Ministry of Mental Health and Addictions

Estimates Binder

BRITISH COLUMBIA

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE **Ministry: Mental Health and Addictions** **Date: October 12, 2017** **Minister Responsible: Judy Darcy**	**Ministry Service Plan and Mandate**

BACKGROUND REGARDING THE ISSUE:

- To support the strategic direction of the Ministry of Mental Health and Addictions a 2017/2018 – 2019/20 Service Plan has been developed to guide the work of the Ministry. The service plan takes into account the July 18, 2017 mandate letter issued by Premier Horgan to Minister Darcy.
- The Ministry of Mental Health and Addictions is tasked with the overall responsibility to improve mental health and addictions services for all individuals across the lifespan in B.C., as well as develop an immediate response to the unprecedented challenges of the opioid overdose public health emergency.
- For both these key strategic priorities, the Ministry is responsible for:
    - ensuring a robust and effective response to the opioid overdose public health emergency;
    - establishing and mobilizing a collective, whole-of-government strategy for mental health and addictions in the province;
    - integrating, focusing, and strengthening the mental health and addictions sector; and
    - driving system-level improvement.
- The Ministry of Health retains responsibility for legislation and implementation of the mental health and substance use strategy.

Approach

- The Ministry will be responsible for planning, policy development, direction setting, and targets related to mental health and addictions services delivered under provincial bodies and agencies. The Ministry will also employ research, monitoring, evaluation, and public reporting on progress to support improvements to the system of care for mental health and addictions.
- The Ministry will take an integrated approach working in partnership with people with lived experience, Ministry of Children and Family Development, Ministry of Health, local governments, First Nations, primary care physicians and the education, justice, employment and housing systems.
- With these partnerships in place, we will work toward the goal of responsive, coordinated, and effective mental health and addictions services that meet the needs of people with lived experiences, families, caregivers, and service providers, including emergency service providers.
- The Ministry will work in partnership with the Office of the Provincial Health Officer in responding to the opioid overdose crisis.

Strategic Direction and Goals

s.13

Work Underway

s.13

ADVICE TO MINISTER

ADVICE AND RECOMMENDED RESPONSE:

s.13

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File Created:	September 8, 2017		
File Updated:			

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FACT SHEET

Mandate of the
Ministry of Mental Health and Addictions and Ministry of Health

ISSUE

Enquiries and questions have been raised by the media, public and major mental health and substance use stakeholders in BC about the role of the new Ministry of Mental Health and Addictions, versus the Ministry of Health and the Ministry for Children and Family Development.

KEY FACTS

- The Minister of Mental Health and Addictions (MMHA) was appointed on July 18, 2017 by Order in Council, stating:
  - The Ministry of Mental Health and Addictions is established.
  - The duties, powers and functions of the Minister of Health respecting policy development, program evaluation and research in relation to mental health and addiction, including in relation to designated facilities within the meaning of the *Mental Health Act,* are transferred to the Minister of Mental Health and Addictions.
- The role of MMHA, as outlined in the mandate letter issued by the Premier of BC, dated July 18, 2017, states:
  - Work in partnership to develop an immediate response to the opioid crisis that includes crucial investments and improvements to mental-health and addictions services.
  - Create a mental-health and addiction strategy to guide the transformation of BC's mental-health-care system. As part of this strategy, include a focus on improving access, investing in early prevention and youth mental health.
  - Consult with internal and external stakeholders to determine the most effective way to deliver quality mental-health and addiction services.
- MMHA has a mandate to develop policies, standards, guidelines and strategies and monitor and evaluate programs across the sectors, using a system level, "whole-of-government" approach in relation to mental health and substance use (MHSU) services, such as the development and implementation of opioid crisis strategy working with the Ministry of Health, social ministries, indigenous organizations, and non-governmental organizations in supporting the development of a cross sector approach.
- The Ministry of Health works in partnership with the health authorities, MMHA and other social Ministries such as the Ministry for Children and Family Development, and has responsibilities for the delivery of high quality health services, including MHSU services in BC managed by the health authorities. This includes:
  - The development, implementation and monitoring of MHSU operational policies and guidelines supporting the delivery of MHSU services, such as the setting of user fees for residential care facilities, information sharing.
  - Health care Legislation, such as the *Mental Health Act*, the *Forensic Act*, *Community Care and Assisted Living Act.*
  - Capital planning of new health care facilities, including MHSU facilities.
  - Emergency management response services, such as psycho-social support during the wildfires in BC.
  - Data management, such as the MHSU Minimum Reporting Requirements for health authorities.
  - Human Resource Planning, including MHSU workforce planning.

- The role of the Ministry for Children and Family Development is unchanged and continues to be responsible for the delivery of child and youth mental health services in BC, including the development of child and youth policies, program evaluation and research.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Ted Patterson, Primary and Community Care Policy Division; October 13, 2017

FACT SHEET

Ministry of Mental Health and Addictions Operations Budget

ISSUE

The Ministry of Mental Health and Addictions (MMHA) was approved for funding of $24,907,000 over the next three years in the Budget 2017 September Update.

KEY FACTS

- MMHA was approved for funding of $4,941,000 in 2017/18 and $9,983,000 in 2018/19 and 2019/20 in the Budget 2017 September Update including $320,000 in 2017/18 and $641,000 in 2018/19 and 2019/20 for the Minister's Office.
- Salaries/benefits funding is $4,085,000 in 2017/18 and $8,570,000 in 2018/19 and 2019/20 including $257,000 in 2017/18 s.13,s.17 in 2018/19 and 2019/20 for the Minister's Office.
- s.12,s.13,s.17

FINANCIAL INFORMATION

	2017/18	2018/19	2019/20	Total
Salaries/benefits	$ 4,085,000	$ 8,570,000	s.13,s.17	
Travel	s.13,s.17			
Professional Services				
Information Systems				
Office and Business Expenses				
Legislative Assembly				
Other Expenses				
Total	$ 4,941,000	$ 9,983,000		

See Appendix A for detailed breakdown.

Prepared by:
Dara Landry, CFO

FACT SHEET

Appendix A

Service Line	CL	RC	SL	STOB	Proj	2018	2019	2020
s.13,s.17								
						4,941,000		s.13,s.17

FACT SHEET

Ministry of Mental Health and Addictions FTEs

ISSUE

The Ministry of Mental Health and Addictions (MMHA) was established on July 18, 2017 and is currently in the process of staffing up.

KEY FACTS

- The Ministry currently has 36 FTEs not including 5 Minister's Office staff.

INFORMATION

	Deputy Minister's Office	Corporate Services	Strategic Planning, Partnerships and Research Division	Policy, Monitoring and Evaluation	Total
Permanent	3		17	7	27
Temporary Appointments		1		8	9
Total	3	1	17	15	36

Prepared by:
Dara Landry, CFO

FACT SHEET

First Nations Engagement in BC's Overdose Response

ISSUE

In April 2016, the Provincial Health Officer declared a public health emergency under the *Public Health Act* in response to an unprecedented increase in the number of overdose deaths. Preliminary data provided by the British Columbia Coroners Service and the BC Centre for Disease Control shows overdoses and overdose deaths disproportionately impact status First Nations people living in BC.

KEY FACTS

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FACT SHEET

Priorities going forward include:

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FINANCIAL IMPLICATIONS

- N/A

Approved by:
Arlene Paton, Population and Public Health Division; July 21, 2017

FACT SHEET

Harm Reduction

ISSUE

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use and is an essential part of the escalated response to the public health emergency that complements prevention, treatment, and drug law enforcement.

KEY FACTS

- Harm reduction refers to policies, programs and practices that prevent or reduce the adverse health, social or economic harms associated with the non-medical use of legal and illegal psychoactive substances and is a pragmatic way of preventing many of the costly, difficult-to-treat, and preventable health harms associated with substance use, including: injuries, overdose deaths, HIV, hepatitis C, and other infections.[1]
- Expanding the reach and range of harm reduction services is a priority action in *Healthy Minds, Healthy People: A 10-Year Plan to Address Mental Health and Substance Use* (2010) and in *From Hope to Health: towards an AIDS-Free Generation* (2012).
- In 2011, the BC Provincial Health Officer reported that over the past decade harm reduction policies and programs have helped to reduce rates of HIV among BC injection drug users[2].
- In 2015, the Ministry of Health began to engage with health system stakeholders to renew its provincial strategy for viral hepatitis; harm reduction interventions will be critical in this approach, as hepatitis C is most often transmitted through shared injection equipment.
- BC has shown leadership in evidence-based harm reduction programs, including the following.

Supervised Consumption Services

- Supervised consumption services are an evidence-based public health strategy to reduce the harms associated with non-medical injection drug use.
- Vancouver's Insite is North America's first legal supervised consumption site. Rigorous evaluation has demonstrated that Insite prevents overdose deaths[3], prevents HIV risk behaviours such as needle sharing[4], and reduces public injecting[5]. Insite also increases uptake of withdrawal management and addiction treatment services[6], but does not increase drug-related crime.
- As part of the response to the overdose public health emergency, health authorities have been seeking federal approval to open new supervised consumption services. As of October 5, 2017, Health Canada has approved 8 applications and 2 more are pending.[7]
- On May 18, 2017, federal bill C-37 received royal assent[8], reversing many of the barriers to establishing supervised consumption sites introduced by the previous federal government.

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[1] BC Ministry of Health. (2005). *Harm reduction: A BC a community guide*. Victoria, BC: Ministry of Health. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2005/hrcommunityguide.pdf (accessed January 20, 2014).

[2] Gilbert, M., Buxton, J., & Tupper, K. (2011). *Decreasing HIV infections among people who use drugs by injection in BC*. Victoria, BC: Office of the Provincial Health Officer of BC. Retrieved January 20, 2014 at: http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf

[3] Marshall, B. D. L., Milloy, M.-J., Wood, E., Montaner, J. S. G., & Kerr, T. (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet*, 377(9775), 1429-1437. Retrieved August 11, 2017 at: http://www.communityinsite.ca/injfacility.pdf

[4] Stoltz, J., Wood, E., Small, W., Li, K., Tyndall, M., Montaner, J., et al. (2007). Changes in injecting practices associated with use of a medically supervised safer injection facility. *Journal of Public Health*, *29*(1), 35-39.Retrieved August 11, 2017 at: https://www.researchgate.net/publication/6572469_Changes_in_injecting_practices_associated_with_the_use_of_a_medically_supervised_injection_facility

[5] Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S. G., et al. (2004). Changes in public order after opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal*, 171(7), 731-734. Retrieved August 11, 2017 at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC517857/

[6] Wood, E., Tyndall, M. W., Zhang, R., Montaner, J. S., & Kerr, T. (2007). Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction*, *102*(6), 916-919. Retrieved from: www.researchgate.net/publication/6308861_Rate_of_detoxification_service_use_and_its_impact_among_a_cohort_of_supervised_injecting_drug_users (accessed August 11, 2017).

[7] Health Canada application status tracking: https://www.canada.ca/en/health-canada/services/substance-abuse/supervised-consumption-sites/status-application.html

FACT SHEET

Overdose Prevention Services

On December 9, 2016, a ministerial order[9] was issued under the *Emergency Health Services* and *Health Authorities Acts* directing health authorities to establish overdose prevention services. Overdose prevention services are temporary locations where people who use drugs can be monitored in case of overdose. More than 20 overdose prevention services have been established.

Crack Pipe Mouthpiece Distribution

Plastic mouthpieces, screens and push sticks are distributed province-wide to protect those who smoke crack from exposure to communicable disease (e.g., hepatitis C).[10] Starting in 2011, Vancouver Coastal Health (VCH) piloted the provision of safer crack smoking kits through 5 partner agencies. Evaluation of the pilot was completed in 2013 with positive results[11] and VCH continues to fund the program; the other regional health authorities are also distributing safer crack smoking kits to varying degrees.

Opioid Agonist Treatment (OAT)[12]

OAT is a proven population health strategy for preventing and reducing HIV infections *and* a gold-standard treatment for opioid use disorder. BC's OAT program has been scaled up to reach nearly 23,000 BC residents as of December 31, 2016 (from fewer than 3,000 in the mid-1990s)[13] . Between 2015/2016 and 2016/2017 the number of OAT prescribers more than doubled, from 401 to 889.[14]

Take Home Naloxone[15]

In 2012, the BC Centre for Disease Control established the BC Take Home Naloxone (THN) program to help prevent overdose fatalities. The program provides kits that include naloxone and additional supplies, as well as overdose response training, at no charge to people who use drugs and those most likely to witness and respond to an overdose. As of September 30, 2017, the kits are available at 590 locations across the province including 58 emergency departments, 14 corrections facilities, and 85 First Nations sites serving 97 communities. The BCCDC has distributed 55,112 kits through the THN program and reports that THN-acquired kits have been used to reverse 11,258 overdoses since August 2012.[16]

Needle Distribution and Recovery

Providing sterile syringes to people who inject drugs is one of the most effective ways to reduce blood-borne pathogen transmission.[17] The BCCDC currently has 236 harm reduction supply sites in BC, which include sterile syringes in their inventories.[18]

Alcohol Harm Reduction

Preliminary evaluations of managed alcohol programs (MAPs) demonstrate improved health for long term, chronic alcohol dependent participants including those with a history of non-beverage alcohol

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[8] Health Canada (2017) Backgrounder: Royal Assent of Bill C-37 - An Act to amend the *Controlled Drugs and Substances Act* and to make related amendments to other Acts. https://www.canada.ca/en/health-canada/news/2017/05/royal_assent_of_billc-37anacttoamendthecontrolleddrugsandsubstan.html

[9] http://www.bclaws.ca/civix/document/id/mo/mo/2016_m488

[10] Tortu, S., McMahon, J.M., Pouget, E.R. & Hamid, R. (2004). Sharing of noninjection drug-use implements as a risk factor for hepatitis C. *Substance Use & Misuse, 39*(2), 211–224. Retrieved August 11, 2017 at: https://www.researchgate.net/publication/8639114_Sharing_of_Noninjection_Drug-Use_Implements_as_a_Risk_Factor_for_Hepatitis_C

[11] *Evaluation Report: Vancouver Coastal Health Safer Smoking Pilot Project* (2013) https://oasis.vch.ca/media/safer-smoking-pilot-2013.pdf

[12] See also Fact Sheet on Methadone and Other Opioid Substitution Treatment, Cliff # 1047026 Note: "opioid agonist treatment" and "opioid substitution treatment" are synonyms, "opioid agonist treatment" being the more current term.

