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STRENGTHENING SERIVCES FOR INDIVIDUALS WITH SEVERE ADDICTIONS AND MENTAL ILLNESS

BUSINESS CASE:

VANCOUVER COASTAL HEALTH ASSERTIVE COMMUNITY TREATMENT TEAM

JULY 31, 2014

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Vancouver Coastal Health Assertive Community Treatment- Business Case Proposition

Vancouver Coastal Health (VCH) implemented a number of new services and initiatives in response to specific recommendations contained in the Ministry of Health (MoH) Mental Health Action Plan released in Fall 2013. Along with the endorsement of VCH's action plan *(Improving Health Outcomes, Housing and Safety: Addressing the needs of individuals with Severe Addiction and Mental Illness)* the Minister further advised that the VCH board directs its staff to put several actions in place over the next 120 days, including:

- *Reconfiguring services at St. Paul's emergency department to better meet the needs of the population with Severe Addiction and Mental Illness (SAMI);*
- *Adding an Assertive Outreach Team targeted to the high-risk SAMI / population in the DTES;*
- ***Adding two additional ACT teams focused on this population;** and,*
- *Further improving information-sharing protocols between key agency partners.*

Vancouver Coastal Health (VCH) has identified 1.8M in operational funds for one Assertive Case Treatment Team as per the MoH Mental Health Action Plan. **VCH is seeking matching annualized funding from the Ministry of Health (1.8M) for a second ACT Team.**

The two Assertive Community Treatment (ACT) Teams (referred to in this document as ACT Teams #4 and #5) were operationalized this year as part of the Ministry of Health 120 Day Action Plan to address the needs of patients with severe addiction and mental illness in the region.

Overview of Business Case

Contained within this Business Case is a request for operational funds to support two Assertive Community Treatment (ACT) Teams in VCH, bringing the total number of ACT Teams in the region to five.

The expansion of ACT across VCH will increase system capacity to effectively serve those with complex mental health and substance use issues with timely low barrier supports within the community. These clients are often high risk of harm to themselves and/or others and experience complex mental health, substance use and concurrent aggression challenges and are in need of intensive care. Because of the limitations of traditional mental health services in engaging these patients in the treatment they need, ACT clients may previously have gone without appropriate care. Consequently, the client group is frequent over-utilizers of emergency and acute services are often over-represented among the homeless and in jails and correctional facilities, and are commonly and unfairly thought to resist or avoid involvement in treatment.

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Clients receiving services from an ACT team are supported through intensive outreach and attachment, with services individually tailored to address preferences and health goals for each client. The approach with each client emphasizes relationship-building and active involvement in assisting individuals with serious mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.

In response to impressive gains in health status and reduction in criminal justice seen in clients from ACT teams already in place in VCH, two more teams were called for as part of the Ministry of Health 120 Day Action Plan. These teams have already been implemented in accordance with BC Standards (Ministry of Health 2008), are now in need of operational support.

This Business Case proposes that VCH, in partnership with Vancouver Police Department (VPD) and BC Housing (BC), continue to support ACT Teams Four and Five. These efforts specifically align with the tactic outlined under Goal #2 (Strengthen community capacity and decrease demand on acute, ED and police services) in the 2013 Ministry of Health Report *"Improving Health Services for Individuals with Severe Addiction and Mental Illness"*.

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Executive Summary

Following several high profile public safety incidents involving individuals with mental health and substance use issues in Vancouver, the Ministry of Health released a report entitled *"Improving Health Services for Individuals with Severe Addiction and Mental Illness (SAMI)"* which outlined a series of strategies to better serve a significant sub-group of people that were not adequately accessing traditional health services. This gap in care was resulting in poor outcomes, risk to clients and providers, and concerns for public safety. It was determined that this was a population for whom a multi-pronged strategy across police, housing, judicial, social and health services was necessary to address care needs, improve social and health outcomes, and mitigate risk to public safety.

As part of this report and accompanying 120 Day Action Plan, it was specifically requested that Vancouver Coastal Health (VCH) implement two additional Assertive Community Treatment (ACT) Teams, bringing the total number of such teams in the region to five. Vancouver Coastal Health (VCH) has identified 1.8M in operational funds for one additional ACT Team as per the MoH Mental Health Action Plan (ACT Team #4). VCH is seeking matching annualized funding from the Ministry of Health (1.8M) for a second ACT Team (ACT Team #5).

Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses and substance use concerns, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

The *British Columbia Program Standards for ACT Teams* (Ministry of Health 2008) serves to guide ACT program start-up, implementation, and ongoing operation by clearly defining the minimum program requirements. Successful ACT model implementation and demonstrated improvements in client outcomes are best accomplished by close adherence to the ACT Standards: i.e., serving persons with the most serious mental illnesses and substance use disorders; multidisciplinary staffing with at least one peer support; low staff-to-client ratios and intensive services; staff who work weekday, evening, and weekend/ holiday shifts and provide 24-hour on-call services; team organizational and communication structure; client-centred individualized assessment and treatment/service planning; and up-to-date individually-tailored treatment, rehabilitation, and support services based on the original Madison, Wisconsin PACT research project.

ACT teams are an essential component for supporting client stability and integration across the continuum of primary, secondary, and tertiary care. This service helps provide access and guided navigation of the health care system, along with integrated and multidisciplinary support based on the unique needs and wishes of users.The ACT team is mobile and delivers services in community locations to enable clients to continue to live in their community. This

service is provided 24 hours a day by a multidisciplinary team, including a GP, with a low client to provider ratio.

ACT Teams already in place in VCH have shown impressive outcomes. When comparing the year prior to and following intervention, those receiving ACT follow-up (Teams 1&2) had a 36% reduction in negative police contact, 49% reduction in Form 4,10,21 and Section 28 Apprehensions, 32% reduction in victimization, 46% reduction in violent offenses, 10% reduction substance related offenses, 31% reduction in criminal justice system involvement, and 38% reduction in street disorder.

Collaboration between health services and the Vancouver Police Department (VPD) are essential for the function of such ACT teams, with police officers are embedded into the team providing ongoing support to facilitate interactions, provide safety, share information, and assist with recall if needed. BC Housing (BCH) is also an important partner, with subsidies and access to congregate housing in the new city sites a part of the new ACT team development.

Approval of this request for operational funding by the Ministry of Health would allow VCH to continue to provide high quality, effective support of some of the region's most vulnerable residents, shifting the burden of care away from high intensity acute and emergency health services and police and criminal justice resources to more appropriate community care and supports.

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Assertive Community Treatment

- We are seeking operational funds to support two Assertive Community Treatment (ACT) Teams to serve individuals with Severe Addiction and Mental Illness (SAMI) in the Vancouver Coastal Health (VCH) region. These teams adhere to established BC Guidelines (Ministry of Health 2008).

- ACT is widely recommended and empirically validated form of multidisciplinary care designed to provide an extensive spectrum of medical, psychosocial, and rehabilitation services to individuals with SAMI within a community setting.

- VCH will identify the most resource intensive clients with SAMI and connect them with ACT in order to support community integration. Thus, clients will include those with severe and persistent mental illness who make high use of general hospital psychiatric services, specialty hospital services, tertiary level services or psychiatric emergency services such as mental health crisis response services. These individuals experience challenges with living independently and are thus over-represented in the homeless population. They also frequently have repeated police and criminal justice contact due to illness and addiction.

- These individuals have difficulty accessing traditional office based out-patient services and thus require assertive outreach services. The ACT team is mobile and delivers services in community locations in order to address these barriers. Services are accessible 24/7 either directly or via the on-call services to intervene with crises as they arise.

- ACT service coordination is done within the multidisciplinary team (see Appendix B) to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment/service plan and is respectful of the client's wishes. Service coordination also includes coordination with acute, tertiary, community and primary care resources, including consumer self-help and advocacy organizations that promote recovery.

- ACT teams follow a recovery model of care which includes emphasis on self-management, work skill development/ training, activities of daily living, leisure time activity, and development of social and interpersonal relationships.

- Client centred care emphasizes education, support, and consultation with families and other major supports; with peer supports from persons with lived experienced engaged as active members.

- With the multi-cultural fabric (including First Nations) of the Vancouver Coastal Health population, all care providers will deliver care reflective of the cultural diversity of the individuals and the communities in which they reside.

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Role of Assertive Community Treatment in the Continuum of Care

- As outlined in the 2013 Ministry of Health Report, "*Improving Health Services for Individuals with Severe Addiction and Mental Illness*" the continuum of care in Vancouver Coastal Health is faces significant challenges to serving individuals with SAMI who also have multiple and complex problems such as homelessness, criminal justice involvement, chronic medical diseases and disabilities, among other issues.

