration of services and care (between ministries, programs, professionals)
- Accessible primary care (including free/low-cost mental health care)
- Housing support
- Empowering communities and community-based services
- Prevention and early intervention
- Hubs for education and community-based care
- De-stigmatization and education
- Client advocacy and navigation support

1. What is working

- **Community, co-location and cooperation**
    - Communication and collaboration with / within the community
    - Community Health Centres
    - Hub model where programs are co-located in a central location so that stronger relationships develop with service providers and there is more access to different services
    - Health connections clinic: opioid replacement therapies, nursing centre
    - Building relationships with health care teams and community groups
    - Ability to have a collegial relationship with other service providers and tell them what to look out for when caring for a patients' needs
    - Using group work to see more clients and benefit from peer experiences, reduce wait times and improve outcomes

- **Harm reduction**
    - Harm reduction approaches
    - Safe consumption services
    - Sobering and assessment centres
    - Overdose prevention services

- **Housing**
    - Housing support
    - Low-barrier housing options

- **Trauma-informed approaches**
    - Support for intergenerational trauma and parenting support
    - Trauma education offered to multiple disciplines in care units (CU), Building Bridges Through Understanding the Village workshop

- **Leadership:**
    - Leadership that models vulnerability and bravery
    - Awareness and recognition of the need for change

"There seems to be more discussion between departments (teams) and a willingness to partner."

"Community-based organizations with expertise working together: i.e. AIDS Vancouver Island working with CoolAid Community Health to get people rapid access to OST/OAT [Opioid Substitution Treatment/Opioid Agonist Treatment] within spaces that people who access drugs already consider "home" or a space for themselves."

"Community Service Agencies talking amongst themselves - AVI (AIDS Vancouver Island), CoolAid, PHS, Our Place, Pacifica Housing, Beacon, LifeRing, Anawim House, B.C. Schizophrenia Society, etc. - coming up with core plans, doing workarounds to make the VIHA systems work."

"Community health centre is an ideal model for care. It's cost effective, but we have a higher number of nurses than family doctors, I am a RN, not an NP and I treat bladder infections, do pap smears etc., services that people would normally have to see a family doctor for. We have social workers on site."

"What works well is when I reach out to Island Health and I've been lucky to not have people who think they have more education and can talk down to me as a frontline worker. I've had the best results when I got a team of 4 service providers together who were touching one case where a woman was dealing with addiction, homelessness, pregnancy."

from leadership

- **Uncategorized approaches:**
  - Funding for violence prevention and intervention, primary Rapid Response Nurses and holistic intervention
  - Supported education and employment programs
  - Recovery-oriented approaches to care
  - Family engagement policy being integrated in a more consistent manner - care planning.
  - Relationships
  - Suboxone, opioid substitution therapy
  - Using students to help reduce waiting times for services (university and college)
  - Better feedback loop between research and practice
  - Cultural awareness
  - Early intervention programs for early psychosis programs including community support teams that follow clients and families for several years
  - Psychosocial rehabilitation programs and supported living programs to teach life skills and track monthly progress.
  - Clear Axis 1 works well
  - Community services/nonprofits, who contribute to the connection (non-governmental service) of youth and families
  - Increased number of prescription options to treatment
  - Medical community response to overdose
  - School district Overdose Prevention Site

"Awareness and recognition for change from leadership."

"Good to see welfare rates increases, increases to asset limits, earning exemptions. I've noticed a new openness to collaboration from MSDPR (Ministry of Social Development and Poverty Reduction) staff. After 8 years of asking I have finally been given a direct line/contact for help with client issues within MSDPR (Ministry of Social Development and Poverty Reduction)."

"We are lucky in Victoria. There are many programs for people with addictions and alcohol. However due to a large population who need help, not enough facilities and too long waiting list. Our help groups are very positive and we have been able to help many people to get clean and sober."

"There needs to be an adequate level of funding for the whole spectrum of services: we are doing many things right, we just need more of the current things that work well."

Specific programs and services:

"Case Managers-VIHA (Vancouver Island Health Authority)."

"Disability services. Clients on disability pensions"

"Police, 911, 811."