[13] Progress Update on BC's Response to the Opioid Overdose Public Health Emergency (March 2017) http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-response-progress-update-march2017.pdf

[14] BCCDC (May 1st, 2017) The Epidemiology of Opioid Overdose in BC, powerpoint presentation.

[15] See also, fact sheet on Naloxone

[16] BC Centre for Disease Control. (2017, September 30). Take Home Naloxone Program in BC. Retrieved from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525 (accessed October 5, 2017).

[17] Gilbert, M., Buxton, J., & Tupper, K. (2011). Decreasing HIV infections among people who use drugs by injection in BC. Victoria, BC: Office of the Provincial Health Officer of BC. Retrieved January 20, 2014 at: http://www.health.gov.bc.ca/library/publications/year/2011/decreasing-HIV-in-IDU-population.pdf

[18] Tracy Liu, BC Centre for Disease Control (personal communication July 10, 2017): Tracy.Liu@bccdc.ca

use (e.g., hand sanitizer), and report reduced health harms and decreases in emergency room visits and police encounters.[19] A University of Victoria-led research team funded by the Canadian Institutes of Health Research is evaluating 5 MAPs across Canada. Results are available for the Thunder Bay research site.[20,21,22]

FINANCIAL IMPLICATIONS

- Funds are designated to the Harm Reduction Supplies Program for the "provision of harm reduction supplies to each health authority and their contracted needle distribution programs, in accordance with needs identified through local ordering".[23]
- In 2016/17, the Ministry of Health provided one-time funding of $3.2 million to the Provincial Health Services Authority to further support the Harm Reduction Program. The actual expenditure for 2016/17 was $5.7 million, the additional costs were absorbed within the BCCDC/PHSA.

Approved by:
Keva Glynn, Policy, Monitoring and Evaluation Division; October 2017
Nancy South obo Teri Collins, Health Sector Information, Analysis & Reporting Division; October 12, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; October 13, 2017

[19] Stockwell, T., Pauly, B., Chow, C., Vallance, K., & Perkin, K. (2013). *Evaluation of a managed alcohol program in Vancouver, BC*. CARBC Bulletin, 9, 1-8. http://www.carbc.ca/Portals/0/Home/CARBC%20Bulletin%209.pdf

[20] Pauly, B., Stockwell, T., Chow, C., Gray, E., Krysowaty, B., Vallance, K., & Perkin, K. (2013) Towards alcohol harm reduction: Preliminary results from an evaluation of a Canadian managed alcohol program. Victoria, BC: Centre for Addictions Research of BC. http://www.carbc.ca/Portals/0/PropertyAgent/1077/Files/423/thunderbaymapdec2013.pdf

[21] Vallance, K., Stockwell, T., Pauly, B., Chow, C., Gray, E., Krysowaty, B., Perkin, K. and Zhao, J. (2016) *Do managed alcohol programs change patterns of alcohol consumption and reduce related harm? A pilot study*. Harm Reduction Journal, 13(13). Retrieved August 14, 2017 at: https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-016-0103-4

[22] Hammond, K., Gagne, L., Pauly, L., and Stockwell, T. (2016). *A Cost-Benefit Analysis of a Canadian Managed Alcohol Program*. Retrieved from: https://www.uvic.ca/research/centres/carbc/assets/docs/report-a-cost-benefit-analysis-of-a-canadian-map.pdf.

[23] 2003/04 funding letter from the Ministry of Health to the Provincial Health Services Authority sent April 1, 2003

FACT SHEET

Injectable Opioid Agonist Treatment: Hydromorphone and Diacetylmorphine

ISSUE

Expansion of opioid agonist treatment (OAT) options to include injectable medications.

KEY FACTS

- A variety of OAT medications are used to treat opioid use disorder (OUD), and are safe and effective within the context of the defined treatment. Providing OAT is a means to prevent overdoses and deaths from illegal drug use, assists with preventing transmission of infectious diseases such as HIV, stabilize peoples' lives, improves quality of life, engages people in treatment, reduces illegal activity, and is cost saving, particularly due to reduction in the cost of enforcement actions, criminal justice involvement and imprisonment, and health care.
- For a portion of the OUD patient population for whom prior treatment attempts with first-line or alternative medications (i.e. methadone, buprenorphine/naloxone, and slow-release oral morphine e.g. Kadian®) have not worked, injectable OAT treatments may provide a new pathway into treatment. This group includes a small number of British Columbians at very high risk for overdose death, some of whom have had survived multiple overdoses.
- Switzerland, the Netherlands, Denmark and Germany offer diacetylmorphine based OAT. In these jurisdictions, roughly 5-8% of their OAT patient population receives injectable treatment.
- In BC there are 26,074 patients on OAT[1], and this number is increasing. Based on a range of 2.5% to 10% of this number of people accessing injectable OAT there could be 650 to 2600 BC patients on injectable OAT treatment in the future.
- In July 2017 Health Canada amended the Food and Drug Regulations to allow for more efficient importation and distribution drugs for urgent public health need, as requested by the provincial Public Health Officers. BC has requested and been given access to diacetylmorphine through this new regulation, reducing the regulatory barriers for OAT with diaceytlmorphine.
- Injectable hydromorphone is a PharmaCare regular benefit for treatment of pain, and is being used for injectable OAT. Diacetylmorphine is available only through Health Canada's Special Access Programme or via an urgent public health need request. PharmaCare, to date, has neither made a coverage decision nor provided any funding for injectable diacetylmorphine.
- Current federal regulatory requirements related to security, transportation and record-keeping are barriers to basing expansion of this service on diacetylmorphine. The Ministry and partners from Providence Health Care/Crosstown Clinic and Lower Mainland Pharmacy Services are working with Health Canada to reduce and eliminate superfluous requirements.
- As an alternative BC-based research (the SALOME trial) shows that treatment with hydromorphone generates comparable outcomes to treatment with diacetylmorphine, without the same regulatory or supply barriers as there are with diacetylmorphine.
- Providence Health Care's Crosstown Clinic in Vancouver currently offers hydromorphone and diacetylmorphine treatment to the SALOME patient cohort who remained in treatment after the conclusion of the trial. Through the SALOME (and earlier, the NAOMI) clinical trials, Crosstown has over 10 years of clinical experience providing supervised hydromorphone and diacetylmorphine. The clinic has an on-site pharmacy; doctors, nurses, social workers and addictions counsellors are available; and it offers life-skills counselling, housing referrals and

[1] Reported by Health Sector Information, Analysis and Reporting Division July 27 2017.

direction to legal assistance. Providence staff has emphasized the necessity of primary care and housing supports, particularly during the induction phase for new patients.

- As of July, 2017, Crosstown has 135 patients enrolled, who remained in treatment following the conclusion of the clinical trial (35 hydromorphone and 100 diacetylmorphine). The total capacity of Crosstown is estimated at 200 patients.
- There are a variety of settings in which hydromorphone treatment could be implemented, each with different costs and benefits, such as private clinics, not for profit organization clinics, and health authority clinics, and a variety of options to implement physician and pharmacy services, ranging from fee for service, to contracted, to health authority provided.
- Different models may be more or less appropriate depending on the financial costs, safety profile, community supports and population to be served.
- The BC Centre on Substance Use has drafted a guidance document with recommendations for clinical protocols and treatment models for injectable treatment with hydromorphone. The document is being reviewed by the Ministries of Health and Mental Health and Addictions and key stakeholders prior to any potential endorsement or publication by the Ministries.
- An important consideration is the cost of the hydromorphone drug product: the Crosstown Clinic currently leverages their inclusion within the Providence Health circle of care to acquire hydromorphone at the price negotiated for hospital pharmacy use. s.13,s.17

s.13,s.17

- Expanding injectable OAT would extend the OUD continuum of care for this particularly vulnerable and challenging population. Although additional funding will be required to expand this service there are predicted to be positive outcomes in terms of saving lives, preventing long term disability, and potential cost savings (depending on the delivery model) due to highly effective outcomes consequent to injectable treatment.
- In May 2017 the Ministry of Health directed [2] Providence Health and Vancouver Coastal Health to expand Crosstown clinic by 50 patients, and offer hydromorphone treatment elsewhere in downtown Vancouver for an additional 50 patients. Fraser Health has been directed to plan for hydromorphone treatment for 50 patients in Surrey, and return to the Ministry for direction before implementing. Both health authorities are expected to work with health authority pharmacies to develop an out-of-Crosstown model.

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:

Deb Godfrey, A/ ADM, Population and Public Health, Ministry of Health
Manjit Sidhu, ADM, Finance and Corporate Services Division; August 24, 2017

[2] Cross reference Decision Briefing Note Cliff #1084362

FACT SHEET

Joint Task Force on Overdose Response

ISSUE

The Joint Task Force on Overdose Response provides leadership and expert advice to the Province on emergency actions to prevent and respond to drug overdoses in BC while ensuring integration between Health and Public Safety system responses.

KEY FACTS

- In April 2016, the Provincial Health Officer declared a public health emergency under BC's *Public Health Act* due to an unprecedented increase in opioid overdose deaths.
- In 2016, 922 individuals died of an apparent illicit drug overdose in BC, an 80.8% increase over 2015 when 510 such deaths occurred.[1] Over the past 5 years, the percentage of drug overdose deaths in which fentanyl is detected has risen from 5% to 60%.[2]
- In July 2016, the Premier announced the creation of the Joint Task Force on Overdose Response to lead BC's integrated response to the emergency across the public health and public safety sectors. The Joint Task Force is led by Provincial Health Officer, Dr. Perry Kendall and Clayton Pecknold, Director of Police Services. Membership includes representatives from both public health and public safety sectors:

	Agency	Name	Title
Co-Chairs	Office of the Provincial Health Officer	**Perry Kendall**	Provincial Health Officer
	Ministry of Public Safety and Solicitor General	**Clayton Pecknold**	ADM and Director of Police Services
Members	Ministry of Health	**Arlene Paton**	ADM, Population and Public Health
	Vancouver Coastal Health	**Patty Daly**	VP, Public Health and Chief MHO Officer
	BC Coroners Service	**Lisa Lapointe**	Chief Coroner
	Vancouver Police Department	**Laurence Rankin**	Deputy Chief Constable
	RCMP (E Division)	**Brian Cantera**	Deputy Criminal Operations, Specialized Investigative & Operational Police Services

The Joint Task Force oversees 6 health- related task groups (i.e., treatment, surveillance, public engagement, naloxone, supervised consumption services and drug checking, and logistics and psychosocial supports) to support the provincial response. The priority areas are:

1. Immediate response to an overdose by expanding naloxone availability and the reach of supervised consumption services in the province.
   - Since 2012, the BCCDC has distributed 30,148 naloxone kits through the BC Take Home Naloxone program, and the kits have been used to reverse 5,483 overdoses.[3]
   - In December 2016, the Minister of Health signed a Ministerial Order under the *Emergency Health Services Act* and *Health Authorities Act* to activate overdose prevention services. Over 20 overdose prevention sites have opened across the province.
   - Health authorities continue to work toward submitting applications to Health Canada to expand the number of supervised consumption services in the province.
2. Preventing overdoses by improving treatment options for people with opioid dependence and exploring drug checking services and improving health professional education and guidance.
   - In January 2017, the Province committed $10 million to provide 60 residential treatment beds and 50 intensive outpatient treatment spaces over the next year. The new beds are in addition to government's commitment to open 500 new beds.

[1] BC Coroners Service. (2017). Illicit Drug Overdose Deaths in BC: January 1, 2007 – January 31, 2017. Retrieved February 20, 2017, from: www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf.

[2] BC Coroners Service. (2016). Fentanyl-Detected Illicit Drug Overdose Deaths: January 1, 2012 to October 31, 2016. Retrieved February 20, 2017, from: www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf.

[3] BC Centre for Disease Control. (2017). Take Home Naloxone Program in BC. Retrieved February 20, 2017, from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525.

- On February 7, 2017, the Province announced $5 million for the BC Centre on Substance Use plus $1.9 million in ongoing funding. The Centre developed the Guideline for the Clinical Management of Opioid Use Disorder that takes effect June 5, 2017.[4]
- The BC Centre on Substance Use is reviewing evidence on street drug checking and will provide recommendations for how this type of service could be modeled in BC.

3. Public education and awareness about overdose prevention and response through public awareness campaigns.
   - Comprehensive resources continue to be made available for teachers, parents, friends, family, drug users, and anyone wanting more information on the public health emergency.
4. Monitoring, surveillance, and applied research by improving timely data collection, reporting, and analysis to inform action, evaluating implementation, and applied research.
   - Enhanced population health surveillance activities are providing detailed information about overdoses and risk factors to enable targeted interventions and evaluation.
   - Provincial Health Services has increased the capacity of provincial toxicology labs to test blood samples for opioids and other substances through the purchase of a mass spectrometer.
5. Improving the scheduling of substances and equipment under the *Controlled Drugs and Substances Act* and the Precursor Control Regulations by regulating drug manufacturing equipment such as pill presses, regulating precursors.
   - In December 2016, the federal government proposed amendments (Bill C-37) to provide additional tools to support health and law enforcement officials to reduce harms associated with problematic substance use in Canada. Among other things, Bill C-37: restricts possession, production sale, importation, or transportation of anything intending to be used to produce or traffic a controlled substance as well as creates a regulatory scheme for the importation of pill presses and encapsulaters; and creates new provisions which will permit the Minister of Health Canada to quickly schedule and control dangerous new substances on a temporary basis.
6. Improving federal enforcement and interdiction strategies by working with the Canada Border Services Agency to increase enforcement activities to interdict the importation of illicit drugs.
   - The Joint Task Force continues to work with police and law enforcement to support the expansion of interdiction efforts including the co-ordination of efforts to intercept, detect, and investigate illegally imported fentanyl and precursors.
7. Enhancing the capacity of police to support harm reduction efforts related to street drugs by providing training to support safe fentanyl identification and handling practices.
   - The Ministry of Public Safety and Solicitor General continues to work with the RCMP and municipal police departments to ensure appropriate information is available to police services to formulate local operational policy and ensure they have the supports to work with community partners to decrease opioid overdose deaths.
   - All police agencies in BC continue to train members to administer intranasal naloxone in cases of opioid overdose. The Ministry of Public Safety and Solicitor General has secured ongoing funding to support police departments contingent on members agreeing to administer naloxone to citizens who overdose.