- The inclusion of ACT in the range of available care in an important step in moving health services from this population from a fragmented, crisis-based system to one that is integrated, innovative and assertive in engaging this complex and often marginalized population.

- ACT teams are an essential component for supporting client stability and integration across the continuum of primary, secondary, and tertiary care. This service helps provide low barrier access and guided navigation of the health care system, along with integrated and multidisciplinary support based on the unique needs and wishes of users.

- Services offered include harm reduction, primary care, counseling, psychiatric services, psychosocial rehabilitation, and crisis intervention; primarily in an outreach or community setting (>75%).

- The ACT team psychiatrist will assess each client individually and prescribe treatment including medications that will be implemented and monitored by the team based on developed policy and procedure.

- Clients with concurrent disorders will have access to stage-based integrated treatment/service from the ACT team members, individually and in groups. Referral to withdrawal management services will be as seamless as possible through relationships and established protocols across services.

- A range of rehabilitation services will be offered directly or through established access points along the continuum.

- ACT teams also facilitate a a range of multi-sectoral supports including employment, housing, financial and social assistance, and police/criminal justice system support; allowing the client to maintain stable community tenure and help them to attain a life that is not driven by their illness.

- ACT services are supported through partnerships and formal agreements with existing providers. Rather than brokering services from other agencies, the team delivers services directly.

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Need for Assertive Community Treatment

The continuum of care in Vancouver Coastal Health is facing the challenge of serving individuals with SAMI as specifically highlighted with the 2013 Ministry of Health Report "*Improving Health Services for Individuals with Severe Addiction and Mental Illness*".

While data is not specific to individuals with SAMI, the strain individuals with mental health or substance use concerns place on health and police resources in the region is growing: In 2012/2013, 18 percent of those presenting to St. Paul's Hospital emergency department did so for mental health or substance use concerns, compared to 8 percent in 2009/2010- representing a total of 3,242 additional visits. A noticeable proportion of this growth was due to an increase in repeat visits. Within this surge of mental health and substance misuse presentations, there has also been a 227 percent increase in total drug related visits and a 450 percent increase in visits due to psychosis (much of which is also drug related). Furthermore, incidents of suicide and violence related to mental health or substance misuse contribute to 21 percent of police reports city-wide, and 27 percent of those in the Downtown East Side (DTES). In 2012/2013, 77 percent of individuals brought in by police to St. Paul's Hospital Emergency Department were for mental health and substance misuse (a 10 percent increase from 2009/10). Of those brought in, 32 percent were from the DTES, 20 percent from Vancouver City Centre, and 11 percent were homeless.

As set out in the report, individuals described as belonging to the SAMI population have one or more psychiatric diagnoses that significantly affect their ability to actively engage in personal, social, and/or occupational areas of daily life. A sub-set of these individuals suffer from chronic, disabling poly-substance use, and often severe mental illnesses (most commonly severe trauma in combination with unmanaged or under-managed psychosis, bipolar, and/or depressive disorders), neuro-developmental disorders and/or cognitive impairment, and significant physical health problems. It has been estimated that approximately 34, 000 individuals with SAMI live in VCH, with 60 per cent of them (20,400) residing specifically in the City of Vancouver. There are further estimates that suggest that 3,000-6,000 of these individuals have an extremely high health risk.

As their substance use and/or mental health symptoms are frequently associated with significant behavioural difficulties, these individuals experience significant barriers in accessing the mainstream supportive and therapeutic networks required to effectively manage their conditions. As a result, they are disproportionately higher users of crisis and emergency services, have frequent criminal justice involvement, and are homeless or at high risk for homelessness.

Often, these clients have no appropriate community care settings available to meet their unique care needs and therefore, they often have multiple extended admissions to acute care and/or they are unable to be discharged from acute inpatient beds, leading to extended length of stays. Unfortunately, attempts to discharge these clients often result in an inappropriate or

under resourced placement setting which cannot meet their unique and intensive care needs, e.g. shelters, residential care, supported housing; leading to high readmission rates. Furthermore, given the complexity of these clients, their presence places can often clients at risk given their younger age, increased mobility compared to other residents, violent and aggressive behaviours, active or opportunistic addiction behaviours and/or mental health issues.

Program Goals and Objectives

Benefits for the clients receiving the services are:

- Ability for clients to live more independently if intensive services are provided.
- Continued recovery in less restrictive living with services and resources wrapped around the client as needed
- Continued relationship with the Acute and Tertiary systems. The client may step up and down as needed according to where they are in their recovery journey
- Recall due to a serious clinical relapse or crisis that might otherwise result in an acute care psychiatric hospitalization, and/or an eviction from their community residential setting may be mitigated by direct access to the required level of care at time of recall.

Intended benefits/outcomes for the system overall are:

- Increased flow of clients through the system when the individual is accompanied by ACT team members (e.g. community health appointments; emergency visits; police encounters)
- Increased access to resources due to support for clients utilizing community resources such as Community centres, family practitioners, etc.

The primary effectiveness and outcome measures of ACT include

- Reduction of hospital beds days
- Reduction in ED Visits,
- Housing stability
- Decreased engagement with the criminal justice system.

Indicators to monitor and evaluate health include:

- Proportion of ACT clients who have a family doctor or are registered with a community health centre where they see a family doctor or nurse practitioner;
- Improved physical health status (treatable medical conditions, chronic diseases well-managed) as measured by self- or clinician-report;
- Number of visits to a primary care practitioner;
- Positive movement towards next stage of readiness to engage in substance use treatment;

Partnerships and Collaborations

VPD is an important partner in the development and ongoing support of ACT, with police officers embedded within the teams. The VPD's role on the ACT team is to assist in the flow of communication to other service providers for ACT clients, as well as to provide assistance when required during field visits to clients. Additionally, the VPD provides police and justice based collateral information and identifies and refers clients who are decompensating, becoming increasingly difficult to manage in the community, or entering into crisis.

As many individuals supported by the team will be homeless or at risk for homelessness, collaboration with BC Housing is essential. Subsidies and access to congregate housing in the new city sites will be offered available through ACT services.

Timelines for Implementation

The two proposed ACT teams have already been implemented as part of the Ministry of Health 120 Day Action Plan.

Assertive Community Treatment as an Evidence- Based Service

ACT is widely recommended and empirically validated form of multidisciplinary care designed to provide an extensive spectrum of medical, psychosocial, and rehabilitation services to individuals with SAMI within a community setting. First developed in Wisconsin in 1980 in response to de-institutionalization and transition to community care models, care principles are focused on assertive, client-based, and recovery-oriented care for clients for whom traditional methods have not worked.

The model has been adopted worldwide, and has been supported as a best practice model for those *"...with serious and persistent mental illness, and accompanying functional disabilities, who are intensive users of the mental health system."* (Ministry of Health 2008).

The first two ACT Teams implemented in VCH have already demonstrated impressive outcomes with this population, with initial evaluations showing a 36% decrease in negative police contact, 49% reduction in Mental Health Act apprehensions, 32% decrease in victimization, 46% decrease in violent offenses, 10% decrease in substance-related offenses, 31% in criminal justice system contacts, and 38% decrease in street disorder in the year following versus prior to connecting with the team. Service also reduced emergency room visits and acute inpatient bed days (Appendix C). ACT also facilitates occupational functioning, with 26% of clients of ACT 1 in supported employment, 9% in competitive employment, and 5% in a volunteer position

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References

British Columbia Ministry of Health Services (2008). British Columbia Program Standards for ACT Teams.

British Columbia Ministry of Health (2013). Improving Health Services for Individuals with Severe Addiction and Mental Illness.