"VIHA (Island Health) sending a nurse practitioner to our agency to see refugee – meanwhile they are looking for a family doctor."

"Using the same approach as Local Action Team is working on a trauma-informed (Brain Story) approach to better train service providers. More professional development needed."

"Interprofessional teams (CAR60), RCMP, MCFD, CYMHLTH."

"FNHA (First Nations Health Authority) sponsoring treatment."

"713 team in Victoria is great."

"Introduction of overdose prevention sites (Harm reduction) at Our Place, Rock Bay Landing, Portland Hotel Society (PHS) on Johnson, AVI (AIDS Vancouver Island) - Keeps people alive and safe."

"VICOT (Victoria Integrated Community Outreach Team) Teams, ACT (Assertive Community Treatment) teams (Housing)"

"ERP (Exposure and Response Prevention Therapy) and Codependency groups."

"Mental Health and Substance Use community offices, Intensive case management team (high addiction, low mental health)."

"Recent BC Housing + City of Courtenay announcement about supportive housing."

"Housing first. Supportive housing with Victoria CoolAid and other agencies provide the foundation that individuals can build from. Having a home, consistency of care are a must."

"Seamless transition from detox (EMP5A, Victoria Royal Jubilee Hospital) into stabilization (EMP5B) seems to provide immense benefits for clients in terms of facilitating access to community services. Extended stays in stabilization are also crucial to clients who are housing-insecure or are seeking additional inpatient treatment."

"Stigma campaign, more needed."

Places & models:

"Intake Assessment Services for Mental Health-Victoria."

"Royal Jubilee Hospital."

"Beacon Heart and Soul Support group Sidney - diagnosed with mental health issues-consistency-stability-longevity."

"Laurel House: Victoria-Drop-in for members identified with mental health issues – provides stability and consistency."

"Forward house providing psychosocial rehabilitation: connection to peers, community, resources, one-on-one emotional support, inexpensive meals, holistic model, 19-90 years age, expressive therapies, client-led programs, free access, doctor- or self-referral, in a house setting."

"RavenSong Community Health Clinic/3 Bridges Community Health Clinic (amazing wrap-around primary health care/addictions/MH support. Great resource for trans clients. Doctors on salary - form clinical relationships based on trust built over time.)"*

"VGH Access + Assessment Centre – not perfect but the idea of providing access to emergency/non-emergency mental health care without having to go to Emergency. Many clients don't have GPs to address their mental health/addictions issues or have GPs with little capacity/willingness to address their issues. Need a street-level entry point for MH care."

"Overdose Prevention site AIDS Vancouver Island CU [care unit?]."

"Duncan Mental Health and Substance Use services work closely with the inpatient psychiatric unit. Provides collaborative care in the form of early integrated care conferences to include pertinent community partners, clients and families. Pilot project 'CAR60' two days per week – a partnership with the RCMP – one crisis nurse and one officer move through the community engaging with people where they are at and offering support and services without expectation. Partnerships with CMHA and Warmland Shelter, the Overdose Prevention Site, Probation, RCMP, First Nations Mental Health, Ministry of Poverty Reduction, MCFD and others."

"What we do well in Duncan is that we have a really small centre and, because we have limited resources, what's working well is the relationships (with mental health centre, with coordinators, with inpatient psych. unit, care transitions, and other community partners in Duncan (RCMP, Probation, Income Assistance, First Nations Health Authority mental health centre."

"We opened a sobering assessment centre in Campbell River last summer. It's provided an opportunity to engage with people wherever they're at – people who may be afraid to go to hospital because they've had a bad experience in the past. The premise is that people can come in, have a rest, get some food, maybe choose to see someone for support or not. We've had 300-400 contacts every month and many people are connecting with the service nurse for supports that they needed. It's been really successful."

"Look to other models to establish more beds and safe places. Varied housing models, including Housing First Models. Examples like Gwa'sala'Nakwaxda'xw up North, where the community began to build some safe homes right in their community."