FINANCIAL IMPLICATIONS

Over $100 million in provincial funding has been earmarked to respond to the public health emergency.[5]

[4] BC Centre on Substance Use. (2017). A Guideline for the Clinical Management of Opioid Use Disorder. Retrieve February 20, 2017, from : www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf.

[5] https://news.gov.bc.ca/factsheets/factsheet-comprehensive-mental-health-and-substance-use-services-in-bc

FACT SHEET

Approved by:
Blair Boland, obo Manjit Sidhu, Finance and Corporate Services Division; February 28, 2017
Arlene Paton, Population and Public Health Division; July 12, 2017

FACT SHEET

Opioid Misuse

ISSUE

Opioids are useful medications for the treatment of pain. However, misuse of prescription opioids is associated with serious harms, including addiction, overdose, and possibly death, placing a significant burden on individuals and their families, health and social services systems, and public safety systems.

KEY FACTS

- The Ministry of Health supports appropriate pain management but recognizes the risks associated with prescription opioid misuse.
- Programs and activities aimed at reducing the abuse and misuse of prescription opioids are provided through a combination of PharmaNet, PharmaCare, and in collaboration with the College of Physicians and Surgeons of BC (CPSBC) and College of Pharmacists of BC (CPBC).
- PharmaCare programs, activities, and strategies aimed at decreasing opioid misuse include:
  - The Restricted Claimant Program limits PharmaCare coverage of certain "at risk" patients to a single prescriber and/or a single pharmacy for medications with a potential for abuse.
  - Limiting the supply of covered opioids to a maximum of 30 days per fill. Prescriptions written for more than a 30-day supply are not paid for.
  - Use of a trends report to regularly examine the use of covered opioids.
  - Coverage of opioid agonist therapies to assist with the treatment of opioid use disorder, including methadone and buprenorphine/naloxone (Suboxone®).
  - Working with the BC Centre on Substance Use to evaluate and consider other opioid agonist therapies.
  - Discontinuation of coverage for long-acting oxycodone (OxyContin®) in March 2012, and beginning of exceptional case-by-case coverage of a more abuse deterrent oxycodone product (OxyNeo®). PharmaCare also does not provide coverage for generic versions of OxyContin®.
- The PharmaNet prescription database allows health professionals to review a patient's medication history to watch for usage irregularities as potential fraud or abuse.
- A subset of PharmaNet data is used by the CPSBC's Prescription Review Program to ensure secure and appropriate prescribing of drugs like opioids. Where reviews demonstrate potentially problematic prescribing, individual physicians may be requested to participate in additional education for the prescribing of these types of medications.
- Work is currently underway to use features of PharmaNet, the Restricted Claimant Program, and the Prescription Review Program to develop a new provincial prescription monitoring program to monitor the prescribing, dispensing, and use of prescription opioids, sedative, and stimulants. This allows earlier identification and intervention of potential problematic medication use.
- The Controlled Prescription Program, a partnership between the CPSBC, CPBC and Ministry, reduces the potential for prescription forgeries by requiring prescriptions for designated prescription opioids and controlled drugs to be written on specially designed duplicate prescription pads.
- In August 2013, the Provincial Academic Detailing Service's launched a topic on "Opioids in Chronic Non-Cancer Pain: The Basics". The topic provides a structured approach to safely using prescription opioids in patients with chronic non-cancer pain and is being presented to physicians, nurse practitioners, pharmacists, and other health professionals.
- The Pharmaceutical Services Division is also involved in intra-, inter-ministerial, and national work aimed at optimizing the appropriate use of prescription opioids for pain and minimizing the misuse

of opioids. This work includes participation in the F/P/T Prescription Monitoring Program Network set up to share information and enhance the capacity of all provinces and territories to monitor opioid prescribing.

- In October 2015, BC PharmaCare broadened the coverage criteria for Subxone® (buprenorphine/ naloxone) by making it a regular benefit rather than a limited coverage benefit. Suboxone is an alternative to methadone but may not be appropriate for all clients.
- In July 2016, the CPSBC removed the requirement that physicians must hold an exemption to prescribe methadone prior to being able to prescribe Suboxone®, enabling any physician to prescribe it for opioid substitution therapy.
- Since 2012, BC Centre for Disease Control and health authorities have delivered the Take Home Naloxone Program to distribute kits containing injectable naloxone to be used for the emergency reversal of opioid overdoses. The kits are distributed to individuals deemed to be high-risk for opioid overdose.
- In April 2016, Health Canada and the CPBC changed the prescription only status of naloxone to allow it to be purchased at retail pharmacies without requiring a prescription.
- In September 2016, the CPBC removed the requirement for naloxone to be sold or distributed through pharmacies, thereby increasing public access to the medications.
- Firefighters in some communities, including Vancouver and Surrey, have been authorized to carry naloxone kits for use in opioid overdose emergencies.
- In October 2016, Health Canada approved the sale of Narcan® Nasal, a nasal spray version naloxone. Police in some communities and guards in some jails and penitentiaries have been authorized to carry Narcan® Nasal.
- On April 14, 2016, the Office of the Provincial Health Officer declared a public health emergency related to the significant increase in drug-related overdoses and deaths. The emergency will allow for increased information related to causes of overdoses, including how many are related to prescription drugs.
- In June 2016, the CPSBC released a new professional standard and guidance for the Safe Prescribing of Drugs with Potential for Misuse/Diversion, including opioids. The standard requires increased documentation of discussions with patients regarding the risks and benefits of using opioids, avoidance of prescribing opioid and sedatives, use of PharmaNet to monitor patient medications histories, prescribing the lowest effective dosage of any opioid, and regular ongoing reassessment of the patient.
- In February 2017, the BC Centre on Substance Use released a guideline for the clinical management of opioid use disorder.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Mitch Moneo, Pharmaceutical Services Division; July 5, 2017

FACT SHEET

Opioid Overdose Public Health Emergency

ISSUE

In April 2016, BC's Provincial Health Officer declared the province's first Public Health Emergency in response to an unprecedented increase in illegal drug overdose deaths. Despite rapid implementation and scale up of numerous evidence-based strategies and diligent efforts among those on the front line, overdose deaths continue to climb to record levels. Over a year into the Emergency, BC is shifting its response focus to strengthen successful interventions and implement novel approaches to prevent harms associated with an ever-evolving contaminated illegal drug supply that continues to impact all corners of the province.

KEY FACTS

- On April 14, 2016, Provincial Health Officer, Dr. Perry Kendall, declared a Public Health Emergency under the *Public Health Act* in response to a significant increase opioid overdose deaths across BC.
- On July 27, 2016, BC established the Joint Task Force on Overdose Response chaired by Dr. Kendall and Clayton Pecknold, Director of Police Services, to lead BC's integrated response to the emergency across the health and public safety sectors. The Joint Task Force's fifth bi-monthly progress report was released on May 31, 2017.
- The province continues to deliver on its 88-point response plan; as of July 7, 2017, 78 actions have been completed, 3 are in progress, and 7 are nearing completion (see Appendix A). The 7 areas of focus are:

1. **Immediate response to an overdose by expanding naloxone availability and the reach of supervised consumption services in the province.**

   BC has rapidly expanded access to naloxone across the province and continues to operate overdose prevention services. 3 applications for supervised consumption services were approved by Health Canada on May 26, 2017 (1 in Vancouver, 2 in Surrey); 5 applications await approval.

2. **Preventing overdoses before they happen by improving treatment options for people with opioid use disorder, exploring drug checking services and improving health professional education and guidance.**

   Released updated guidelines on treating opioid use disorder, opioid substitution treatments (methadone and Suboxone™) are 100% covered for individuals who experience financial barriers, and the province met its commitment to open 500 new substance use beds by March 31. Focus shifts to improving the substance use continuum of care and bolstering long-term capacity of BC's treatment system.

3. **Public education and awareness about overdose prevention and response through public awareness campaigns.**

   Public campaigns continue on multiple mediums, and the province's microsite, www.gov.bc.ca/overdose, is regularly updated so the public is well-informed and has access to resources such as school curriculum and HealthLinkBC files.

4. **Monitoring, surveillance, and applied research by improving timely data collection, reporting and analysis to inform action, evaluating implementation, and applied research.**

   The BC Centre for Disease Control publicly released updated epidemiological information on March 17, 2017. Detailed surveillance data is reported regularly; analysis of individuals who have suffered from non-fatal and fatal overdose is underway. A rapid review of how other jurisdictions respond to opioid overdoses is proceeding; these findings will inform an evaluation of BC's response.

5. **Improving the scheduling of substances and equipment under the Controlled Drugs and Substances Act and the Precursor Control Regulations by regulating drug manufacturing equipment such as pill presses, and regulating precursors.**

   Bill C-37, an Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts received Royal Assent on May 18, 2017, and addressed this issue.

6. **Improving federal enforcement and interdiction strategies to increase enforcement activities to interdict the importation of illegal drugs.**

   The RCMP and the Canada Border Services Agency have been working cooperatively to interdict the flow of fentanyl with numerous successful seizures and arrests. The RCMP are working with the Chinese Ministry of Public Security to stem the flow of illegal fentanyl and other illegal drugs into Canada.

7. **Enhancing the capacity of police to support harm reduction efforts related to street drugs.**
   BC has provided 7,800 naloxone kits and training to the RCMP and municipal police; over 7,400 police members and civilian staff have been trained and 195 opioid overdoses have been reversed out of 210 overdoses attended. Funding has been provided for outreach and awareness, including community dialogues through the Centre for Additions Research of BC, enhancing the "Know your Source" campaign, and developing workshops for first responders through the Justice Institute of BC.

- Going forward, the Joint Task Force recommends the province focus on:
  - Reducing the disproportionate impact of the emergency on First Nations and Aboriginal people.
  - Reaching people who use drugs alone.
  - Stopping overdoses before they happen through upstream approaches.
  - Supporting families, peers, volunteers at community organizations, and first responders dealing with the emotional toll of overdoses and overdose deaths.
  - Ensuring rapid access to improved treatment services for people with opioid use problems in all regions of the province.
  - Improving the range of pain management services for patients living with acute and chronic pain.
  - Reducing the risk of opioid use disorder and diversion of prescription opioids into the illegal drug supply by improving prescribing practices through prescription monitoring.
  - Continuing to engage with local government to support community information sessions and public discourse on the risks and challenges associated with a contaminated illegal drug supply.
  - Protecting public safety by continuing efforts to interdict illegal fentanyl and other illegal drugs.
  - Continuing to engage with the federal government to increase or reinstate funding for RCMP and Canada Border Services Agency initiatives.
- In 2016, 967 people died of an apparent unintentional illegal drug overdose in BC, an 80% increase over 2015 (517 deaths). The Coroners Service reports 640 deaths occurred in the first 5 months of 2017.
- On June 30, 2017, the BC Cororner Service reported there were 129 suspected drug overdose deaths in May 2017. Fentanyl and fentanyl analogues (e.g., carfentanil) continue to be detected in the illegal drug supply; of the overdose deaths in 2017, 72% of cases had fentanyl detected.