Alignment with Regional Mental Health and Substance Use Plan

Establishing these two additional ACT Teams is a key recommendation from the Ministry of Health 2013 Report "*Improving Health Services for Individuals with Severe Addiction and Mental Illness,*" specifically named as part of a tactic outlined under Goal #2 (Strengthen community capacity and decrease demand on acute, ED and police services)

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Appendix A: Budget

Expenditure Categories	ACT Team #4 2014/15	Annualized	ACT Team #5 2014/15	Annualized
Compensation:				
Salaries & Wages (see below)	$ 1,070,259	$ 1,070,259	$ 1,070,259	$ 1,070,259
Employee Benefits	$ 267,565	$ 267,565	$ 267,565	$ 267,565
Purchased Services-Personnel	$ -	$ -	$ -	$ -
Purchased Services-Physicians	$ 217,755	$ 217,755	$ 217,755	$ 217,755
Subtotal	$ 1,555,579	$ 1,555,579	$ 1,555,579	$ 1,555,579
Supplies				
Drugs & Medical Gases	$ 7,000	$ 7,000	$ 7,000	$ 7,000
Food & Dietary Supplies	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Med/Surg or Patient Supplies	$ 6,000	$ 6,000	$ 6,000	$ 6,000
Diagnostic	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Printing, Stationery & Office	$ 15,000	$ 15,000	$ 15,000	$ 15,000
Housekeeping				
Laundry & Linen				
Subtotal	$ 46,000	$ 46,000	$ 46,000	$ 46,000
Sundry:				
Communication & Data Processing	$ 10,300	$ 10,300	$ 10,300	$ 10,300
Travel (staff and patients/clients)	$ 33,000	$ 33,000	$ 33,000	$ 33,000
Professional Fees				
Other	$ 24,978	$ 24,978	$ 24,978	$ 24,978
Subtotal	$ 68,278	$ 68,278	$ 68,278	$ 68,278
Equipment Expenses				
Referred Out Services				
Gov't Reporting Entity - Gov't Orgs & SUCH	$ -	$ -	$ -	$ -
Other (non-GRE)	$ -	$ -	$ -	$ -
Subtotal				
Building & Grounds				
B & G Service Contracts	$ 42,300	$ 42,300	$ 42,300	$ 42,300
Plant Operation (Utilities)				
Rent	$ 87,843	$ 87,843	$ 87,843	$ 87,843
Interest on Mortgages/LT Debt				
Other				
Subtotal	$ 130,143	$ 130,143	$ 130,143	$ 130,143
Total Expenditures[1]	$ 1,800,000	$ 1,800,000	$ 1,800,000	$ 1,800,000

Notes:

1 Annualized funding will be composed of $1.8 M from VCH global funding and $1.8M from SAMI $2.0 M funding allocation

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Appendix B: Staff Model

Position	Urban/Full size
Team Coordinator	1.0 FTE
Manager, MH & A	0.6 FTE
Registered Nurse	4.0 FTE*
Social Worker	1.0 FTE
Occupational Therapist	1.0 FTE
Substance Use Specialist	1.0 FTE
Vocational Specialist	1.0 FTE**
Peer Support Specialist	1.0 FTE
Other Clinical Staff	2.0 FTE
Total Multidisciplinary Clinical Staff (excluding psychiatrist and program assistant)	12.6 FTE
Psychiatrist	0.8 FTE
Program/Administrative Assistant	1.0 FTE
Total	**14.4 FTE**

Notes:

* There are an additional nurse (4 rather than 3) per team to accommodate the acuity of the clients and their primary care needs. We anticipated proposed suggestions outlined in the draft Standards to address high acuity, high primary care needs, and safety with the SAMI population. We added an additional nurse and developed a schedule to provide for 2 nurses every day except Sunday (one nurse). Please see below from the draft Standards:

> *"Sometimes these expected ratios need to be adjusted to account for communities that are impacted by population factors such as central drift, high rates of co-morbidity or homelessness. The staff-to-client ratio may need to be adjusted in settings where the clients are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions that require more service contacts. Staff-to-client ratios may also need to be adjusted in settings where safety is an issue and staff must pair up to work in a particular neighborhood and where staff must travel great geographical distances".*

** We have yet to hire Vocational Specialists for ACT 4 &5, as our client numbers do not justify having them at this time (anticipated start date Spring 2015). This is consistent with the implementation process for ACT 1 & 2.The Occupational Therapists have taken on the role for pre-vocational assessment and planning and have been working with the Vocational Specialists from ACT 1 & 2 during the interim.

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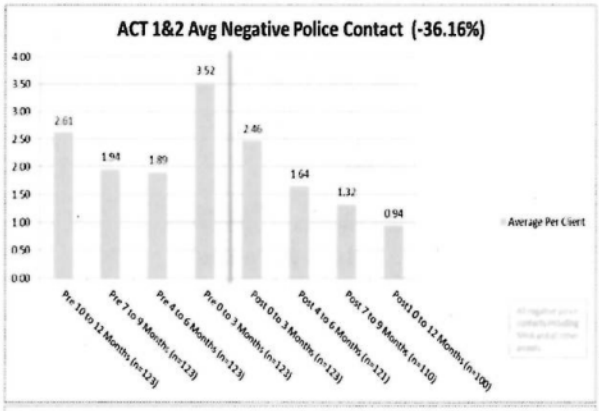
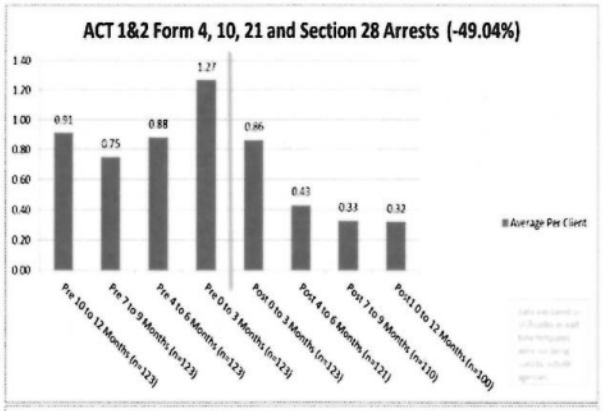
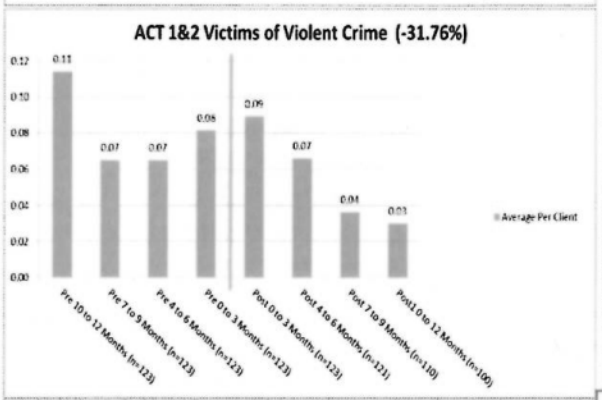
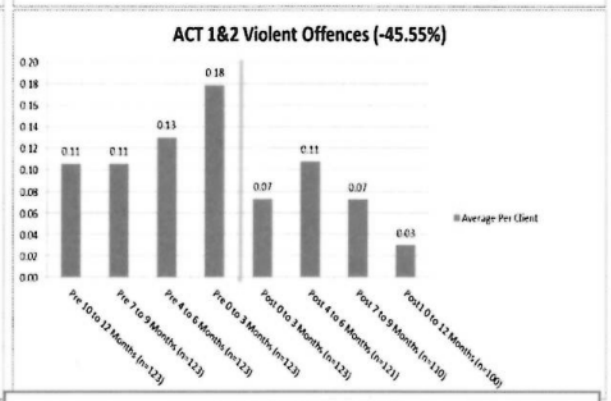
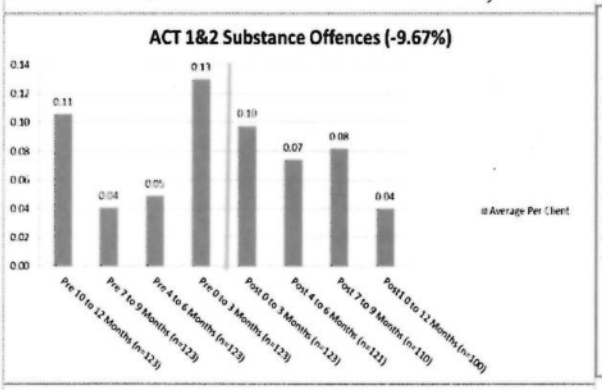
Appendix C: Supporting Data for ACT (Teams 1 and 2)