2. Themes for suggested changes and improvements

- **Increased treatment and service options / reduced wait times**
    - Easier access to treatment
    - Easier access to social services, including income assistance
    - Access to psychiatrists
    - Increased beds in sobering and assessment centres
    - More detox beds / detox on demand
    - More day-beds
    - More pre- and post-support
    - Step-down care
    - More homecare
    - Addressing concurrent disorders
    - Specialized programming for complex needs clients (i.e. borderline, Obsessive Compulsive Disorder)
    - MSP-funded AIDS programs
    - More programs and services specifically for youth/young people
    - More support services specifically for LGBTQ2S+ communities
    - Trauma-informed/specific practice
    - Culturally-sensitive / multicultural services
    - Managed alcohol program
    - More psychosocial rehab programs
    - Expand intensive case management team
    - Accredited and funded alcohol and drug programs
    - Less downloading to nonprofits

"Having counsellors who are sensitive to the different cultures and/or having counsellors from a variety of different countries/cultures."

"Funding that is appropriate to ensure quality holistic services delivery and safety for clients. An 11-bed facility funded by BC Housing gets double the funding provided to our 12-bed residential."

"Detox/stabilization wait times are devastating."

"Women flee to the Comox Valley or are referred to Comox Valley and are unable to access MHSU Outpatient Services because 'they aren't from here' until they have been in the community for 30 days. Then they have to have an address, but the transition house or residential recovery address doesn't count."

"Nanaimo has a crisis counsellor where you can walk in and right away get a referral, but in other communities it's not like that."

"The number of detox beds is atrocious. A safe place for people to stabilize and stay safe before they enter into detox. We know that people experience better outcomes when their stabilization stay is extended"

"Addictions treatment programs are unaffordable to some people. If you are on income assistance, you can't go to treatment because you don't have enough money to also pay for rent. People have to take the risk of becoming homeless again."

- **Service integration (between Ministries, programs, professionals)**
    - Clear understanding of roles and responsibilities throughout the continuum of care
    - Combine service delivery for children, youth and families for continuity and seamless care
    - Consistent services across communities
    - Liaison for connecting services and community organizations with public (website, database, phone, etc.)

- **Accessible primary care (including free/low-cost mental health care)**
    - Free counselling services, including for youth
    - Access to family doctors
    - Mental health services provided through family practitioners
    - Access to nurse practitioners
    - Medical practitioners who prescribe opiate antagonists

- **Housing support**
    - Access to supported housing
    - Housing with services for tenants with mental illnesses, including complex needs and concurrent disorders
    - More transitional housing for post-residential recovery
    - Affordable housing
    - Shelter rates indexed to market housing
    - Partnerships with landlords, CMHA, BC Housing

- **Empowering communities and community-based services**
    - Community building
    - Grassroots community input from community agencies and members at funding decision meetings
    - Secure and predictable funding for agencies that are tailored to meet specific groups' needs

"A smooth pathway – bridges between government, agencies like BC Housing and income assistance"

"A solution could be a central organization of resources for youth and education for family and emergency doctors, school counsellors and parents."

"Some way to liaise between smaller and larger organizations – a lot of the smaller, very community-based organizations are creating their own models that are very effective – how do we share these examples?"

"Build a primary care model"

"Pots of money can't be so important to ministries. For example, the Ministry of Social Development won't fund someone's eyeglasses; MSP will pay for an ophthalmology consultation, but not optometry. Because an unemployed person can't afford glasses, can't fill out forms to look for work. Ministry of Health won't pay for IUD for an addicted woman, so she gets pregnant and now [the] child [is] in Ministry care, costing [the] system much more. If the Ministry would pay for small items, it would prevent huge problems."

"Key services should be provided for free for all kids starting at prenatal. It's unconscionable that we are not providing everything for free. We can't let money be an obstacle."

"Any development has to incorporate 10% social housing. It makes a difference for a generation."

"Empower community-run resources - people often don't trust health services - they've been tossed around in the referral game, etc. and choose not to access supports."

"Give money directly to community organizations – skip the health authority process. Community organizations doing work understand and target monies directly."