FINANCIAL IMPLICATIONS

Provincial funding to support the overdose response totals just under $100 million. In fiscal 2017/18, BC dedicated $5 million and the federal government has provided $10 million in one-time funding.s.13,s.17
s.13,s.17

Approved by:
Arlene Paton, Population and Public Health Division; July 10, 2017
Manjit Sidhu, Finance and Corporate Services Division; July 20, 2017

FACT SHEET

Summary of Actions In Progress, Nearing Completion and Complete, as of July 7, 2017

#	Actions In-Progress	Response Plan Component
1	Ensure linkage between Ministry of Health and College of Physicians and Surgeons of BC to work together on the expansion of prescription monitoring for controlled substances	Monitoring, surveillance and applied research
2	Support BC family practice residency programs to include opioid agonist treatment as a core competency	Preventing overdoses before they happen
3	Continue to promote trauma-informed practice to reduce stigma against people who use drugs and improve quality of care	Preventing overdoses before they happen

#	Actions Nearing Completion	Response Plan Component
1	Collaborate with public health and community partners to establish a service to detect composition and adulterants of street-acquired drugs prior to their use.	Immediate response to an overdose
2	Work with Ministry of Justice and federal justice department to enhance criminal sanctions for production, importation and trafficking	Improving federal enforcement and interdiction strategies
3	Work with police on local engagement strategies with at risk communities with a focus on youth	Enhancing the capacity of police to support harm reduction efforts related to street drugs
4	Direct Combined Forces Special Enforcement Unit of BC to increase enforcement on illicit labs	Improving federal enforcement and interdiction strategies
5	Develop common/standard template for Community Impact Statements	N/A
6	Explore policy options for expanding supervised injectable opioid agonist treatment medications and availability	Preventing overdoses before they happen
7	Develop entry-level, intermediate, and advanced core competency standards of practices for all nurses	Preventing overdoses before they happen

#	Actions Completed	Response Plan Component
1	Expand and measure reach and range of harm reduction supplies and services.	Immediate response to an overdose
2	Expand traditional concept of first responders and standardize protocols to indemnify first responders who administer naloxone.	Immediate response to an overdose
3	Develop a provincial policy that rationalizes response to overdose-related 911 calls, so police only respond in situations that require police intervention or they are requested to attend by paramedical staff.	Immediate response to an overdose
4	Remove regulatory burdens to the administration of naloxone in hospital settings.	Immediate response to an overdose
5	Ensure that WorkSafeBC is aware of regulatory changes to facilitate naloxone administration by anyone in any setting.	Immediate response to an overdose
6	Remove barriers to the administration of naloxone by Court Service Branch staff (e.g., sheriffs) and some corrections staff in multiple non-health settings.	Immediate response to an overdose
7	Develop decision support tool for College of Registered Nurses of BC to allow naloxone distribution beyond a self-identified opioid user.	Immediate response to an overdose
8	Secure adequate funding to support the coordinated expansion of the BC Take Home Naloxone program.	Immediate response to an overdose
9	Expand BC Take Home Naloxone program eligibility to include those most likely to witness and respond to an overdose.	Immediate response to an overdose
10	Facilitate distribution of facility overdose response boxes.	Immediate response to an overdose
11	Develop and proliferate standardized overdose response training.	Immediate response to an overdose
12	Expand access to naloxone by making it available to MCFD staff working with vulnerable populations.	Immediate response to an overdose
13	Develop a strategy for intranasal naloxone where appropriate and cost effective.	Immediate response to an overdose
14	Create mobile naloxone dispensing units in high overdose areas.	Immediate response to an overdose
15	Standardization of risk assessments for non-health sectors.	Immediate response to an overdose
16	Create a consistent process for purchase of naloxone kits.	Immediate response to an overdose
17	Address surge capacity for naloxone administration training	Immediate response to an overdose
18	Expand access to overdose response education materials and first aid supplies (e.g., rescue breathing masks).	Immediate response to an overdose
19	Overdose Prevention Services	Preventing overdoses before they happen / Immediate response to an overdose
20	Develop operational guidelines for supervised consumption services	Immediate response to an overdose
21	Guidelines for supportive housing providers, homeless shelters, and regional health authorities on overdose prevention and response	Immediate response to an overdose
22	Pilot the efficacy of drug testing strips to detect the presence of fentanyl.	Preventing overdoses before they happen

FACT SHEET

#	Actions Completed	Response Plan Component
23	Expand reach of supervised consumption services in each health region	Immediate response to an overdose
24	Weekly and monthly situation reporting	Monitoring, surveillance and applied research
25	Reporting on analysis priorities	Monitoring, surveillance and applied research
26	Participate in national Prescription Drug Abuse working group on prescription drug surveillance	Monitoring, surveillance and applied research
27	Review opportunities for First Nations data on overdose, including linking the First Nations Client File to the overdose cohort.	Monitoring, surveillance and applied research
28	Review opportunities for First Nations data on overdose, including: identifying specific frequencies in Interior Health emergency department data.	Monitoring, surveillance and applied research
29	Increase toxicology lab capacity to test for opioids/other new substances.	Monitoring, surveillance and applied research
30	Review opportunities for First Nations data on overdose, including identifying First Nations frequencies in coroner data	Monitoring, surveillance and applied research
31	Develop overdose cohort: linkage and analyses	Monitoring, surveillance and applied research
32	Morgue capacity support for the BC Coroners Service.	N/A
33	Provide psychosocial support services for those who have lost a family member to a fatal overdose.	N/A
34	Coordinated psychosocial supports for community based agency and non-profit staff/volunteers that do not have access to these services through their employer	N/A
35	Provide public information on overdose prevention and response (HealthLinkBC, school-based resources for students, teachers)	Public education and awareness
36	Provincial social marketing campaign to reduce stigma and ensure target groups are aware of risks and how to prevent overdose	Public education and awareness
37	Provincial marketing campaign of "Recovery is Possible"	Public education and awareness
38	Educational resources for schools, parents, caregivers, & organizations that work with youth: Adaptation of Alcohol Sense resources	Public education and awareness
39	Educational resources for schools, parents, caregivers & orgs that work with youth: Additional iMinds modules and guidebook resources	Public education and awareness
40	Report out on progress regularly to media and the public	Public education and awareness
41	Improved BC Ambulance response to areas experiencing high volumes of overdoses by ensuring additional transportation options (ATVs, bikes) are available	Immediate response to an overdose
42	Real time information provided to BC Ambulance supervisors to redeploy resources as needed	Immediate response to an overdose
43	Increase in paramedics (both full-time and part-time)	Immediate response to an overdose
44	Activation of mobile medical unit to treat multiple overdose victims without having to admit to hospital	Immediate response to an overdose
45	Work with Public Safety Canada and RCMP to increase restrictions and enforcement on precursors	Improvement to federal legislation (CDSA and Precursor Control Regulations)
46	Training of police officers and other 1st responders for safe fentanyl identification and handling practices	Enhancing capacity of police to support harm reduction efforts related to street drugs
47	Increase timely sharing of information related to problematic substances in communities	Public education and awareness
48	Work with ECOMM on messaging for 9-1-1 calls	Immediate response to an overdose
49	9-1-1 policy for police to not attend overdose calls unless requested to do so	Immediate response to an overdose
50	Greater police partnership with CBSA to improve interdiction of products	Improving federal enforcement and interdiction strategies
51	Obtain commitment of the Canada Border Services Agency for measurable expansion of interdiction efforts	Improving federal enforcement and interdiction strategies
52	Explore options to restrict pill presses in BC	Improving federal enforcement and interdiction strategies
53	Improvements to the *Controlled Drugs and Substances Act* and Precursor Control Regulations, including scheduling of equipment and precursors used in manufacture of illicit pills; greater criminal sanctions associated with manufacturing street drugs; improved process for safe destruction of seized substances.	Improvement to federal legislation (CDSA and Precursor Control Regulations)
54	Increase capacity of CLEAR team and clan lab capacity	Improving federal enforcement and interdiction strategies
55	Improve connections to harm reduction and problematic substance use services for inmates incarcerated in and being discharged from provincial correctional facilities.	Preventing overdoses before they happen

FACT SHEET

#	Actions Completed	Response Plan Component
56	PharmaCare implementation of Slow Release Oral Morphine for OAT as per new BCCSU Guideline	Preventing overdoses before they happen
57	Direct licensed care facilities to stock naloxone kits and have staff trained to administer in the event of an overdose	Immediate response to an overdose
58	Network of HA Addictions Clinical and operations Leads	Preventing overdoses before they happen
59	PainBC Provincial Pain Summit	Preventing overdoses before they happen
60	Update and release of Opioid Use Disorder Treatment Guidelines	Preventing overdoses before they happen
61	Development of a tiered pharmacy service payment plan and reduction/removal of patient deductible for methadone and suboxone	Preventing overdoses before they happen
62	University of Victoria's Centre for Addictions Research Patient to Patient Opioid Agonist Treatment Handbook	Preventing overdoses before they happen
63	Promote knowledge and use of a practice support program module on pain management	Preventing overdoses before they happen
64	Expansion and promotion of the Rapid Access to Consultative Expertise line – addictions medicine expertise	Preventing overdoses before they happen
65	Rural Education Action Plan Program	Preventing overdoses before they happen
66	College of Registered Nurses of BC fast-track scope of practice for Nurse Practitioners to include Suboxone prescribing	Preventing overdoses before they happen
67	Release of provincial guidelines for biopsychosocialspiritual withdrawal management services for adults and youth	Preventing overdoses before they happen
68	Detox safety bulletin	Preventing overdoses before they happen
69	Conduct and apply findings from research on innovations in addiction treatment, including extended release naltrexone and buprenorphine	Preventing overdoses before they happen
70	Additional capacity for public treatment beds	Preventing overdoses before they happen
71	"Did you know" factsheet on Slow Release Oral Morphine for physicians	Preventing overdoses before they happen
72	Expand access to opioid agonist treatment through primary care and other physicians with addictions training by offering more suboxone training sessions	Preventing overdoses before they happen
73	Expand access to opioid agonist treatment through primary care and other physicians with addictions training, by raising physician awareness of OAT and supports available.	Preventing overdoses before they happen
74	Support health care providers to improve skills in caring for people living with problematic substance use by establishing interdisciplinary addiction medicine training programs	Preventing overdoses before they happen
75	College of Registered Nurses of BC fast-track scope of practice for Nurse Practitioners to include Suboxone prescribing	Preventing overdoses before they happen
76	Expand existing access to opioid agonist treatment via telehealth	Preventing overdoses before they happen
77	Support health care providers to improve skills in caring for people living with problematic substance use establishing an online diploma program	Preventing overdoses before they happen
78	Support creation of a Practice Support Program module focused on addiction	Preventing overdoses before they happen

FACT SHEET

Overdose Emergency Response (General)

ISSUE

- BC continues to experience an illegal drug overdose epidemic that has complex and dynamic underpinnings, with the rapid introduction of new substances and consistently high rates of unintentional illegal drug overdose deaths across the province.
- The Ministry of Mental Health and Addictions (MMHA) was established in July 2017, with the mandate to work in partnership to develop an immediate response to the opioid crisis that includes crucial investments and improvements to mental health and addiction services.

KEY FACTS

- Despite considerable efforts to prevent and respond to overdoses, it is projected that BC will see over 1,500 overdose deaths by the end of 2017. The contamination of BC's illegal street drug supply means anyone who uses an illegal substance – even for the first time – is at risk for overdose or overdose death.
- The Ministry of Mental Health and Addictions (MMHA) is leading a cross-government response to this public health emergency. The MMHA is focused on four key areas of action:
  - *Saving lives*: Services for people who continue to use drugs that help reduce the risk and severity of overdose and/or provide immediate lifesaving interventions when an overdose has happened.
  - *Ending the stigma around addictions and mental illness*: Activities that reduce negative attitudes about people who use drugs or have a mental illness that may keep people from seeking and receiving help.
  - *Building the network of mental health and addiction treatment services*: Activities that set the foundation for an integrated mental health and substance use service delivery system and that support the delivery of treatment interventions and supports that enable sustained recovery from addiction.
  - *Addressing the full range of supports and social factors*: Activities and services that address social factors related to substance use such as housing, income, employment, and that foster personal resiliency and independence.
- s.12,s.13,s.17

- The Minister of Mental Health and Addictions has continued to meet with people with lived experience, their families, first responders, volunteers and staff from community-based organizations, addiction experts and others working on the front line of the opioid emergency. Under the direction of the Minister of Mental Health and Addictions, and informed by those working in the system, the Province is developing a cross-sector action plan and dedicating resources– s.13,s.17 –to accelerate the response.
- The Province is focused on transitioning from an emergency response to building and sustaining an improved system that meets the needs of people when and where they need it. Ensuring actions are informed by the latest data and evidence available is integral to an effective and robust response.
- The complex nature and causes of BC's overdose epidemic require generating and gathering together multiple data sources to monitor, analyze, and understand the emergency and its underlying issues. This data provides the best available evidence for implementation and evaluation of effective actions. Enhanced population health surveillance activities are now providing more

detailed information about overdoses and risk factors to enable targeted interventions and evaluation.

- BC is grappling with an overdose epidemic that has complex and dynamic underpinnings, with the rapid introduction of new substances and consistently high rates of unintentional illegal drug overdose deaths spread evenly right across the province. With significant new investments in accelerated cross sector action, the Ministry of Mental Health and Addictions is taking action to ensure a comprehensive and robust response to BC's opioid overdose emergency.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Carolyn Davison, Director, Problematic Substance Use; October 12, 2017
Keva Glynn, A/ADM, Policy, Monitoring and Evaluation; October 12, 2017

FACT SHEET

Addressing the Full Range of Supports/Social Factors (Overdose Response)

ISSUE

- A multi-sectoral, coordinated approach is needed to strengthen the supports available to families that help them avoid mental health and substance use problems.
- *Addressing the Full Range of Supports and Social Factors* is 1 of 4 key areas of focus for the newly established Ministry of Mental Health and Addictions.

KEY FACTS

Social Factors

- Adequate housing and income are key factors that help people to maintain good mental wellness and avoid substance use problems.
- While housing and income have health implications, the main responsibility for these areas rests with other ministries.
- The Ministry of Mental Health and Addiction has a mandate to work across government to create a mental health and addictions strategy. The strategy will include a focus on improving access and investing in early prevention and youth mental health.

Psychosocial Supports

- The opioid overdose emergency has highlighted the need for psychosocial supports for people involved in responding to overdoses.
- Responding to overdose events, especially repeat overdose events, take a devastating emotional toll on those who play an essential role in the front line response.
- Families, volunteers at community organizations, those working in programs reaching vulnerable populations are reporting extreme stress, burnout, and trauma – all factors that can lead to poor mental health outcomes.
- Health Emergency Management BC has deployed a Mobile Provincial Psychosocial Response Team to support front line workers who do not have any other type of employer-provided psychosocial support programs.
- This team is composed of skilled workers who lead outreach, deliver customized training, and help build local capacity in support of staff resilience.
- Team members are available to all regions of the province. An advisory council, with representation from health authorities and community partners, has been established to provide guidance and direction to the team.
- The BC Coroners Service has increased capacity to support families who have lost loved ones to an overdose by staffing a dedicated Affected Persons Liaison and Community Outreach position. This position provides emotional support to family members and facilitates referrals to resources in the community.
- First responders and health authority staff that have employer-provided crisis service programs are encouraged to utilize these programs; however, it has been reported that employees are reluctant to use these programs due to their short-term nature and the perception that counselors cannot relate to the lived experience of the employees.