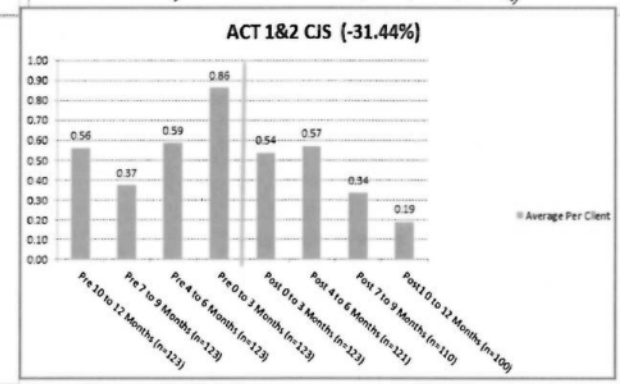


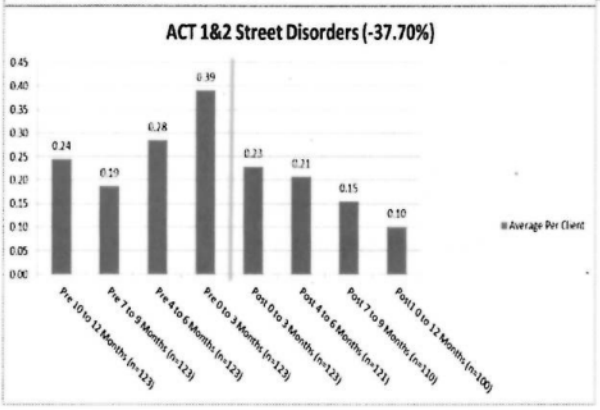


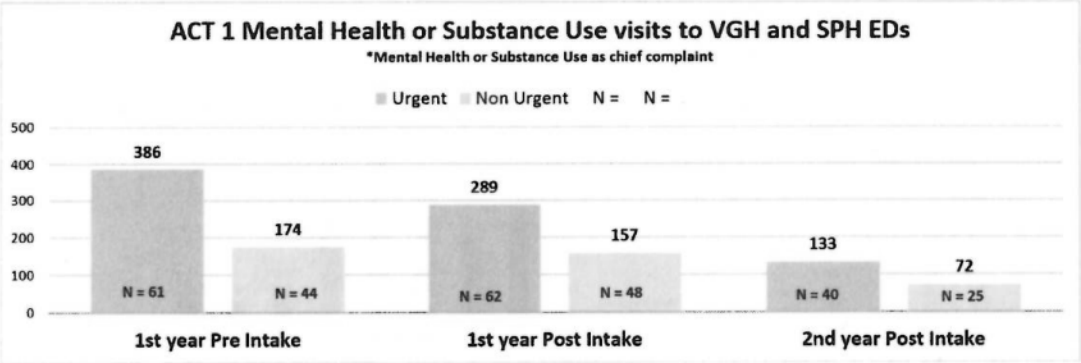


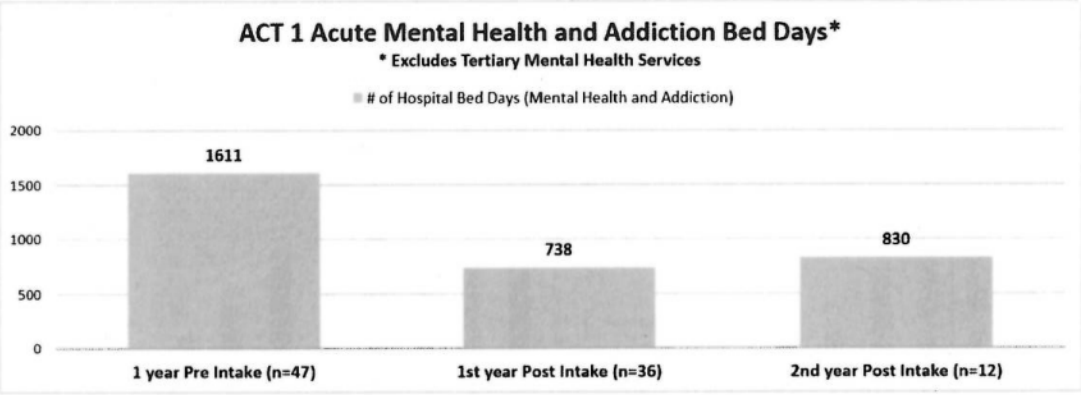


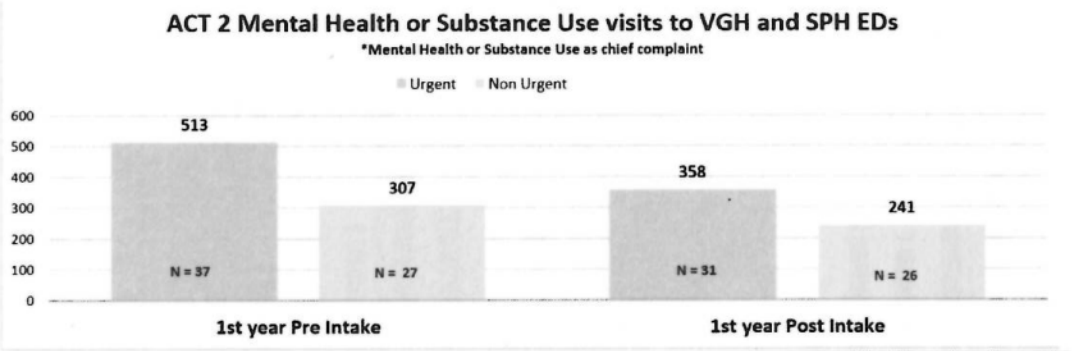


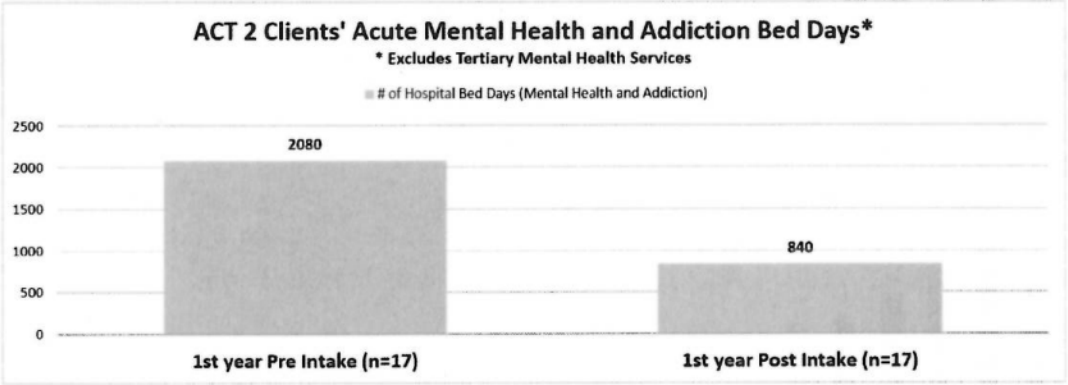





ACT 1 Mental Health or Substance Use visits to VGH and SPH EDs
*Mental Health or Substance Use as chief complaint
Urgent
Non Urgent
N =
N =
500
400
300
200
100
0
386
174
289
157
133
72
N = 61
N = 44
N = 62
N = 48
N = 40
N = 25
1st year Pre Intake
1st year Post Intake
2nd year Post Intake


ACT 1 Acute Mental Health and Addiction Bed Days*
* Excludes Tertiary Mental Health Services
# of Hospital Bed Days (Mental Health and Addiction)
2000
1500
1000
500
0
1611
738
830
1 year Pre Intake (n=47)
1st year Post Intake (n=36)
2nd year Post Intake (n=12)


ACT 2 Mental Health or Substance Use visits to VGH and SPH EDs
*Mental Health or Substance Use as chief complaint
Urgent
Non Urgent
600
500
400
300
200
100
0
513
307
358
241
N = 37
N = 27
N = 31
N = 26
1st year Pre Intake
1st year Post Intake


ACT 2 Clients' Acute Mental Health and Addiction Bed Days*
* Excludes Tertiary Mental Health Services
# of Hospital Bed Days (Mental Health and Addiction)
2500
2000
1500
1000
500
0
2080
840
1st year Pre Intake (n=17)
1st year Post Intake (n=17)

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STRENGTHENING SERIVCES FOR INDIVIDUALS WITH SEVERE ADDICTIONS AND MENTAL ILLNESS

BUSINESS CASE:

VANCOUVER COASTAL HEALTH-

NORTHSHORE YOUTH INTENSIVE CASE MANAGEMENT TEAM

JULY 31, 2014

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North Shore Youth Intensive Case Management Team - Business Case Proposition

Vancouver Coastal Health – North Shore has identified $200,000 in available funding for a **Youth Intensive Case Management Team**, and is seeking matching annualized funding from the Ministry of Health ($200,000) for a total annual program budget of $400,000. This proposal will outline the proposed service as well as identify key linkages within the broader continuum of care across VCH/ PHC and Provincial services.

Overview of the Business Case

Contained within this Business Case is a proposal to develop Youth Intensive Case Management (ICM) capacity for Lions Gate Hospital (LGH) and the North Shore Community in order to better address the needs of youth/ transition aged youth presenting with a serious substance use and/ or mental illness. These youth are not accessing mainstream office based services and are presenting in high numbers to the emergency department. This is a high risk, vulnerable population for whom an intensive outreach case management service is required.

The Youth ICM Team will form an integral component of the broader continuum of mental health and addiction care for youth / transition aged youth on the North Shore. As identified in the BC standards, ICM is a form of case management that meets the needs of clients with moderate to severe substance use problems, concurrent disorders and/or mental illness, and is part of the spectrum of community-based case management service. While standards currently do not exist for the youth population, this team will be aligned with current guidelines as appropriate for a youth population.