- Community health centres with multidisciplinary teams
- Small integrated centres to maximize resources.
- Resources for elders
- Peer support for clients

- **Prevention & early intervention**
  - Raising awareness about mental health early (starting in daycare)

- **De-stigmatization, education and outreach**
  - Stigma reduction campaigns
  - Education (for service providers, policy makers, bureaucrats)
  - Mental Health awareness training in schools and for families/supports
  - More outreach services
  - More interdisciplinary outreach
  - Outreach workers in schools

- **Hubs for education and community-based care**
  - Community-based primary care
  - Community health centres with multi-disciplinary teams
  - Central organization of resources for youth and education for family and emergency doctors, school counsellors and parents.

- **Client advocacy & navigation support**
  - Interprofessional teams with client navigators / advocates
  - Provide community navigators

"Ideal service: community-based primary care expanded to include nurse practitioners, social work, addictions treatment, mental health counsellors. Ability to easily access tertiary care."

"Early intervention for substance abuse is extremely important and decreases the chance of long term abuse."

"'Stop Overdose'" should be 'Stop Poisoning' to acknowledge the role of drug adulteration in unregulated markets and shift the onus away from people who use drugs."

"We need to overcome the notion that mental health patients are dangerous."

"Targeted approach to combat people dying inside private residence - more targeted approach to engage landlords to make it easier to get outreach and overdose prevention teams/people inside without residents risking the loss of their housing."

"Fund advocates! We are barrier busters. We can help mitigate the damages caused by the completely inappropriate service delivery model adopted by Ministry of Social Development and Poverty Reduction (MSDPR). A very inexpensive way to try to address years of bad decision-making about how social assistance is administered. Peer navigators have their role but advocates have the legal knowledge (we aren't lawyers, just trained to interpret the legislation) required to interpret and apply the legislation."

- **Social determinants of health**
    - Fund resource/social determinants of health for early intervention and prevention
    - More "stabilization" services to facilitate safe access to community services and housing
    - More education and employment programs
- **Support for direct service providers**
    - Recognition of the contributions of community-based social services.
    - Funding for professional development
    - More training for people who are helping immigrants counselling
    - Wage grids for community social services sector
- **Change mental health emergency response**
    - Direct frontline intervention
    - Mental health emergency units in hospitals
- **Harm reduction**
    - Prescription drugs (with other supports)
- **Peer support for clients**
    - Strength-based peer programs and mentorship, (e.g. young adult assisting youth)
- **Services for youth and young adults**
- **Alcohol and drug program accreditation**
- **Trauma-informed and trauma-specific services**

"We need to look at the social determinants of health – income security, housing, human rights – mental health clients are disproportionately poor and reliant on government benefits."

"The single most important change you can make is to address the barriers to accessing or maintaining income assistance and disability benefits. […] MSDPR [Ministry of Social Development and Poverty Reduction] is a system designed around its own needs not the needs of the clients. Online/web-based service delivery as the only option is not ok. MSDPR is not meeting its duty to accommodate clients with mental health and addiction challenges."

"More professional development funds – front line workers can offer more."

"There is a huge wage disparity between the health sector and community support sector."

"Clients who are being admitted to hospital for drug-induced psychosis are being discharged right away and they're at serious risk to themselves and to others."

"The biggest change would be prescription to opioids – it would allow people to have dignity to walk-in and get what they need so they can look at making changes in their lives with support. Not having to resort to crime to support their habits. And get pulled into criminal justice system – they need to have normalcy to their lives. Suggest a pilot and seeing the impact that has."

"More attention and focus on youth and substance abuse. The rate of youth reporting heavy drinking and drug use has been increasing."