FINANCIAL IMPLICATIONS

- s.13,s.17

FACT SHEET

Approved by:
Carol Davidson, Problematic Substance Use; October 12, 2017
Keva Glynn, Ministry of Mental Health & Addictions, Mental Health & Substance Use Division; October 12, 2017
Nancy South obo Teri Collins, Health Sector Information Analysis and Reporting Division; October 13, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; October 13, 2017

FACT SHEET

Ending Stigma (Overdose Response)

ISSUE

Stigma, discrimination, and the isolation of people who use drugs leads to increased vulnerability and risk of overdose death. The stigma associated with illegal drug use undermines the willingness of people to engage in treatment, to call 9-1-1 in the event of an emergency, and to attend supervised consumption or overdose prevention services. Public Engagement is the development of public messaging and information campaigns informed by available data and intended to raise awareness of the public health emergency in a manner that reduces stigma for people most at risk of overdose.

KEY FACTS

- Stigma takes significant time and effort to change.
- The Public Engagement Task Group works to increase public awareness about how to prevent, identify, and respond to illegal drug overdoses.
- The Public Engagement Task Group includes representatives from the Ministries of Mental Health and Addictions, Health, Public Safety and Solicitor General, Education, Children and Family Development, all health authorities, including the Provincial Health Services Authority and First Nations Health Authority (FNHA), RCMP E Division, BC Coroners Service, Surrey Fire Department and people with first-hand/lived experience of the opioid overdose.
- As a result of surveillance data indicating high prevalence of fatal and non-fatal overdose events among urban Indigenous and First Nations people, a sub-committee of the Public Engagement Task Group is working with the First Nations Health Authority to support engagement and information sharing with this population.
- Overdoses and overdose deaths affect Indigenous populations and males aged 30 to 59 disproportionately, relative to other British Columbians.
- Overdose deaths also occur disproportionately among people who use drugs alone; more knowledge is needed to support efforts to reach and engage this hidden population
- A public information campaign was launched in August 2016, consisting of:
    - A microsite, www.gov.bc.ca/overdose (with over 100,000 page views), featuring information and stories on how to identify, respond and prevent illegal drug overdoses
    - Television advertising, out-of-home advertising (including restaurant-bar and transit posters) throughout BC, radio spots, community newspaper advertisements, and Facebook and digital advertising
    - Print materials distributed to more than 60 stakeholder organizations and groups across BC for parents, community, people who use drugs and first responders
    - Resources for parents and those working with kids posted on HealthLink BC.
    - In June 2017, a letter from the Provincial Health Officer was circulated to parents of students across BC with information about the importance of prevention and talking openly with youth about drug use.
- Social marketing continues to highlight stories from people with lived experience to encourage others to consider the real impacts of problematic substance use and the overdose emergency on people's day-to-day lives.

FACT SHEET

- Results from this campaign include:
  - Evidence that behaviours are changing. More people are calling 9-1-1, and more are seeking naloxone kits, with increased distribution and use of naloxone
  - Media analysis is measuring the impact of the public information campaign including review of over 660 print articles and 16,500 social media comments
  - Social media comments included a balance of positive and negative reactions. Positive themes include recognition of the importance of the public information campaign, sharing of personal experience, and support for tools like naloxone being made available. Negative themes include blame (parents, devaluing people who use drugs, their choices, the health system, and government) and resistance to government advertising.
  - Social media engagement (click-through rates, comments, and reactions) surpassed much of the provincial government's previous public awareness experience using social media.
- Strategy, tactics and activities for the 2017/2018 fiscal year ensure the continuation of a province wide public information campaign with a key focus on Indigenous and First Nations engagement, partnerships, people with lived experiences and stigma reduction.

FINANCIAL IMPLICATIONS
s.12,s.13,s.17

Approved by:
Keva Glynn, Ministry of Mental Health & Addictions, Ministry of Health; October 2017
Jason Butler, CFO, Finance and Corporate Services Division; October 12, 2017

FACT SHEET

Saving Lives (Overdose Response)

ISSUE

BC is currently experiencing a public health emergency due to an unprecedented increase in illegal drug overdose deaths caused by the introduction of fentanyl and other highly-toxic synthetic opioids into the illegal drug supply. Saving lives is a main priority in escalating the provincial response and will involve expanding access to services for people who continue to use drugs that help reduce the risk of overdose, reduce the severity of overdose, or provide immediate lifesaving interventions when an overdose has happened. Services include supervised consumption and overdose prevention services, drug checking services, and naloxone.

KEY FACTS

Supervised Consumption Services

- Supervised consumption services are an evidence-based public health strategy to reduce the harms associated with non-medical injection drug use.
- Supervised consumption services can help reduce the transmission of blood-borne illnesses, link marginalized individuals with complex chronic disorders to primary care, prevent serious infections, improve uptake of substance use disorder treatment, and prevent overdose deaths.
- On May 18, 2017, the Government of Canada amended the *Controlled Drugs and Substances Act* to simplify the application process for supervised consumption services.
- Health Canada has provided exemptions under Section 56 of the *Controlled Drugs and Substances Act* for 8 supervised consumption sites (3 in Vancouver, 2 in Surrey, and 1 each in Kamloops, Kelowna, and Victoria) with another 2 (one each in Vancouver and Victoria) currently under review.
- Northern Health is examining the feasibility of supervised consumption services for Prince George
- Island Health is in the planning stages for a supervised consumption service in Nanaimo.
- The BC Centre on Substance Use (BCCSU) has developed operational guidelines for supervised consumption services based on available scientific evidence, policies, and procedures in place in BC.[1]

Overdose Prevention Services

- In December 2016, the Minister of Health issued an order directing the establishment of overdose prevention services under the *Emergency Health Services Act* and the *Health Authority Act.*
- Overdose Prevention Sites have been established in select locations to monitor people who have used illicit drugs for signs of an overdose and provide rapid intervention when an overdose occurs, preventing catastrophic brain injury and death.
- As of September 24, 2017, there are 24 supervised consumption service sites across the province.[2]
- The Provincial Health Officer has developed a guidance document for community organizations and landlords about overdose prevention in supportive housing and homeless shelters.[3]

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[1] BC Centre on Substance Use and BC Ministry of Health. (2017). *Supervised Consumption Services – Operational Guidance*. Retrieved from: http://www.bccsu.ca/wp-content/uploads/2017/07/BC-SCS-Operational-Guidance.pdf (accessed October 5, 20170.

[2] BC Centre for Disease Control. (2017, September 24). Overdose Data & Reports. Retrieved from: http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction/overdose-data-reports (accessed October 5, 2017).

[3] http://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/guidelines-and-resources-for-supportive-housing-providers-feb2017.docx Accessed July 11, 2017

FACT SHEET

Drug Checking

- Drug checking services provide technology for people who use drugs to test the composition of their drugs and identify potential adulterants.
- A pilot study conducted at Insite found fentanyl in 79% of drugs voluntarily tested. The study also found that people who checked their drugs before consumption and had a positive result for fentanyl were 10 times more likely to reduce their dose, and people who reduced their dose were 25% less likely to overdose.[4]
- The Supervised Consumption and Drug Checking Task Group recommends expanding the use of fentanyl test strips to other supervised consumption and overdose prevention service locations.
- The BCCSU conducted an evidence review of drug checking technologies, applications, and issues.

Naloxone

- Naloxone is an opioid antagonist that reverses life-threatening respiratory depression caused by opioid overdose. Although naloxone only works on opioid overdoses, it will cause no harm to someone who does not have any opioids in their system.
- The BC Centre for Disease Control (BCCDC) operates the BC Take Home Naloxone (THN) program to help prevent overdose deaths by providing people who use drugs and those most likely to witness and respond to an overdose with access to no-charge naloxone kits and overdose recognition and response training.
- Overdose recognition and response training highlights the importance of calling 911 immediately when an overdose occurs, and providing rescue breathing to the person who overdosed.
- As of September 30, 2017, THN kits are available at 590 locations across the province including 58 emergency departments, 14 corrections facilities, and 85 First Nations sites serving 97 communities. The BCCDC has distributed 55,112 kits through the THN program and reports that THN-acquired kits have been used to reverse 11,258 overdoses since August 2012.[5]
- In December 2016, the BCCDC launched the Facility Overdose Response Box to provide naloxone and other supplies at no charge to community organizations serving people at risk of overdose.
- The Government of BC has also worked to ensure that anyone who witnesses an overdose event can administer naloxone legally to prevent opioid overdose harms including death.
- On January 28, 2016, the Emergency Medical Assistants Regulation was amended to permit licensed fire rescue first responders to administer naloxone and expand the number of BC Emergency Health Services paramedics able to do so.
- On March 24, 2016, Health Canada amended the Prescription Drug List to remove naloxone's prescription-only status, making it available to anyone for purchase over-the-counter.
- Pharmacists complete training on how to dispense naloxone using materials available through the College of Pharmacists of BC in partnership with the BCCDC and the Ministry of Health (MoH).
- In May 2017, the MoH developed a risk assessment tool to support public and non-public sector organizations to determine whether staff or settings should have naloxone to administer to employees, clients, and members of the public who have overdosed.[6]

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[4] Vancouver Coastal Health. (2017, May 15). Drug checking at Insite shows potential for preventing fentanyl-related overdoses. Retrieved from: www.vch.ca/about-us/news/news-releases/drug-checking-at-insite-shows-potential-for-preventing-fentanyl-related-overdoses (accessed July 11, 2017).

[5] BC Centre for Disease Control. (2017, September 30). Take Home Naloxone Program in BC. Retrieved from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525 (accessed October 5, 2017).

[6] BC Ministry of Health. (2017). *Naloxone risk assessment tool: For non-public sector organizations*. Retrieved from: http://www2.gov.bc.ca/assets/gov/overdose-awareness/naloxone_risk_assessment_-_non-governmental_sectors.pdf (accessed July 19, 2017).

- BC's Product Distribution Centre provides naloxone kits that are similar to those available through the THN. These can be purchased by public sector organizations, including Government of BC Ministry staff, once they have completed the risk assessment.
- The MoH has partnered with St. John's Ambulance (SJA) to increase overdose recognition and response training capacity. SJA has created a naloxone training module consistent with BCCDC recommendations for purchase by organizations not eligible for the THN program.

FINANCIAL IMPLICATIONS

- The September 2017 Budget Update allocated $322 million over 3 years to the overdose emergency response consisting of:
    - $265 million for the MoH;
    - $32 million for the Ministry of Public Safety and Solicitor General to increase police resources and address pressures at the BC Coroners Services; and
    - $25 million to establish the Ministry of Mental Health and Addictions.
- As part of the $322 million in new funding, s.13,s.17

s.13,s.17

Approved by:
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Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; October 13, 2017
Nancy South obo Teri Collins, Health Sector Information, Analysis & Planning & Reporting; October 13, 2017

FACT SHEET

Opioid Overdose Data

ISSUE

Despite the efforts to prevent overdoses and deaths, an unprecedented number of people continue to die; projections suggest BC may see more than 1,500 overdose deaths in 2017. The complexity and dynamic nature of the overdose emergency demand careful analysis of all available information to understand underlying issues and to ensure effective action. Partnerships across public organizations are enabling the timely analysis of linked data sets to provide evidence to guide action.

KEY FACTS

- On April 14 2016, prompted by an increase in drug-related overdoses and deaths in BC, the Provincial Health Officer declared a public health emergency, and subsequently issued 2 Orders to expedite the collection of suspected and confirmed overdose data. Analysis of timely, accurate data provides crucial guidance for the province's response.
- Current overdose event data collection and analysis activities include unlinked data streams (BC Coroners data, BC Emergency Health Services data, BC Emergency Department (ED) data, BC Take Home Naloxone data, and toxicology data from various laboratory services); linked data (BC Provincial Opioid Cohort, a study of detailed overdose data that links 911 calls, ED visits and the comprehensive health history of people who have experienced possible fatal and non-fatal opioid overdose); and weekly and monthly summary dashboards and reports, as well as BC Centre for Disease Control (BCCDC) data sharing and visualization tool.
- Illegal opioid overdose mortality in BC has been high compared to other provinces and territories for many years. The increase in deaths related to fentanyl began in 2012/13, with a marked increase from 2015 to present, especially since November 2016[1]. 982 British Columbians died from illegal opioid overdose in 2016 and 1,013 died in the first 8 months of 2017[2].
- BC's population rate of illegal drug overdose deaths is extremely high – in 2016, 21 people died for each 100,000 British Columbians.[3] This rate is higher among First Nations in BC.[4]
- Overdoses and overdose deaths are widespread and include urban, suburban, rural, and remote communities throughout the province. There is some geographic variation in the rates of overdose deaths, with Vancouver, North Vancouver Island, Thompson Cariboo Shuswap, Fraser East and Okanagan HSDAs having the highest rates of overdose deaths in 2016/17[5]; however, death rates are all comparably high across the province[6].
- In 2016, fentanyl was detected in 67% of illegal drug overdose deaths in 2016. From January to August 2017, this number increased to 81%[7].
- In 2015/16, men made up 64% of patients attending ED for a known or suspected opioid overdose but 80% of the deaths. This raises important questions such as whether men are more likely to use substances alone, not have someone nearby who can call 911 or use substances in less safe ways, as compared to females[8].

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[1] BC Centre for Disease Control (2017) Summary of Evidence on Opioid Overdose. Quarterly Briefing Report. June 2017.
[2] BC Coroners Service (2017) Illicit Drug Overdose Deaths in BC January 1, 2007 - August 31, 2017. Retrieved on October 13, 2017 from http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf (Page 4)
[3] Ibid. Page 4
[4] http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf
[5] BCCDC – Overdose Data and Reports –Interactive Dashboard: http://maps.bccdc.org/projects/ODdashboard/hsda_deaths_map.jpg, Retrieved October 16, 2017
[6] BC Centre for Disease Control. Weekly Overdose Dashboard. September 24,2017 - September 30, 2017
[7] BC Coroners Service (2017) Fentanyl-Detected Illicit Drug Overdose Deaths January 1, 2012 to August 31, 2017. Posted October 12, 2017. Retrieved on October 13, 2017 from https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf
[8] BC Centre for Disease Control. Comparing fatal and non-fatal overdoses. Descriptive analysis from the Provincial Overdose Cohort. Presentation to the Health System Steering Committee. September 20, 2017.