The ICM standards suggest that services may be provided to a broad range of individuals who are in need of more intensive services than standard, office-based case management but do not meet the criteria for Assertive Community Treatment (ACT) (MoH 2008). ICM clients may be persons with high health needs and low or inappropriate levels of health system access that are in need of support to help engage them in the services they need. Without such care, these individuals often fall through gaps in health and social systems. In other cases, individuals may be poorly or inappropriately served by existing services.

The statistics for the North Shore demonstrate that 337 youth presented to the Lions Gate Hospital (LGH) for substance misuse and/or mental illness in 2012/13, with 59% not having any prior contact with mental health services or addiction services. Of all the youth discharged from LGH Emergency Department in 2012, 30% had a primary presentation of alcohol or drug misuse. A review of the data further demonstrated that this is a population of youth that does not engage in traditional office based services, is loosely connecting to community and often ends up in a crisis situation resulting in presentation to the emergency department.

From a patient and family perspective, difficulty navigating the healthcare system and frustration with delays in receiving care can lead untreated illness and a cycle of crises, with prolonged morbidity and the eventual development of chronic illness with disability continuing into adulthood. By improving

timely access to assessment, case management, and facilitated transitions, both experiences of care and health outcomes can be improved for these vulnerable, at risk youth. Intensive case management decreases the likelihood of further deterioration, homelessness or correctional involvement, as well as unfortunate trajectories of untreated illness.

From a systems perspective, the ICM team will bridge acute and community services for youth / transition aged youth with serious addiction and mental illness concerns. This in turn relieves pressure on the acute care system and ensures that the intervention received matches the need of the youth. An ICM also ensures appropriate follow-up, diminishing the risk of further crises.

Goals of ICM are to improve health, social functioning, and access to care for the clients they serve. ICM is a wrap-around service including street outreach and provision of services in the community, where people are located geographically. The North Shore ICM team aligns with evidence based guidelines draws on a strengths-based philosophy promoting a focus on the assets and abilities of clients and their environments rather than deficits. This is achieved through implementation and application of clinical frameworks informed by cultural, sex and gender competency, cultural safety, harm reduction and trauma informed care.

This Business Case proposes that VCH – Coastal in partnership with key community stakeholders, develop a Youth Intensive Case Management Team. Key partners include: youth and families, Psychiatrists, Primary Care, Public Health, MCFD-C&YMH, Lion's Gate Hospital, School Districts 44 and 45, First Nations communities, community police services, community agencies, North Shore municipalities, Inner City Youth Program and Portage Residential Treatment Program.

These efforts align with strategies outlined in the 2013 Ministry of Health Report "Improving Health Services for Individuals with Severe Addiction and Mental Illness," including:

- Goal #1: Improve the ability for ED services to respond to increased volumes and strengthen community transitions
- Goal #2: Strengthen community capacity and decrease demand on acute, ED and police services
- Goal #4: Build capacity for early intervention and sustainable system change

This Business Case will:

- Outline the proposed Intensive Case Management Model
- Provide a rationale for the Service Delivery Model in the Continuum of Care
- Review data particular to the North Shore community
- Describe the Program Objectives
- Identify a Model of Collaborative Partnership
- Propose an implementation Budget (Appendix A)
- Provide a general overview of similar services in BC (Appendix B)
- Provide a proposed Program Description (Appendix C)
- Provide relevant detailed data (Appendix D)

Executive Summary

Youth experiencing a mental health and/or substance use crisis present significant challenges to the acute care system. Without adequate Intensive Case Management capacity within the community, youth, families and the professionals who work with them default to the local hospital Emergency Department (ED). The absence of Intensive Case Management (ICM) Teams providing in-reach to the ED may result in youth having protracted Emergency Length of Stay and increased admission rates to either pediatric or adult psychiatric units.

This has had a significant impact on the Lions Gate Hospital (LGH) ED as youth in crisis present to the ED due to a lack of community access points. Family Practice Physicians, families, and community resources all report an inability to access urgent mental health/psychiatric assessments for their youth in a timely manner. The default access point becomes the LGH ED where, in the absence of specialized resources, assessment, planning and follow-up are uncertain and admissions to the acute beds more likely.

From a patient and family perspective, difficulty navigating the healthcare system and frustration with delays in receiving care can lead untreated illness and a cycle of crises, with prolonged morbidity and the eventual development of chronic illness with disability continuing into adulthood. By improving timely access to assessment, case management, and facilitated transitions, both experiences of care and health outcomes can be improved for these vulnerable, at risk youth. Intensive case management decreases the likelihood of further deterioration, homelessness or correctional involvement, as well as unfortunate trajectories of untreated illness.

While ICM standards do not exist for the youth population at this time, there is clear clinical evidence that this model of ICM Team is a 'Promising Model of Practice' and the proposed model of service has been successfully implemented with adult populations. More recently, the standards were adopted by the Inner City Youth Program in urban Vancouver.

The proposed ICM team will provide service to both the LGH ED and the North Shore community seven days per week; from 9 am to 11 pm. Services will include assertive outreach and assessment, outpatient psychiatric assessment and treatment, access to primary care, substance use counselling, crisis intervention, wrap around case management, outreach and referral coordination for longer term community follow-up. This service will form an integral component of the continuum of care for youth presenting with acute mental health and/or substance use concerns, and will respond to youth where youth need the response.

It is anticipated that by providing an alternative to presenting to the LGH ED, there will be a corresponding drop in the number of youth presenting in crisis. For those youth who do present at the ED, this service provides a much needed resource to the ED Physicians and will provide a viable alternative to admission into the acute site for those youth who can be safely managed in the community with the type and intensity of follow-up that the Youth ICM Team provides.

Collaborative partnerships with community resources, acute care stakeholders and intensive treatment resources such as Portage Residential Treatment Program and Inner City Youth Program will help ensure that the model of care is integrated and that youth and families can move through this system with the fewest barriers possible ensuring the continuum of care for youth and families is easily navigated and accessible regardless of point of entry.

In summary, this Business Case contains the research, rationale and detailed description for the proposed Youth ICM Team for the North Shore. Approval of this request for matched funding by the MoH would allow us to begin to impact and shift the current patterns of service access by youth on the North Shore and begin to address the current pressure that this places on the acute care system, and provide early intervention to individuals at high risk for developing lifelong severe addiction and mental illness. In addition, the capacity to provide intensive outreach services for our most at risk youth will provide a much needed component to the continuum of care for youth struggling with severe mental health, substance use or concurrent disorders on the North Shore.

Youth Intensive Case Management for the North Shore Community

- The proposed Youth Intensive Case Management (ICM) Team will be developed to improve care for North Shore youth / transition aged youth with serious substance use and mental health concerns currently not accessing traditional office based services and are thus over represented in emergency department and acute services.

- The Youth ICM Team will work across hospital and community. Therefore, when a youth presents to the ED, the team will assess the youth in the ED. This comprehensive mental health assessment will then assist the ED Physician in establishing the appropriate disposition of the patient.

- Youth not requiring hospital admission will be discharged to the community with clinical follow-up and wrap around support available 7 days per week provided by the Youth ICM Team.

- Referrals originating from the community will receive a comprehensive assessment and clinical / case management follow-up by the Youth ICM team thus preventing the need for ED presentation.

- Services provided include crisis intervention, psychiatric assessment, substance use counseling, stabilization, access to primary care, assessment, assertive outreach, intensive case management and referral coordination with capacity for support and transition to appropriate community based services or referral to higher intensity programs when required.

- The Youth ICM Team will build and maintain effective linkages with the wide range of youth-serving resources in the North Shore community to ensure the smooth transition across and between resources along the continuum of care. In addition, the program will work collaboratively with specialized resources across the Health Authority, MFCD, Portage Residential Treatment Program and Peak House.

- The Youth ICM Team will build linkages with the Inner City Youth Program, an ICM Team in urban Vancouver that has modeled in-reach to St Paul's Hospital with linkages to community services. This will facilitate opportunities for data collection and evaluation, shared training and the smooth transition of youth from one service to the other.

- Clear referral pathways with community resources will be developed in order to mitigate the risk of youth falling through the cracks as they transition from one service to the next. To further facilitate the transitions in care, the Youth ICM staff will attend transition sessions with the youth and the new referral sources to ensure strong transitions.

- Where the youth can transition to adult services, the Youth ICM Team will support youth with serious substance use and mental health concerns transition to the adult mental health system, following with or supporting their care as determined by the youth's clinical needs. The teams will work together with the transition aged youth to determine the best fit of service that can support outreach clinical care as well as primary care and support with vocational and educational needs.

- Youth, regardless of where they present along the continuum of care will receive timely access to the right level of care and will be supported through wrap around case management and in their transition to follow-up resources.