Other comments and suggestions

- Dialectical Behaviour Therapy (DBT): “At the youth level, we see 25 kids (out of 500 total clients in our program) in Victoria at any given time, who are regularly in and out of hospital, chronically suicidal, likely using substances and we’re not meeting their needs. What we need is a bona fide DBT program for Victoria and any other jurisdiction that has the numbers to warrant it–have one in Vancouver). These are the individuals that become so chronic that they wreak havoc on our system. They also have a DBT program in Nanaimo but the waitlist is huge.”
- Improve withdrawal management services: “I can’t leave here without mentioning that withdrawal management services are absolutely abysmal. Someone has overdosed the day before and comes in and wants detox. If they don’t already know, I have to tell them it’s likely going to be four weeks. Then stabilization (but that will also come with a wait time of one or two weeks at which point they’ll be at greater risk for overdose because their tolerance has gone down). It’s not about the people; it’s the system that has not ever changed. Some of those services need to be taken out of the bureaucracies and put into the communities where the trust lies, especially within the context of so many people dying—people need to be where they have trusting relationships” (and this is often not with the health authority).
- Address research gap: “The research is 20-30 years behind where we are and where we are practicing.”
- Address confidentiality barriers: “There is a barrier with confidentiality - nobody wants to share information and consent is needed for everything. But then we cannot work together.”
- Focus on recovery: “A recovery-oriented system of care.”
- Reduce paperwork associated with accreditation for alcohol and drug programs: “Limitations is the overwhelming paperwork that’s associated with it – needs to be lean.”
- Involve private sector: “What has business done towards mental health this year?”
- Appropriate evaluation metrics: “A different metric for measuring the success/evaluating services that people with mental health and addictions issues use.”
- Accountability is important: “If you are setting goals for working with a client, how do you follow through and how are we learning from the experience? There is no systematic process for Island Health to understand what is working when clients set their own goals. Are we evaluating what we are doing? Britain has done some good work on national outcomes; just published a new mental health strategy. Canada has done some evaluation at the federal level.”
- Emergency treatment: “People with drug-induced psychosis are treated too quickly in hospital. Our clients who are being admitted to hospital under the mental health act are being discharged often right away and they’re at serious risk to themselves and to others. We’re not able to hold on to people for long enough to get help for them.”
- Reduce barriers to services: “Our social assistance system erects barriers to those who experience mental health and addictions issues. I have worked frontline with these clients as they try to access income assistance benefits from MSDPR. The service delivery changes have directly negatively affected my clients. The reliance on phone

access, closure of MSD offices, online applications mean the assistance that is so needed by mental health clients is out of their reach. At the same time, advocacy service resources have seen massive cuts. In Vancouver in the past five years, I have seen 10 advocates lose their funding. This is disastrous given the complexity of the income assistance regime."

3. What gives you hope? And what more needs to change?

"*The hope is that these voices will actually mean something to the system. For me, the largest thing is access (affordability, access to specific programs, etc.)."*

"Had no idea about some of the services that were out there. This gives me hope – that we have so many people doing such good work. So how do we connect these voices on a day-to-day level? What more needs to change? We need to continue to build a relationship that is meaningful and sustainable"

"Hearing what others were saying gave me more hope to make a change really soon."

"I'm hoping for a major shift. It seems that a lot of people are sharing the same struggles, it's reassuring to know that these issues are not just our own."

"I'm hoping that the system transforms itself soon enough that some of the young people I've been working with will benefit."

"I'd like to see this education and dialogue happening beyond our own community of service providers. There is a new supported housing building being brought into Comox and I was upset to see the number of NIMBYs."

"Sometimes it feels like the community is not invited to share all the wisdom that we hold."

"I'm hopeful that people providing direct care – with the right amount of training, with the right amount of support, with lots of learning opportunities – can do wonderful work with individuals. And when you don't have that and you're under-resourced, then we see the other side of that."

"I hope that something really good will come out of this meeting."

"I'm hopeful for this Ministry's stewardship for a framework going forward (more so than when I came in tonight). I think we need more effort around on-going engagement to show that it's not 'you and I', but it's 'we'."

"To not feel alone in the fight to get help and more services for our clients. But I'm more cynical than hopeful because I know that these things are expensive. Hopeful that this Ministry will communicate between governments to make sure Ministry of Children & Family Development, Ministry of Health, etc. all work together and spend money more seamlessly."

"Hopeful that we'll get more services for people we see today who are in survival mode."