- The majority of illegal opioid overdoses, both non-fatal and fatal, occur in adults aged 20–49 years. Youth make up 1–3% of illicit drug overdose deaths each year and this proportion is not increasing over time.[9]
- Overdoses are being experienced across all socioeconomic strata but deaths are more likely to occur in deprived groups. Opioid overdose patients interviewed in EDs are more likely than the general population to be experiencing housing instability[1].
- In 2016/17, about 60% of fatal overdoses occurred in private residence and only up to 15% occurred in public spaces[Error! Bookmark not defined.]. In 2015/16, 68% of fatal overdoses had no health system or ambulance response[8]. The probability of surviving an overdose depends on the timely availability of help. Factors such as using drugs alone and not receiving ambulance response reduce the chances of survival. This data highlights the need for reaching people using drugs alone in private residences and working to address fear of legal consequences and to reduce stigma of drug use to improve rates of 911 calls.
- People experiencing fatal and non-fatal overdoses demonstrated higher levels of healthcare service utilization in the year prior to the overdose[8]. This data can be potentially used to identify individuals at risk of overdose.
- BC Status First Nations make up 3.4% of BC's population but are 13.5% of overdose events and 10% of overdose deaths. First nations in BC have 4 times higher rates of overdose than non-First Nations; this number is almost 10 times higher in Vancouver Coastal Health[10].
- First Nations women are experiencing overdose almost as often as men as (and 7 times more often than other women). First Nations men are much more likely to die from the overdose than women, reflecting the overall BC trend[10].
- First Nations Health Authority developed a framework for action to address opioid overdose in BC First Nations Communities. It includes increasing access and training for Naloxone, improvement of 911 services and increased awareness of the Good Samaritan Drug Overdose Act, as well as improving harm reduction and addressing stigma, improving treatment and supporting people on their healing journey.[10]
- The Ministry of Mental Health and Addictions is developing an enhanced data analytics strategy to inform policy, action plans, and implementation strategies.

FINANCIAL IMPLICATIONS

- The September 2017 budget update included a commitment of $322 million over the next 3 years to begin building a better system for mental health and addictions, consisting of:
    - $265 million for the Ministry of Health;
    - $32 million for the Ministry of Public Safety and Solicitor General to increase police resources and address pressures at the BC Coroners Services; and
    - $25 million to establish the Ministry of Mental Health and Addictions.
- s.13,s.17

[9] First Nations Health Authority. Overdose in First Nations: Further Analyses of the Provincial Overdose Cohort. Presentation at the Health System Steering Committee meeting, September 20, 2017.
[10] Ibid.

FACT SHEET

Approved by:
Keva Glynn, Ministry of Mental Health & Addictions, Ministry of Health; October 12, 2017
Nancy South obo Teri Collins, Health Sector Information, Analysis & Planning & Reporting Division; October 16, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; October 17, 2017

FACT SHEET

Acute and Tertiary Care Mental Health and Substance Use Beds

ISSUE

A range of mental health and substance-use (MHSU) acute and tertiary care options are available for individuals with severe MHSU problems, in order to respond appropriately and in a timely fashion to an individual's service needs and intensity.

KEY FACTS

- Simon Fraser University's Centre for Applied Research for Mental Health and Addiction estimates approximately 130,000 adults in BC have severe and complex mental health and/or substance-use problems. Annually, approximately 25,000 unique individuals require more intensive service approaches such as acute and tertiary care services.[1]
- Health authorities provide acute and tertiary level services for people with serious MHSU disorders. People experiencing acute or longer term serious mental illness and/or substance-use disorders require access to these services to stabilize and support longer-term recovery, if required.
- Patients with a mental health diagnosis have an average length of stay (ALOS) of 14 days for involuntary admissions, and 12 days for voluntary admissions[2] within acute MHSU beds. ALOS within Tertiary MHSU beds is considerably longer, ranging from 3-24 months. As shown in Table 1, there are 744 acute care and 1,249 tertiary MHSU beds in the province. Of the tertiary beds, 190 are forensic psychiatric beds.

Table 1: Mental health and substance-use acute and tertiary beds in BC, September 2016[3,4]

Health Authority	Acute MHSU Beds	Tertiary MHSU Beds
	2016	2016
IHA	99	158
FHA	206	267
VCHA	215	213
VIHA	159	178
NHA	65	69
PHSA		364
BC Total	**744**	**1,249**

- Of these 1,249 Tertiary MHSU beds, 826 are specialized Tertiary Care Mental Health beds developed as part of the Riverview Redevelopment.

Table 2: Riverview redevelopment beds by health authority[5]

Health Authority	Allocated Beds
Northern Health	65
Interior Health Authority	150
Vancouver Island Health Authority	129
Fraser Health Authority	267
Vancouver Coastal Health Authority (includes 25 provincial refractory beds)	215
Total	826

Acute Care Beds

- Health authorities provide acute care inpatient treatment to adults and youth experiencing mental illness, concurrent MHSU problems, and the acute stages of withdrawal from alcohol or other drugs.

[1] Housing and Support for adults with Severe Addiction and/or Mental Illness in BC – CARMHA 2008

[2] *Hospitalization of Mental Health Patients in BC With Involuntary/Voluntary cases from 2006/07 - 2013/14*; HSIAR Division, Ministry of Health. Project 2015_0043. Data extracted on January 13, 2015.

[3] MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIARD

[4] Ministry has only recently begun collecting acute and tertiary mental health and substance use bed data; therefore, there is no comparison across years.

[5] Correspondence from FCS - Regional Grants and Decision Support.

These specialized MHSU hospital inpatient beds are usually short-term in nature providing assessment, treatment and stabilization; most are located in facilities designated under the *Mental Health Act*.

- MHSU acute beds include inpatient treatment (adult, youth, geriatric), designated observation units, psychiatric intensive care units, short-term assessment, early psychosis intervention, and acute behavioural stabilization units.
- There are no dedicated substance-use acute care beds[6]; however, individuals experiencing the acute symptoms of withdrawal from alcohol or other drugs are treated within acute care medical units.

Tertiary Care Beds

- Tertiary care beds meet the needs of individuals who require more intensive, long-term and/or specialized treatment, and have not been successfully treated in the primary and secondary mental health system. Services include: assessment, treatment including stabilization of acute symptoms not resolved in other settings, and rehabilitation focusing on psychosocial rehabilitation and recovery.
- MHSU tertiary beds include in-patient (acute, rehabilitative, geriatric), residential care, eating disorder, neuropsychiatry, mood disorders, addictions/concurrent, refractory psychosis, child and youth, and forensic services.
- In November 2013, the Ministry announced the provincial action plan *Improving Health Services for Individuals with Severe Addiction and Mental Illness,*which included funding to expand the continuum of the Burnaby Centre for Mental Health and Addiction, a tertiary care MHSU facility. On December 19, 2014 to support this continuum, Vancouver Coastal Health transferred the operational governance of the Centre to the Provincial Health Services Authority (PHSA).
- As of November 2014, to accommodate a more severe client population within the Centre, the PHSA relocated 26 beds from the existing site to a new 40-bed community facility operated by Coast Mental Health Society (Hillside/Brookside). The facility is comprised of 26 existing beds, plus 14 new rehabilitation/recovery beds on the Riverview lands. An additional 20 acute stabilization beds were developed at the Centre and operational as of April, 2016.[7]
- Forensic psychiatric hospital beds are located at a secure, inpatient 190 bed facility that provides court-related forensic psychiatric assessment, treatment, and community case management to adults experiencing MHSU problems who are in conflict with the law. Specialized forensic mental health teams work to enable the re-integration of individuals back into the community.
- Initial provincial standards for mental health tertiary care facilities designated under the *Mental Health Act* have been drafted by the PHSA, in partnership with regional health authorities and the Ministry. These standards are complete and awaiting final approval by the Standing Committee on Health Services and Population Health.
- In February 2015, the Office of the Auditor General initiated a review of adult tertiary level services in BC. The final draft report "*Access to Adult Tertiary Mental Health and Substance Use Services*" was released in May 2016, and contains 10 recommendations.[8]

FINANCIAL IMPLICATIONS

The MHSU sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.

[6] Mental Health and Substance Use (MHSU) Bed Survey. (September2016). HSIAR Division, Ministry of Health. Project:2016.0202.
[7] See Fact Sheet - Burnaby Centre for Mental Health and Addiction
[8] See Fact Sheet - OAG–Access to adult tertiary care mental health and substance use services.

FACT SHEET

Approved by:
Sharon Stewart, Primary and Community Care Policy Division; July 31, 2017
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Aureleo Reyes, obo Manjit Sidhu, Finance and Corporate Services Division; August 9, 2017

FACT SHEET

Naloxone

ISSUE

The Government of British Columbia has taken significant action to increase the number of people equipped and trained to administer naloxone to prevent opioid overdose morbidity and mortality in response to the unprecedented increase in illegal drug overdose deaths across the province.

KEY FACTS

- Opioids are a class of drug, which includes heroin, morphine, fentanyl, methadone, and codeine. They are most often prescribed for pain relief.
- Fentanyl is a synthetic opioid that is more potent than most other opioids. While it has indications for severe pain control, in recent years it is also being produced in illegal labs and sold on the streets, often mixed with other drugs.
- Fentanyl or fentanyl analogues (drugs chemically similar to fentanyl) have been found in all illegal drugs in BC with the exception of cannabis.
- The introduction of fentanyl and highly toxic analogues into the illegal drug supply is driving the increase in overdose deaths in BC (XREF 1088908 "Opioid Overdose Public Health Emergency).
- Harms associated with opioid overdose, including catastrophic brain injury and death, can be averted with timely administration of naloxone and rescue breathing.
- Naloxone is an opioid antagonist that reverses life-threatening respiratory depression caused by opioid overdose. Although naloxone only works on opioid overdoses, it will cause no harm to someone who does not have any opioids in their system. Naloxone should be given to an unresponsive person, particularly if they are breathing slowly or not at all.
- Naloxone has been used by first responders in emergency settings for over 40 years in Canada. It is a safe, non-toxic drug with minimal side effects[1].
- In 2012, the BC Centre for Disease Control (BCCDC) established the BC Take-Home Naloxone (THN) program to help prevent overdose fatalities. The program provides kits that include naloxone and additional supplies, as well as overdose response training, at no charge to people who use drugs.
- In December 2016, the BCCDC expanded program eligibility so that people most likely to witness and respond to an overdose can receive kits and training at no charge.
- In December 2016, the BCCDC launched the Facility Overdose Response Box to provide naloxone and other emergency response supplies at no charge to community-based organizations working with people at risk of overdose.
- Overdose recognition and response training highlights the importance of calling 911 immediately when an overdose occurs, and providing rescue breathing to ensure that the person who overdosed receives oxygen.
- As of July 4, 2017, THN kits are available at 558 locations across the province including 58 emergency departments, 13 corrections facilities, and 85 First Nations sites serving 97 communities[2].
- As of July 4, 2017, the BCCDC has distributed 49,766 kits through the THN program and reports that THN-acquired kits have been used to reverse more than 10,066 overdoses since August 2012[3].

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[1] Kim, D., Irwin, K., & Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *American Journal of Public Health, Health Policy and Ethics*, *99*(3), 402-407.

[2] BC Centre for Disease Control. (2017). Take Home Naloxone Program in BC. Retrieved from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525 (accessed July 17, 2017).

[3] BC Centre for Disease Control. (2017). Take Home Naloxone Program in BC. Retrieved from: https://infograph.venngage.com/publish/2245254a-ccaa-461b-87ec-ec97a4840525 (accessed July 17, 2017).

- In addition to expanding naloxone availability through the THN program, the Government of BC has also worked to ensure that anyone who witnesses an overdose event can administer naloxone legally to prevent opioid overdose harms including death.
- On January 28, 2016, the Emergency Medical Assistants Regulation was amended to permit licensed fire rescue first responders to administer naloxone and expand the number of BC Emergency Health Services paramedics able to do so[4] .
- BC Ambulance Service paramedics administered naloxone on average 380 times per month between January 1, 2016, and November 30, 2016, an increase of 50 percent over 2015[5] .
- On March 24, 2016, Health Canada amended the Prescription Drug List to remove naloxone's prescription-only status, making it available for purchase over-the-counter.
- People who are not eligible for the THN program can now purchase naloxone kits from community pharmacies across the province without a prescription.
- Pharmacists complete training on how to dispense naloxone, including how to train people on how to recognize an overdose and administer naloxone, using materials available through the College of Pharmacists of BC in partnership with the BCCDC and the Ministry of Health (MoH).
- In May 2017, the MoH developed a risk assessment tool to support public and non-public sector organizations to determine whether staff or settings should have naloxone to administer to employees, clients, and members of the public who have overdosed. The tool also outlines where organizations can obtain naloxone and overdose recognition and response training[6]. The tool was sent to all Deputy Ministers and was made publicly available on the government website.
- BC's Product Distribution Centre provides naloxone kits that are similar to those available through the THN. These can be purchased by public sector organizations, including Government of BC Ministry staff, once they have completed the risk assessment.
- The Ministry of Children and Family Development has obtained more than 500 naloxone kits through the Product Distribution Centre to provide to staff working with youth at risk of overdose.
- The MoH has partnered with St. John's Ambulance to increase overdose recognition and response training capacity. St. John's Ambulance has created a naloxone training module consistent with BCCDC recommendations for purchase by organizations not eligible for the THN program.

FINANCIAL IMPLICATIONS

- The Provincial Health Services Authority (PHSA) covers ongoing costs associated with the expansion of the BC THN program. In 2016/17, PHSA naloxone supply expenditures were approximately $1.747 million, of which $0.459 million was for naloxone drugs, and $1.288 million was for kit supplies (e.g., syringes, masks, and information materials)[7] .
- The MoH provided $20,000 through a contract with the College of Pharmacists to prepare educational materials and training to enable pharmacists to dispense naloxone to British Columbians and train them on how to administer the intramuscular medication safely.