The Intensive Case Management Model within the Continuum of Care

- ICM services are part of the spectrum of case management services provided to a broad range of individuals who are in need of more intensive services than standard, office-based case management but do not meet the criteria for ACT services. Such individuals often fall through gaps in health and social systems. In other cases, individuals may be poorly or inappropriately served by existing services. ICM can be a strategy to engage individuals in needed services. The development of an ICM service in the North Shore targeting a youth population will address this gap and provide wrap around outreach service to this high risk population.

- The team will provide a bridge between the acute and community service sectors for high risk youth experiencing serious substance use and/or mental health issues. This in turn relieves pressure on the acute care system while ensuring that these high-risk youth receive the comprehensive assessment, intensive case management, assertive outreach and treatment they need in a timely and efficient fashion.

- Informed by utilization trends, the service is available for up to seven days a week providing both evening and weekend coverage.

- These youth would be presenting with thoughts, feelings or behaviour that were markedly different from their usual state and which were seriously interfering with the tasks of daily living. In addition to serious issues related to substance use these youth may present with acute disturbance in mood, thinking or behavior which might manifest with suicidal ideation, mood problems or psychotic symptoms.

- The Youth ICM Team provides assessment, crisis intervention, assertive outreach, intensive case management, substance use counseling, urgent psychiatric consultation/assessments, access to primary care and referral coordination.

- Clinicians assess and intervene at the point of referral, accepting referrals from the hospital ED, community partners or self-referral (youth/family). Community referral sources would include Primary Care, Psychiatrists, Pediatricians, Public Health, community agencies, First Nations communities and schools.

- This model ensures both the acute care system and the community have access to urgent mental health and substance use assessment, and intensive case management services and that this access is timely to the needs of youth and the referral source.

- Clear care plans and referral pathways with follow-up resources and careful attention to care transitions ensure effective continuity of care for youth accessing this service.

- This model aligns with ICM Standards and Guidelines (Ministry of Health 2013), with guiding clinical frameworks of assertive engagement and outreach, trauma informed care, stages of change, harm reduction, cultural safety, sex and gender perspective, and psychosocial rehabilitation.

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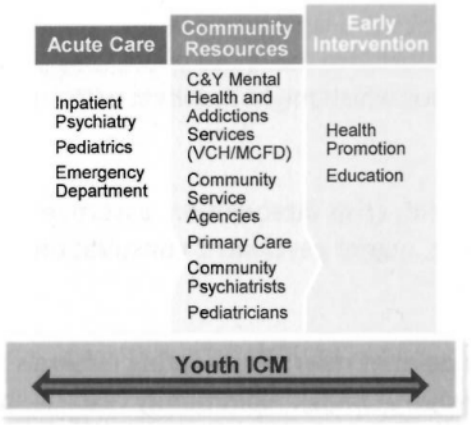
Continuum of Care

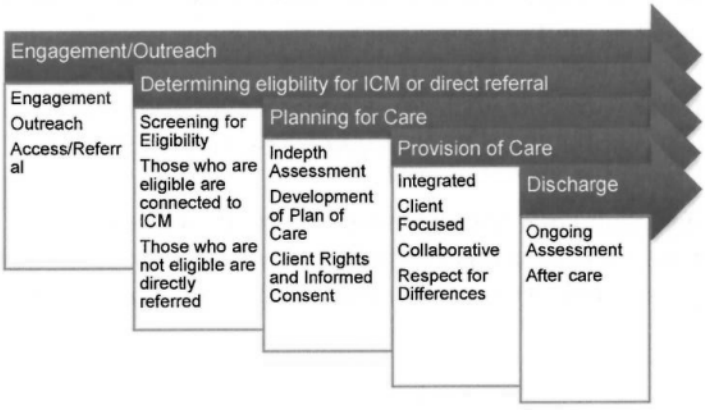
Continuum of care refers to the full range of services available to a particular population or sub-group of the general population. These services range in level of intensity from prevention to the most intensive tertiary level of services. Conceptually, youth should be able to move through the continuum of services as their needs require with both ease and ready access.

As many have identified, including the Representative for Children and Youth in the recent publication ***Still Waiting, First Hand Experiences with the Youth Mental Health System in BC (2013)***, the current system of mental health care is often fragmented and, as reported by those who use it, difficult to navigate. Care transitions for this population occur at developmental milestones (youth to adult) but may also occur between one level of care to another (acute care to community).

The proposed Youth ICM Team is intended to be responsive to youth/ transition aged youth across the continuum of care. From the ED to the primary care physicians office, this program will be able to respond with timely intervention, stabilizing the immediate mental health/substance use crisis and supporting the youth/family with assertive outreach and intensive wrap around case management services ensuring smooth transitions to appropriate community based services or referrals to higher intensity programs when required. Acting as an integrator, this program will form linkages across the continuum or care, thereby fostering smooth transitions from one service to another as illustrated below.



The service will be aligned with the MoH ICM Standards and Guidelines (MoH 2013, pictured below), with initial stages of the process including engagement, referral, and access to screening for eligibility. This is followed by in depth assessment, development of a care plan and linkages to appropriate services, with specific attention to client rights and informed consent throughout the process.

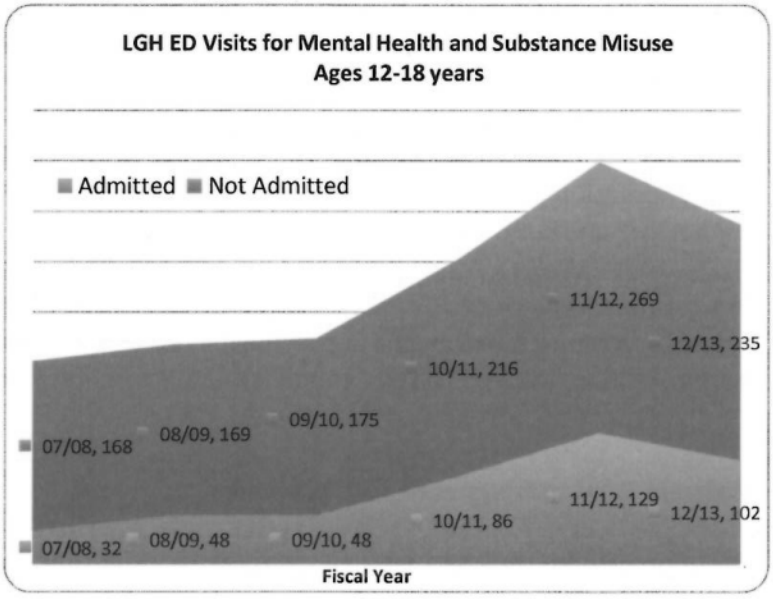


Need for Service: Data Highlights for Youth presenting to LGH ED (see Appendix C for details)

- **337** youth presented to LGH ED in 2012/13 for Mental Health and/or Substance Misuse
- **43%** of these youth were admitted to LGH
- **88%** of these youth presented to the LGH ED between Monday- Saturday in 2012/13
- **76%** of these youth presented to LGH ED between 10 a.m. and midnight in 2012/13
- **59%** of youth discharged from LGH ED in 2012 following a Mental Health or Substance Use presentation were not connected to VCH/MCFD CYMH or to a private psychiatrist prior to visiting the ED.
- **30%** of youth discharged from LGH ED in 2012 had a primary presentation of Alcohol/Drug misuse.

Rationale for a Youth Intensive Case Management Team

The estimated prevalence rates in children for clinically significant mental disorders is estimated to be 14% and frequently these disorders will persist into adulthood (Waddell et al. 2007). For many of these youth, access to services poses many challenges. In the recent report from the Representative for Children and Youth, ***Still Waiting, First Hand Experiences with Youth Mental Health Services in BC***, many of these obstacles were highlighted. A lack of services, difficulty navigating the system and long waitlists are just a few of the challenges facing youth experiencing mental health and substance use issues.



Community resources, including schools, also face challenges when confronted with a youth requiring intensive support or a mental health/psychiatric assessment, or for linking youth that are identified as being at risk and loosely connected to care to appropriate services. The default in the system of care for these cases often becomes the hospital emergency department.

When these youth experience a mental health and/or substance use crisis, often the only resource for help is the local hospital emergency room. LGH ED has experienced a rapidly increasing number of youth with mental health and substance use issues presenting to the emergency department with current numbers remaining high (09/10-223, 10/11-302, 11/12-398, 12/13 - 337).

At the current time the North Shore community inclusive of Lions Gate Hospital does not have any resources specifically designed to respond to this growing need. Without access to specialized resources that link community and the emergency department, assessment and planning for these

high-risk young people is difficult, community follow-up is uncertain and admission to the acute site is more likely. Acute care settings can lead to further stigmatization of illness or help seeking and in some cases, traumatization of the youth.