"For the first time in many years, I am actually feeling hopeful. In the last few months I've had a chance to speak directly to the Minister of SSDSI [sic] [Social Development and Poverty Reduction?] and now the Minister of Mental Health and Addictions. To me, this signals a different approach to

government. Fixing the status quo doesn't look after our clients or treat them with the dignity that they deserve. I don't think it's any more expensive than the status quo when police and hospital wards are carrying the bulk of the work of supporting people in crisis. We can do better and it doesn't need to bankrupt the province."

"What we need is an attitude change—getting the sense of 'how do we get there' rather than 'we can't do this'."

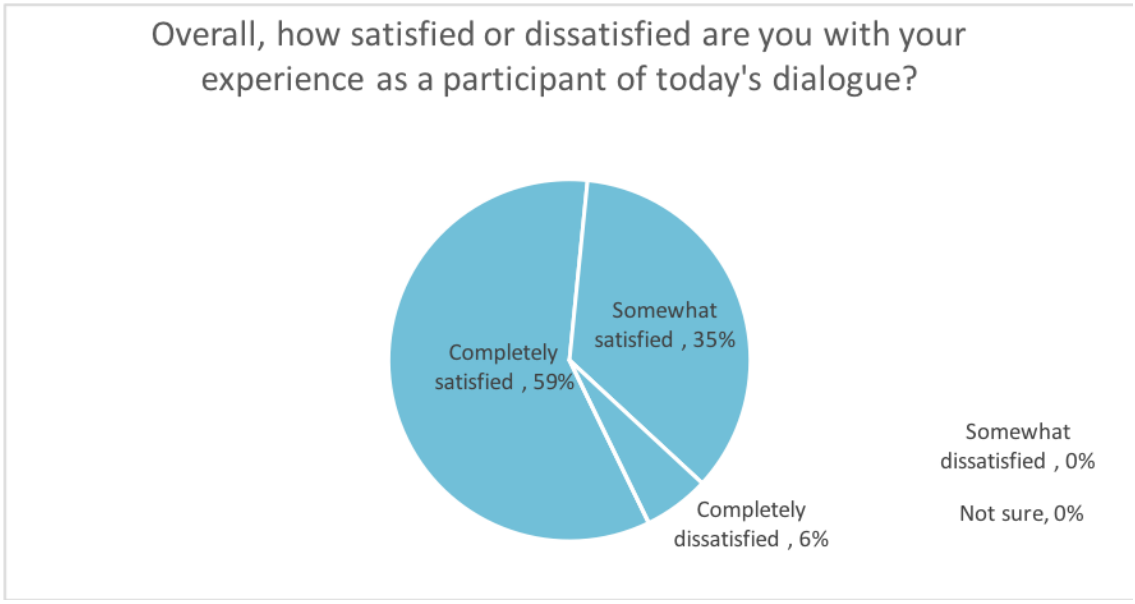
"Our priorities and suggestions were attainable—that gives me hope."

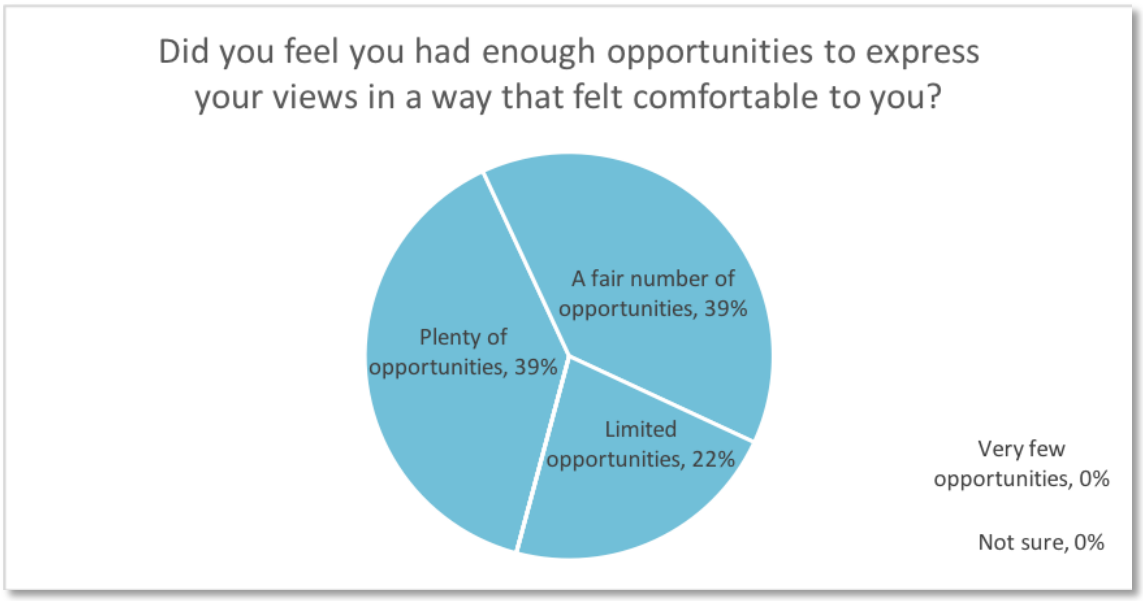
"I hope that we can keep having the confidence to be a bit outrageous in our work. To take those little risks that help us innovate. Often the things that happen 'off the side of our desk.' We need to bring this to the 'centre of our desk.' I actually think the change is right here. If we just actually believe that we can put some other things aside and do the most important thing in front of us, it can happen."