Approved by:
Arlene Paton, Population and Public Health Division; August 2, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; August 1, 2017

[4] Government of British Columbia. (2016, January 28). Fire rescue crews to carry naloxone for drug overdose patients. Retrieved from https://news.gov.bc.ca/releases/2016HLTH0008-000101 (accessed July 17, 2017).
[5] BC Centre for Disease Control. (2017). The BC Public Health Opioid Overdose Emergency. Retrieved February 14, 2017, from www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/Public%20Facing%20Surveillance%20Report_Jan2017.pdf.
[6] BC Ministry of Health. (2017). *Naloxone risk assessment tool: For non-public sector organizations.* Retrieved from: http://www2.gov.bc.ca/assets/gov/overdose-awareness/naloxone_risk_assessment_-_non-governmental_sectors.pdf (accessed July 19, 2017).
[7] Per PHSA Finance, July 18, 2017.

FACT SHEET

Assertive Community Treatment

ISSUE

Assertive Community Treatment (ACT) is a client-centred, recovery-oriented service delivery model that facilitates community living support and psychosocial rehabilitation for persons with severe and persistent mental illness, and/or substance use disorders. This community-based service addresses the complex needs of individuals who have difficulty maintaining access to traditional office-based mental health and substance use services.

KEY FACTS

- An estimated 130,000 people in BC live with severe addictions and/or mental illness. These individuals have one or more psychiatric diagnoses that significantly affect their ability to actively engage in personal, social, and/or occupational areas of daily life.[1]
- ACT is an evidence-based model of care, primarily for individuals who have a history of severe mental illness such as psychosis, significant functional challenges, and multiple complex needs which may or may not include substance use issues.
- Many clients have had difficulty maintaining access to traditional community mental health services, and have high utilization rates of emergency, acute, and tertiary care services.[2]
- ACT operates 24 hours a day, 7 days a week and provides a low staff-to-client ratio (1:10), frequent contact with clients, and an integrated multi-disciplinary team approach.[3]
- ACT teams are comprised of nurses, nurse practitioners, social workers, peer support workers, occupational therapists, vocational rehabilitation specialists, concurrent disorder clinicians and psychiatrists, as well as partnerships with local law enforcement, housing providers, primary care physicians and other clinical specialists, as needed.
- In 2008, the Ministry of Health developed Standards of Care for ACT in order to ensure high quality services consistent with a proven program model. The standards guide ACT program start-up, implementation and ongoing operations by clearly defining the minimum program and staffing requirements.
- In 2009, a provincial ACT Evaluation Framework was developed to guide team data collection and reporting.
- In 2013, Vancouver Coastal Health established an ACT Advanced Practice to: support ACT teams on clinical and program levels (e.g., ACT website, community of practice, fidelity reviews); develop provincial training for new ACT team members; and provide coordination and administrative functions.
- Key provincial strategies have supported the development of ACT teams in recent years:
  - ACT teams in Campbell River/Port Hardy, Port Alberni, and Vancouver were funded via the Acceleration funds linked to the *Integrated Primary and Community Care initiative.*
  - The November 2013 provincial action plan *Improving Services for Individuals with Severe Addiction and Mental Illness* supported the development of two of the five Vancouver teams, and the four new teams in Fraser Health and Interior Health.[4]
- Across the province, the number of ACT teams has increased from 0 in 2007 to 20 teams by 2015.[5] Sixteen of these teams were developed between 2007 and 2014, and an additional four new teams were developed in early 2015.

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[1] Patterson et al. 2008. *Housing and Supports for Adults with Severe Addiction and / or Mental Illness in BC.* Vancouver, BC: *Centre for Applied Research on Mental Health and Addiction*. pg. 8.

[2] Ministry of Health. (2008). *British Columbia Program Standards for Assertive Community Treatment (ACT) Teams*. Page 6. Retrieved on October 10, 2014 from http://www.health.gov.bc.ca/library/publications/year/2008/BC_Standards_for_ACT_Teams.pdf

[3] Ibid. Page 11.

[4] Ministry of Health. (2013). *Improving Health Services for Individuals with Severe Addiction and Mental Illness.*.

FACT SHEET

- The Ministry's *Integrated Models of Primary Care and Mental Health & Substance Use Care in the Community* (2012) identifies ACT as a BC best practice in wrap-around, integrated team care services for individuals with severe and persistent mental illness, and concurrent substance use disorders.
- ACT has demonstrated significant impacts for the system and for people with mental illness and/or substance use problems. In 2013, those receiving ACT team supports in Vancouver showed a 70 percent reduction in emergency department visits, 61 percent reduction in criminal justice involvement, and a 23 percent reduction in incidents of victimization.[6]
- In 2016/17, Fraser Health reported a reduction in acute care utilization of ACT clients, including 73 percent and 54 percent decreases in acute care and alternative level of care (ALC) bed days.[7] That year VIHA reported that 82 percent of Island Health's urban ACT team clients are attached to a family physician, and 89 percent of ACT clients are in stable independent housing or in a facility/ supported living. [8] In 2016/17, the 20 ACT teams served a total of approximately 1,600 clients[9] with the capacity to support approximately 1,700 people with severe mental illness.[10]

Assertive Community Treatment (ACT) Teams in BC - May 2017

Health Authority	Number of ACT teams	Location
Interior Health	2	• Kelowna • Kamloops
Fraser Health	4	• Surrey • Surrey/North Delta • Abbotsford/Mission • New Westminster/Tri-Cities
Vancouver Coastal Health	5	• Vancouver (5 teams)
Island Health	8	• Victoria (4 teams) • Duncan/Cowichan • Port Alberni • Campbell River/Port Hardy • Nanaimo
Northern Health	1	• Prince George
BC Provincial Total	20	

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:

Sharon Stewart, OBO Doug Hughes, ADM Primary and Community Care Policy; July 5, 2017

Maria Perri for Gordon Cross OBO Manjit Sidhu, ADM Finance and Corporate Services Division; July 6, 2017

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[5] Survey of ACT Teams in BC, April 2013, by the MHSU Branch identified 13 ACT teams. Two more teams were announced in MoH through the 2013Ministry Action Plan. *Improving Health Services for Individuals with Severe Addiction and Mental Illness (SAMI).* Island Health also created a new team in February 2015 via Riverview Redevelopment. Four more teams were developed in early 2015 via the SAMI Action Plan.

[6] Vancouver Coastal Health and Providence Health Care (2013). *Improving Health Outcomes, Housing and Safety: Addressing the Needs of Individuals with Severe Addiciton and Mental Illness.* Page 8. Retrieved on October 10, 2014. http://www.health.gov.bc.ca/library/publications/year/2013/improving-severe-addiction-and-mental-illness-services.pdf.

[7] Fraser Health Authority. (2017). Assertive Community Treatment (ACT) Evaluation Report.

[8] Vancouver Island Health Authority. (2014). *Assertive Community Treatment: Final Evaluation Summary.*

[9] Ministry of Health. (2017). *ACT, ICM and AO Team Regional Breakdown Data.*

[10] Teams operate at an average maximum capacity of 85 clients according to the client-staff ration outlined on pg. 11.Ministry of Health. (2008). *British Columbia Program Standards for Assertive Community Treatment (ACT) Teams.*

FACT SHEET

CHILD AND YOUTH MENTAL HEALTH AND SUBSTANCE USE COLLABORATIVE

ISSUE

The purpose of the *Child and Youth Mental Health and Substance Use Collaborative* is to increase the number of children, youth, and their families receiving timely access to integrated mental health and substance use services and supports in BC. The Collaborative was funded for a period of three years, up to March 2017. In late 2016, a decision was made by the Shared Care Committee of Doctors of BC to utilize unexpended funds from 2016/17 to extend the role of the Collaborative to December 2017. The Collaborative has committed to developing local pathways of care from the Patient Medical Home to Specialized MHSU services through to December 2017.

KEY FACTS

- In June 2013, the Ministry of Health (the Ministry), the Doctors of BC, the Ministry of Children and Family Development (MCFD), the Ministry of Education (MoE), the Interior Health Authority, and children, youth and families developed a *Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative* to improve access to child and youth mental health, and substance use services.
- The *CYMHSU Collaborative* is based on an established "structured collaborative" change model[1] as a method of rapid, continuous quality improvement in health care, and brings together children and youth with lived experience, their families, care providers and decision makers, to address important local issues, while contributing to the larger regional and provincial picture.
- The majority of the *Collaborative's* success occurred at the local level through the Local Action Teams (LATs).
- A sustainment strategy is in development and proposes the development of local multi-lateral agreements to support pathways of care and supports between primary care physicians, health authorities and community stakeholders. These agreements will outline roles and responsibilities in order to clarify and provide more consistent pathways of care between primary and specialized MHSU services.
- The *CYMHSU Collaborative* includes over 2600 participants[2] and 64 LATs across a large number of communities.[3]
- Working groups - sometimes in conjunction with LATs - collaborate with the Steering Committee, Mental Health Clinical Faculty, and Substance Use Clinical Faculty to create solutions for both structural and clinical system issues such as: Emergency Department Protocol, Information Sharing, Physician Compensation, Transitions – Youth to Adult, Youth and Young Adult Services, Specialist Support, Physician Recruitment and Retention, Telehealth/Rural and Remote, Evaluation and Measurement, and Schools. LATs address issues relevant to their local communities, as well as the broader strategic vision. The vision for 2017 is *Pathways to Wellness, Care and Supports* and alignment with the MHSU policy paper, *Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues.*
- Provincial policy documents provide stewardship and guidance for the *Collaborative*. In 2014 the Ministry released *Setting Priorities for the BC Health System*, outlining a number of priorities, including the need to strengthen the interface between primary and specialist care and treatment, as well as examine the role and functioning of the acute care system, with focus on driving inter-professional teams and functions with better linkages to community health care.

[1] http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

[3] http://sharedcarebc.ca/initiatives/cymhsu-collaborative

FACT SHEET

- In 2015, the *CYMHSU Collaborative* won a national award for recognition of innovation and team-work. The award is co-sponsored by the *College of Family Physicians of Canada* and the *Canadian Psychiatric Association*.
- In March, 2017 the CYMHSU Collaborative is presenting at the 30th International Policy Conference on Child, Adolescent and Young Adult Behavioral Health sponsored by the Children's Mental Health Network in Tampa, Florida.

FINANCIAL IMPLICATIONS

- As of March 31, 2016, the Ministry has provided $10.22 million (2013/14 =$0.753M; 2014/15 = $3.662M; 2015/16 = $5.805M) in funding to the *CYMHSU Collaborative* in partnership with Doctors of BC's *Shared Care Committee*[4]
- s.13,s.17

Approved by:
Sharon Stewart OBO Doug Hughes, ADM Primary and Community Care Policy; February 28, 2017
Darryl Conner obo Manjit Sidhu, ADM Finance and Corporate Services; March 23, 2017
Nancy South obo Teri Collins, ADM, Health Sector Information, Analysis and Reporting; March 24, 2017

[4] As per Doctors of BC Shared Care Committee Audited Financial Statements \\Decision Support-MSP\1MSP_BCMA Committees\Shared Care Committee (SCC)\Financials.

FACT SHEET

CHILD & YOUTH MENTAL HEALTH AND SUBSTANCE USE SYSTEM OF CARE

ISSUE

Children and youth (C&Y) with mental health and or substance use (MHSU) problems require access to a continuum of evidence-based care ranging from prevention, health promotion, early intervention, primary and community care to specialized tertiary care services. The Ministry of Health (the Ministry), with partner organizations, are responding to the MHSU needs of this population.

KEY FACTS

- An estimated 70 percent of mental health problems in Canada begin during childhood or adolescence[1]. Research indicates that half of all cases of mental disorder start by age 14, and three quarters by age 24, while half of all people with a substance use disorder will have experienced substance use issues before the age of 20[2].
- In 2013, approximately 130,000 C&Y (aged 0-25) in BC used acute and emergency services, or saw a primary care physician for an MHSU issue[3]. Approximately 50 percent of the 130,000 C&Y identified are between the ages of 0-18[4], with the remaining between the ages of 19-25.
- In BC, ensuring the mental wellness of children and youth is a collective responsibility. In terms of service provision in the community and acute settings, the Ministry of Children and Family Development (MCFD) and the Ministry share responsibility. The Ministry of Education and school districts also play fundamental roles in mental wellness.
- MHSU services funded by the Ministry are provided through the Provincial Health Services Authority and regional health authorities (HAs), which may partner with external service providers. C&Y community mental health services are provided by the MCFD.
- MHSU services and supports in BC are provided along a continuum from health promotion and prevention through to early intervention and treatment, and are represented by a five-tiered model (see Mental Health and Substance Use Services Overview Fact Sheet).
- Treatment is most commonly offered in outpatient settings. Outpatient treatment is traditionally recommended for youth with less severe MHSU problems. Evidence suggests that more severe cases can be treated in outpatient settings as well.
- Early Psychosis Intervention (EPI) programs are available in each HA, and provide early detection of developing mental disorders, rapid assessment, and treatment for young people (usually ages 13-30) who have had their first episode of psychosis. EPI is oriented toward the early recognition of psychosis and the provision of timely comprehensive treatments that are stage and age-appropriate.
- Residential treatment is generally for youth with severe mental and substance use disorders where their MHSU and/or medical needs requires a structured environment to enable recovery.
- In total, there are 181 C&Y MHSU beds in BC. Of these, 78 are specialized acute (30) and specialized tertiary MHSU inpatient beds (48) for C&Y (generally ages 5-18) and 103 are community based youth (generally ages 15 -18) beds (14 eating disorders residential treatment, 20 substance use residential treatment, 26 supportive recovery, 4 substance use transitional services, 36 withdrawal management, and 3 supported housing)[5].