Many jurisdictions report this trend of increasing demands on ED's to respond to children and youth presenting with mental health emergencies. In a recent publication of Pediatric Emergency Care, it was felt to be of paramount importance for the ED to have access to the appropriate resources. The most important element was identified to be establishing a relationship with a 'specialized mental health team' for consultation and collaboration with case planning and disposition. (Pediatric Emergency Care, 2008).

Greenfield found that suicidal adolescents who received rapid-response outpatient follow-up had a lower hospitalization rate than those who did not (Greenfield, B et al. 2002).

In a review of the literature related to mental health care for pediatric suicide presentations in the ED, it was found that "transition interventions appear most promising for reducing suicide-related outcomes and improving post-ED treatment adherence" (Newton, A et al. 2010).

There is clear clinical evidence that this model of Youth ICM is a 'Promising Model of Practice' and implementation of this service at LGH provides an opportunity to embed a rigorous evaluation framework and contribute to this growing body of research

In a recent review of crisis interventions and specialized care models used in the ED, studies were found to demonstrate that the use of specialized care models for mental health in the ED reduced hospitalization, return ED visits, and length of ED stay (Hamm, M. et al. 2010).

Program Goals, Objectives and Alignment

The proposed Youth ICM Team will perform an important transition or bridging function by responding to the youth regardless of where they first present, providing assessment and wrap around case management and by ensuring referrals for long term follow-up are in place upon discharge from the service. Many youth find it difficult to transition from one service to another. This program will have the capacity to be responsive to this by supporting the youth through the transition process including providing transition sessions with the youth and the receiving resource.

It is also proposed that this service, with its focus on intensive outreach and wrap around case management, will facilitate and support youth with serious mental health and substance use issues as they transition into the adult mental health system, following with their care as determined by functional need not chronological age.

Benefits of the Youth ICM Team will include:

- **Timely access** to crisis substance use and mental health services for youth currently at risk of presenting to the Lions Gate Hospital (LGH) Emergency Department with symptoms of serious

mental illness and/or substance use (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #1)

- **Decongest Emergency Department** of youth presenting at LGH by providing a service option for redirecting youth to the community for intensive crisis intervention, assertive outreach and intensive case management services (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #2)

- **Emergency Department Diversion** through the provision of crisis assessment, assertive outreach and intensive case management for referrals originating in the community as an alternative to presenting at the ED. (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #2)

- **Reduce admissions to LGH Pediatrics Unit / Adult Inpatient Unit** through the provision of intensive community based crisis intervention and ongoing outreach based follow up for youth with severe psychiatric and/or substance use issues. (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #2)

- Provide **Rapid Access** to engagement, assessment, intervention, care planning, and intensive case management for hospital referrals, community referrals and self-referrals (youth/family). (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #4)

- **Facilitate Transitions** for youth and families from the Intensive Case Management Team to ongoing clinical resources within the community including supporting youth transitioning to the adult mental health system or specialized services like the Early Psychosis Intervention Program. (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #2)

- Provide **Integrated service** across the continuum of care including care pathways with Inner City Youth ICM Portage Residential Addiction Treatment Program and Peak House (MoH Improving Health Services for Individuals with Severe Addiction and Mental Illness Goal #2)

This proposal aligns with Vancouver Coastal Health Regional Mental Health and Addictions objectives of developing a continuum of services using the ***tiered framework*** *that includes a focus on* ***integration & transitions.*** Target areas of focus for the regional objectives include ***ER flow and crisis response, and complex concurrent disorders and youth mental health and addiction.*** The broader organizational strategic priorities of reducing presentations to ER and decreasing overall admission rates to hospital will also be addressed through the implementation of this service.

Collaborative Partnerships in Delivering Care to Youth on the North Shore

- Collaborative partnerships involve shared ownership and responsibility to work together to find solutions that no one stakeholder alone can implement.

- Youth experiencing a mental health and/or substance use crisis impact on both the acute and community systems of care. Using a model of collaborative partnership will facilitate the development of a program that successfully addresses the needs of youth while also addressing the needs of both the acute care system and the community sector.

- Collaborative partnerships will help ensure that the model of care is integrated and that youth and families can move through this system with the fewest barriers possible.

- A model of collaborative partnership will help ensure that access to urgent mental health and/or substance use services are available regardless of where a youth first presents and that rapid access and urgent intervention is a shared responsibility across the service system.

- Key Stakeholders in this Collaborative Partnership
    - Youth and Families
    - Acute Care: ED
    - Inpatient Psychiatry/Pediatrics
    - Psychiatrists, Pediatricians, Primary Care Physicians
    - VCH/ MCFD-CYMH,
    - Public Health
    - First Nations communities
    - Community service organizations, Schools, Municipalities
    - Specialized resources i.e. Portage, Inner City Youth Mental Health Program

- Successful implementation of a Youth ICM Team will require the ongoing commitment from the stakeholders to engage in this collaborative partnership, working together to ensure the continuum of care for youth and families is easily navigated and accessible regardless of point of entry.

Timelines for Implementation

The North Shore Community has identified the need for this specialized service and is well positioned to move forward once MoH approval of matched funding is granted.

The team could be operational within four months of the time approval is provided.

Summary

- The proposed Youth Intensive Case Management Team is an integral component of the continuum of care for youth presenting with serious substance use and/or mental illness. It will form a vital link in addressing the dramatic number of youth who, for the lack of anywhere else to go, present to the LGH ED.

- This service will act as a bridge that is responsive to youth where youth need the response. Over time it is hoped that by raising the public profile of this service, youth would have an alternative to presenting to the ED, resulting in a corresponding drop in the number of youth presenting to LGH ED in a substance use and/or mental health crisis.

- For those youth who do present at the LGH ED, this service provides a much needed resource to the ED Physicians and will provide a viable alternative to admission into the acute site for those youth who can be safely managed in the community with the type and intensity of follow-up that the Youth ICM Team provides.

- By improving timely access to assessment, intensive case management, and facilitated transitions both the experience of care and health outcomes can be improved, with risk for these youth to attempt suicide or go on to develop severe addiction and mental illness greatly reduced.

- Developing Collaborative Partnerships with key stakeholders will enhance the program's ability to establish the relationships necessary to begin to address the gaps and fractures in the system of care for youth. The bridging function of this program will highlight opportunities for these partnerships across the continuum of care. From the emergency department, the mental health and addictions system, primary care, public health and the many local community resources, no service sector is beyond the reach of this program.

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Appendix A

Proposed Budget for North Shore Youth Intensive Case Management Team

Expenditure Categories	2014/15	Annualized
One-time Start-up Costs		
Community engagement & advertising	$ 10,000	
Implementation of new team in PARIS	$ 25,000	
Start up - office supplies	$ 1,500	
Subtotal	$ 36,500	$ -
Compensation:		
Salaries & Wages (see separate tab- 3.2 FTE's)	$ 173,329	$ 297,135
Employee Benefits	$ 43,332	$ 74,284
Purchased Services-Personnel	$ -	$ -
Purchased Services-Physicians (to be reallocated from within existing APP sessional allocation)	$ -	$ -
Subtotal	$ 216,661	$ 371,419
Supplies		
Drugs & Medical Gases		
Food & Dietary Supplies		
Med/Surg or Patient Supplies		
Diagnostic		
Printing, Stationery & Office	$ 5,108	$ 8,757
Housekeeping		
Laundry & Linen		
Subtotal	$ 5,108	$ 8,757
Sundry:		
Communication & Data Processing	$ 5,352	$ 9,174
Travel (staff and patients/clients)	$ 6,038	$ 10,350
Professional Fees		
Other	$ 175	$ 300
Subtotal	$ 11,564	$ 19,824
Equipment Expenses		
Referred Out Services		
Gov't Reporting Entity - Gov't Orgs & SUCH	$ -	$ -
Other (non-GRE)	$ -	$ -
Subtotal		
Building & Grounds		
B & G Service Contracts		
Plant Operation (Utilities)		
Rent		
Interest on Mortgages/LT Debt		
Other		
Subtotal	$ -	$ -
Total Expenditures[1]	$ 269,833	$ 400,000

Notes:

1 Annualized funding will be composed of $200,000 from VCH global funding and $200,000 from SAMI $2.0 M funding allocation

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Appendix B

North Shore Youth Intensive Case Management Team
Program Description

Assumptions

- Current rate of youth in presenting to Emergency will continue (398 in 11/12 – 337 in 12/13)
- Estimated community referrals with new program being made available to professionals and clients/families – approx. 100 per year
- Total referrals projected 425 – 475 per year
- Program will accept referrals for youth and transition aged youth (13 – 21 years)
- The ICM Team ages will float upward to reflect the broader program changes that are underway to address the transition aged youth on the North Shore with a goal to aligning the North Shore services with other services providing transition aged services for youth i.e. ICY Program in Vancouver.
- The ICM caseload suggests 1:20 ratio, the Youth Team will use this as a guideline as there are currently no standards for youth ICM

Staffing Model

- 2 Case Managers
  Monday – Sunday 11am – 11 pm (single coverage)
- .8 Case Manager
  Tuesday – Friday 10 – 6 pm
- .4 Administrative Support
- 2 Psychiatric Sessions

Hours of Operation

- Monday – Friday 9 am – 11pm
- Saturday – Sunday 11 am – 11 pm

Psychiatric Assessment (outpatient)

- Within 24 - 72 hours.