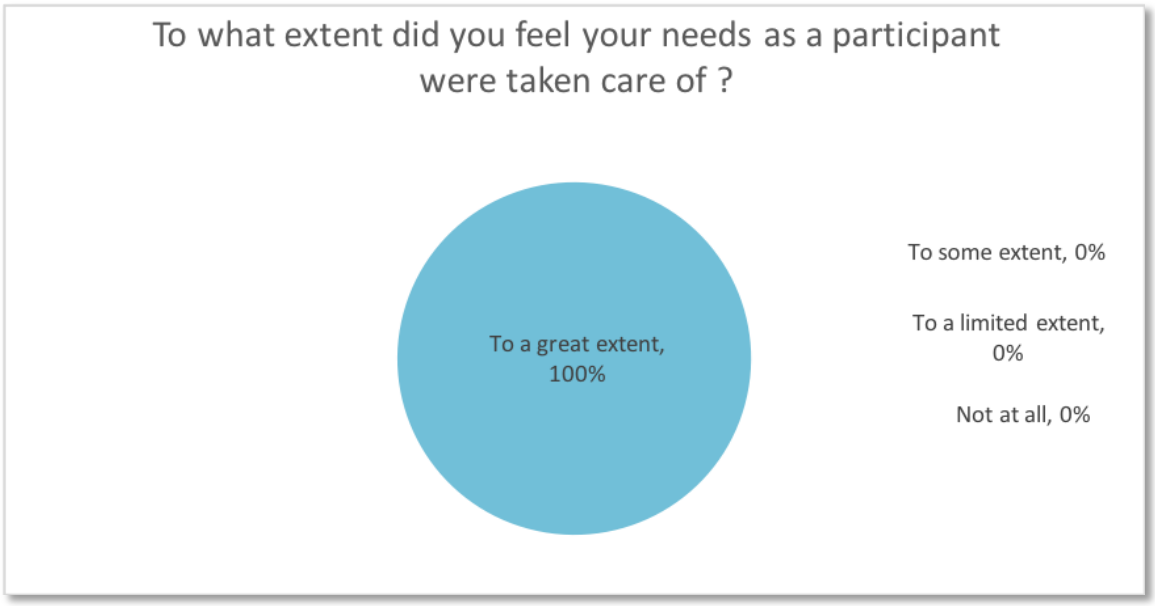
"I'm hopeful to see people discussing many different types of evidence and different ways of approaching the work."

"I don't think I could keep doing this work if I didn't have hope. But that hope is based in the relationships that we build within the community. The risks that are in people's worlds right now—it's not just the clients, it's the people I work with, it's my friends. It's all around. It relies on the community being able to give back to itself. A lot of where my hope lies is modelled in community and can start there."

5. Participant feedback about the session






To what extent did you feel your needs as a participant were taken care of ?
To a great extent, 100%
To some extent, 0%
To a limited extent, 0%
Not at all, 0%