Referral Sources

- LGH Emergency Department
- Community Psychiatrists, Pediatricians
- MCFD-CYMH
- Primary Care Physicians
- Public Health, Schools
- First Nations Communities
- Community Resources
- Youth and Families

Type of Service provided

- Assessment (including psychiatric assessment)
- Engagement, Assertive Outreach and Crisis Intervention
- Intensive Case Management
- Substance Use Counselling
- Care planning
- Referral Coordination / Transition Planning

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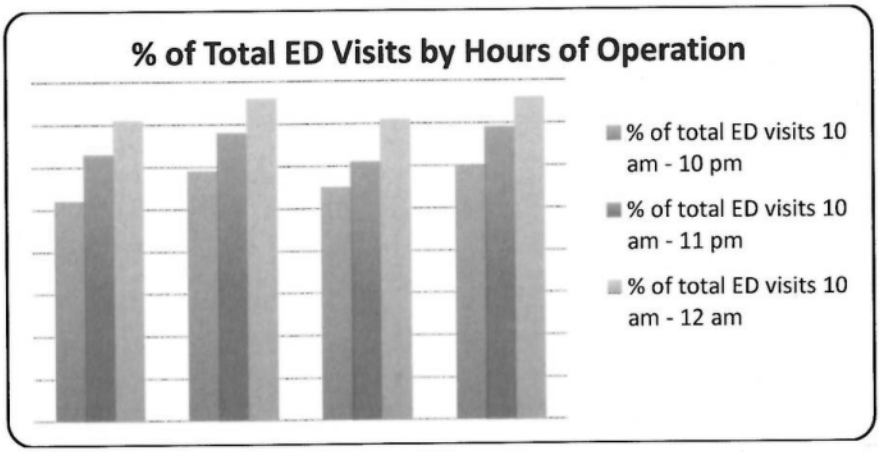
Appendix C: Supporting Data

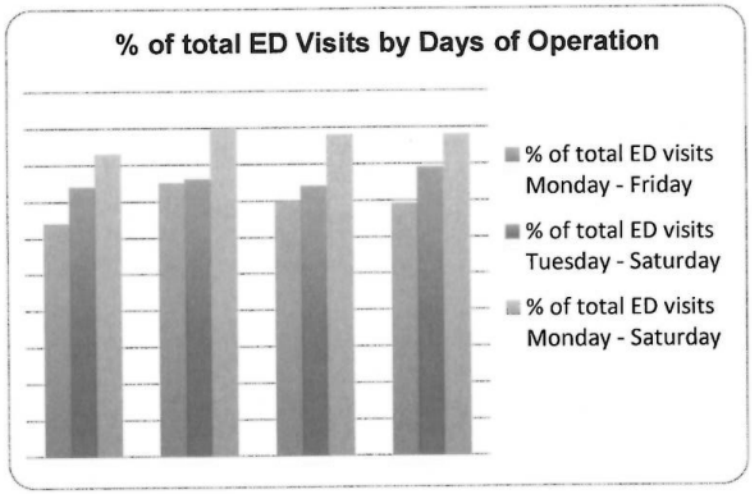
% of Total Youth ED Visits by Hours of Operation

Year	Total ED Visits	% 10 am – 10 pm	% 10 am – 11 pm	% 10 am – 12 am
2009/2010	223	52%	63%	71%
2010/2011	302	59%	68%	76%
2011/2012	398	55%	61%	71%
2012/2013	337	60%	69%	7%



% of Total ED Visits by Days of Operation

Year	Total ED Visits	Mon. – Fri.	Tues. – Sat.	Mon. – Sat.
2009/2010	223	64%	74%	83%
2010/2011	302	75%	76%	90%
2011/2012	398	70	74%	88%
2012/2013	337	69%	79%	88%



BRITISH COLUMBIA

1013673

To: Health Authority Chief Executive Officers

Subject: Strengthening Services for Individuals with Severe Addictions and Mental Health (SAMI): Matched Funding Criteria and Application Process

On November 15, 2013, the Minister of Health released a report: *Improving Health Services for Individuals with Severe Addiction and Mental Illness* including an action plan to respond to the immediate and long-term health needs of people with severe substance use and mental illness in all health regions (www.health.gov.bc.ca/library/publications/year/2013/improving-severe-addiction-and-mental-illness-services.pdf).

This action plan is designed to reduce barriers and service gaps and better meet the needs of a specific subset of people with the most complex form of Severe Addiction and/or Mental Illness (SAMI) who present a greater risk to themselves and/or others. The plan is in response to community concerns in Vancouver and ensures evidence-based approaches are in place to better support this client population throughout the province.

As outlined in the Government Letter of Expectation dated May 9th, the Ministry of Health (the Ministry) has provided $2 million in matched funds to your health authority towards strengthening approved services for this population as part of an overall incremental provincial approach. Further to the information on funding allocations provided at that time, the purpose of this letter is to outline the criteria, expectations and process for regional health authorities (RHAs) to access the matched funding, which is currently frozen.

To access these funds, RHAs must submit business plans to the Ministry for approval that clearly address eligibility criteria related to client population, financial information and service delivery areas (See Appendix A, B, C). Appendices D outline the respective program and business plan information required. We encourage you to engage with major stakeholders such as local police departments and Corrections in the development of business plans.

Please submit your business plan to Mr. Mark Armitage, Ministry of Health by August 31, 2014 or earlier. Questions in relation to these instructions can be directed to Mr. Mark Armitage by email at: mark.armitage@gov.bc.ca or by telephone at: (250) 952-3519.

Sincerely,

Doug Hughes
Assistant Deputy Minister,

Manjit Sidhu
Assistant Deputy Minister

Ministry of Health
Assistant Deputy Minister
Health Authorities Policy and Quality Assurance Division
6-2, 1515 Blanshard St
Victoria BC V8W 3C8

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cc: Andrew Neuner, Vice President Community Integration, Interior Health

David Harrhy, Network Director - Mental Health & Substance Use, Interior Health

Suzanne Johnston, Vice President Clinical Programs and Chief Nursing Officer, Northern Health

Jim Campbell, Jim Campbell, Executive Lead, Mental Health and Addictions, Northern Health

Lois Dixon, Vice President Clinical Operations, Fraser Health

Andy Libbiter, Executive Director, Mental Health & Substance Use, Fraser Health

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Yasmin Jetha, Regional Program Director, Mental Health & Addiction Services, Vancouver Coastal and Providence Health Care

Catherine Mackay, Executive Vice President and Chief Operating Officer, Island Health

Cheryl Damstetter, Executive Director, Mental Health, Family and Public Health Services, Island Health

Keva Glynn, Director, Mental Health and Substance Use Strategic and Tertiary Care, Island Health

Arden Krystal, Executive Vice President and Chief Operating Officer, Provincial Health Services Authority

Mark Armitage, Executive Director, Integrated Primary and Community Care, Ministry of Health

BRITISH COLUMBIA

1022345

October 27, 2014

Ms. Mary Ackenhusen
President and Chief Executive Officer
Vancouver Coastal Health Authority
11th Floor 601 W Broadway
Vancouver BC V5Z 4C2

Dear Ms. Ackenhusen:

I am writing in response to Vancouver Coastal Health Authority's (VCHA) business plan for strengthening services for individuals with severe addictions and mental illness (SAMI) and request for matching funding.

As you are aware, $2.0 million in base operating funding was provided to VCHA in 2014/15 to be used to strengthen approved services for the SAMI population in your region as part of a provincial approach coordinated through the Ministry of Health (the Ministry) and the Provincial Health Services Authority. This funding was frozen pending submission of proposals/business plans and subsequent approval by the Ministry.

s.17

Yours truly,

MSidhu

Manjit Sidhu, CA
Assistant Deputy Minister
Finance and Corporate Services

Ministry of Health
Office of the Assistant Deputy Minister
Finance and Corporate Services
PO Box 9647 Stn Prov Govt
Victoria BC V8W 9P4
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pc: Mr. Glen Coping, Chief Financial Officer, VCHA
Mr. Doug Hughes, Assistant Deputy Minister, Health Services Policy and Quality Assurance Division
Mr. Gordon Cross, Executive Director, Regional Grants and Decision Support
Mr. Mark Armitage, Executive Director, Integrated Primary and Community Care