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[1] Government of Canada (2006) The human face of mental health and mental illness in Canada. Retrieved from http://www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php

[2] Kessler, 2005; Davis, 2003; Vander Stoep A. et al, 2000; Carter EW & Wehby JH, 2003.

[3] According to available data from the Discharge Abstract Database (hospital use), the Medical Services Plan database (physician visits), the National Ambulatory Care Reporting System (emergency department visits), and PharmaNet (prescription drugs), Project 2015_0123.

[4] Child and Youth Mental Health and Substance Use: Service Utilization in the Health Sector for Fiscal Years 2009/10 to 2013/14. Prepared by: Business Analytics Strategies and Operations Branch, Health Sector Planning and Innovation Division, MoH, March 30, 2015 for the CYMHSU Collaborative, Project 2015_0123.

[5] MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIAR

FACT SHEET

- There are a number of initiatives underway across BC to enhance the C&Y MHSU serving system.
  - A new 10-bed inpatient unit at the HOpe Centre will open in spring 2017 and provide specialized, intensive services for youth aged 13 – 18 living with MHSU challenges.
  - A 10-bed Child and Adolescent Psychiatric Stabilization Unit at Surrey Memorial Hospital will open in 2017 to provide short-stay assessment and crisis stabilization for urgent access to psychiatric care.
  - The reopening of the renamed Ashnola at The Crossing will offer a 22-bed program to provide intensive residential substance-use treatment for youth and young adults aged 17-24 (March 2017).
- Renfrew House, a six-bed youth group home that opened in November 2014, offers housing, social supports and clinical care for youth, with $1.5 million in annual government support.
- The Child and Youth Mental Health and Substance Use Collaborative has health-care providers and other community members working together as part of 64 local action teams in all health regions to improve care and increase access to services and supports for children, youth and families struggling with MHSU issues. As of March 31, 2016, the Ministry, in partnership with Doctors of BC, has invested about $10.2 million in the collaborative since 2013.
- In 2015 the Ministry and MCFD launched an online map to make it easier for children, youth and families to locate MHSU services and navigate the system of supports and services around BC.
- In 2015, the Ministry and MCFD worked collaboratively with HAs to create a refreshed provincial youth to adult mental health transition protocol. The protocol is now being implemented across the province. Currently, the Ministry and MCFD are working to develop another provincial protocol to promote effective transitions for children and youth between acute and community MHSU services.
- The Ministry is working in partnership with MCFD to implement tools, guidelines and education for front-line staff to identify parents with MHSU and/or intimate partner violence concerns where children's safety is at risk, and to link family members to supports/services through a family-centered approach. In 2014 the initiative was expanded from 2 pilot sites to 20 locations. Province-wide implementation is planned for 2017-18.
- Foundry is launching five integrated youth centres - Kelowna, Campbell River, Prince George, North Shore Vancouver and Abbotsford - in addition to the existing Granville Youth Health Centre.

FINANCIAL IMPLICATIONS

- The Ministry $3 million to the InnerChange Foundation in March 2015, and $500,000 in base funding to each regional HA to support five integrated youth centres. In February 2017, the Province announced $2.8 million per year to support up to five additional centres for total of up to 11 centres.
- s.13,s.17 for the provision of a new online counselling resource, Youth Bounce Back, which will be based on the success of the adult-oriented program. This resource will serve an anticipated 3,000 youth per year with evidence-based, online therapy services for mental-health concerns, such as mild to moderate depression or anxiety.
- s.13,s.17
  s.13,s.17 for youth who are struggling with severe substance use disorders.
- s.13,s.17

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 15, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services; March 21, 2017
Heather Richards obo Teri Collins, ADM Health Sector Information, Analysis & Reporting; March 27, 2017

FACT SHEET

COMMUNITY MENTAL HEALTH AND SUBSTANCE USE BEDS

ISSUE

A range of mental health and substance use community residential treatment, residential care, and supported housing options are available for individuals with mental health and/or substance use problems in order to respond appropriately to an individual's service needs.

KEY FACTS

- A stable, supportive living environment is an important determinant of both physical and mental health and well-being. People who are struggling with substance use or their mental health require options to support their recovery and live effectively in their communities.
- Health authorities provide a wide range of community mental health and substance use programs for people with serious mental and or substance use disorders. These include short-term, intensive residential programs such as withdrawal management and substance use residential treatment programs, and longer-term housing such as community residential care, family care homes, and supported housing.
- Through a partnership with BC Housing and Health Authorities, the BC Housing Health Services Program provides increased access to safe and affordable housing directly managed or funded through BC Housing for individuals with mental health and/or substance use problems.
- As shown in Table 1, mental health beds have increased by 153 percent since 2001, and substance use beds have increased by 206 percent since 2003.

Table 1: Mental health and substance use community residential beds in BC by region, September 2016

Health Authority	Substance Use Beds		Mental Health Beds	
	2003[1]	2016[2]	2001[3]	2016[2]
IHA	121	151	548	1,111
FHA	286	380	1,498	3,355
VCHA	173	1,514	1,769	5,782
VIHA	113	495	930	1,671
NHA	181	97	195	441
PHSA		34		151
BC Total	**874**	2,671	**4,940**	12,511

[1] *Health authority survey;*
[2] *MHSU Bed Survey, September 30, 2016, Project 2016_0202, HSIARD*
[3] *Health authority survey (note: excludes data on Rental Subsidies, Community Crisis Stabilization Units and Emergency Shelter or Short Stay Crisis Residential Care beds)*

Mental Health Community-Based Care

Health authorities provide community mental health care through three main programs: Licensed community residential care facilities, family care homes, and community crisis stabilization beds. Community residential care facilities are licensed under the *Community Care and Assisted Living Act* for individuals who cannot live independently. These facilities range in size from 6 to 30 beds. Family care homes, while unlicensed, also provide care for individuals who cannot live independently and require supports in a family setting. Family care homes accommodate up to two residents, and have to meet requirements set out by each health authority. Community crisis stabilization beds are a community-based alternative to inpatient crisis stabilization for voluntary patients benefitting from a community and more home-like setting.

FACT SHEET

Substance Use Intervention and Treatment Beds

Health authorities are responsible for providing substance use services in a variety of community residential settings. Community substance use treatment and intervention services include:

- Sobering and assessment: Short-term (less than 24 hours) safe place for people under the influence of substances. Monitoring of health is provided as it relates to acute intoxication.
- Adult and youth withdrawal management: A hospital, community residential (non-hospital), or a supportive residential setting, where Individuals going through the acute stages of withdrawal from substances are medically monitored or supervised.
- Adult and youth transitional services: A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems, and requiring short- to medium- term supports.
- Adult and youth residential treatment: Time-limited, live-in intensive treatment for individuals who are experiencing substance use problems, and whose assessment indicates that they will be effectively served through intensive treatment. Settings are usually licensed under the Community Care and Assisted Living Act (CCALA). Programs generally range from 30-90 days.
- Adult and youth supportive recovery: A temporary residential, substance-free setting that provides a safe, supportive environment for individuals who are experiencing substance use problems and require time-limited supports. These beds meet the needs of individuals who are preparing to enter residential treatment, or those who have left more intensive residential treatment but who require additional support to reintegrate into the community, or for those requiring a longer term structured environment while preparing to transition into a more stable lifestyle. (For more details see *Government Commitment to 500 Additional Addiction Spaces* fact sheet).

MHSU Supported Housing

Health authorities provide a significant number of MHSU supported housing units for people with severe MHSU disorders, however not all housing available to clients in BC are funded by health authorities. Supported housing services are delivered through an array of configurations that include three core components: Affordable and safe permanent housing, home support services, and MHSU clinical case management services. Models include clustered supported housing, congregate care, wet housing for clients with severe substance use problems, and scattered supported housing such as the Supported Independent Living Program (SILP). Supported housing is not regulated by the assisted living registrar.

Role of BC Housing

BC Housing is responsible for providing access to safe, affordable and appropriate mainstream housing for people in greatest financial need, including subsidized housing for individuals with mental health and substance use problems.

FINANCIAL IMPLICATIONS

The mental health and substance use sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71 percent over the 2000/01 total of $851.4 million.

Approved by:

Sharon Stewart OBO Doug Hughes, ADM Primary and Community Care Policy; March 16, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services Division; March 31, 2017
Christine Voggenreiter obo Teri Collins, ADM, Health Sector Information, Analysis and Reporting Division; March 17, 2017

FACT SHEET

DOWNTOWN EASTSIDE REDESIGN

ISSUE

Vancouver Coastal Health (VCH) has completed a two-year comprehensive consultation process to determine the best approaches to build on the improved health outcomes in the Downtown Eastside (DTES). A design paper was developed, and feedback from communities and agencies was received to support a three year implementation strategy. The strategy is well underway, and new initiatives have been implemented.

KEY FACTS[1]

VCH spends $58 million in yearly funding for health care in the DTES, including direct VCH services and 16 external contracted agencies, offering a total of 68 health programs and services. The DTES is made up of approximately 12 square blocks with a resident population of 18,000. Of these residents, about 10,000 people use hospital and non-geriatric community care annually.

- A 2016 study by Simon Fraser University (SFU) found that the number of people in the DTES who come from outside of Vancouver has risen significantly in the past decade to 52 percent from 17 percent. Researchers surveyed 433 residents of the DTES who met criteria for chronic homelessness and serious mental illness, examining the location of each participant over the past 10 years.[2]
- In 2015, SFU examined the costs of people in the DTES making frequent use of healthcare, corrections, income assistance and social services. It concluded that about 100 people with severe mental health and substance use problems incurred costs of $27.5 million in five years; about half of the total costs were linked to health care services.[3]
- There has been significant improvement in health outcomes in the DTES over the past 15 years, but it remains a community where some of Vancouver's most marginalized, addicted, and chronically ill clients reside, and an area to which people migrate from other areas of Canada.
- VCH consulted with the community regarding services were funded, how well agencies worked together, and what could be done to improve the health of those living in the DTES. VCH also solicited innovative and cost-effective ideas from VCH staff, physicians and service providers about how to respond to the challenges.
- Based on that feedback, VCH developed a design paper, the Downtown Eastside Second Generation Health System Strategy which discusses five approaches to improve care:
  - Strengthened relationships with partners;
  - Expanded care teams and competencies (e.g. VCH job descriptions and Schedule A contracts requiring staff be knowledgeable in Aboriginal cultural safety, needs of aging clients, trauma-informed care, workplace safety, etc.);
  - Integrated services for better coordinated care (e.g. using a clinic model that identifies a most responsible provider who is the lead for coordinating a client's care);
  - Alignment of services with client demand (e.g. expanding overdose prevention training using the Train the Trainer model to build capacity for peers and colleagues); and
  - Achievement of performance excellence (e.g. developing service definitions and outcome measures consistently across contracted and VCH direct services).

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[1] Ryan Jabs, Director, Health Communications Office, email: DTES IN, February 11, 2015

[2] 2016, SFU study, author: Julian Somers "Migration to the Downtown Eastside, neighbourhood of Vancouver and changes in service use in a cohort of mentally ill homeless adults: a 10-year, retrospective study".

[3] 2015, SFU study, High-frequency use of corrections, health, and social services, and association with mental illness and substance use. Authors: Julian M. Somers1*, Stefanie N. Rezansoff1, Akm Moniruzzaman1 and Carmen Zabarauckas2

FACT SHEET

- In March 2015, a peer support framework was developed to support a continuum of peer support services across VCH and contracted services.
- In June 2015, a shelter pilot was developed to improve transitions from acute care to the community.
- In the fall of 2015, a peer navigation program was developed and implemented by the Canadian Mental Health Association for the urban Vancouver area. People with a history of mental health and or substance use (MHSU) problems were employed to help others access services.
- Since November 1, 2015, new hours for Insite have been implemented to provide better access in the morning, when demand for supervised injection services are highest.
- In April 2016 VCH announced the opening of a new DTES MHSU Drop-in centre that improved support services provided to vulnerable clients to strengthen connections to the health care system.
- In September 2016 VCH announced the completion of a new Integrated MHSU Health Service Delivery model within the DTES through a multi-phased approach. The new Integrated Health Services Delivery Model requires reconfiguration of teams, work sites, work schedules and job descriptions, including:
  - Establishment of three Integrated Health Centres (to be named Pender, Powell and Heatley)
  - Establishment of "Primary Care Homes and Special Care MHSU programs," through:
    - Six Integrated Care Teams, each comprised of a mix of disciplines including RNs, RPNs, LPNs, community liaison positions, social workers, nurse practitioners, counsellors and peers, supporting clients with VCH-funded physicians or nurse practitioners;
    - Community Care Services, in which care teams support clients who have private practice family physicians;
- In January 2017, VCHA announced the opening of 38 substance use treatment beds for women in the DTES. The 38 new spaces are part of the Province's commitment to open 500 new substance use treatment beds throughout the Province, including 131 in the Vancouver Coastal Region.[4]
  - In February, 2017 a preliminary report was developed of the Vancouver 1st phase Collective Impact project. This project was initiated in 2015 as an experimental initiative flowing from the Mayor's *Task Force on Mental Health & Addiction*. Its task was to explore the readiness for creating a common framework of success and action for the MHSU system across the system's diverse stakeholders. The development of this report is funded jointly by VCH, the City of Vancouver, The Vancouver Foundation, and the Pacific Blue Cross Foundation.
  - In March 2017, VCH is introducing a new service, the DTES Connections Team for people with untreated substance use disorders. The DTES Second Generation Strategy identified the need for low barrier services that are well integrated with other health services. The Connections Team will provide fast access to evidence-based treatment and supports, such as opioid replacement therapy, withdrawal management and other clinical and psychosocial supports.

FINANCIAL IMPLICATIONS

There is no net new funding associated with this redesign. VCH's financial commitment to the DTES has increased by $1 million from within its existing allocation; VCH plans to use resources more effectively through a coordinated system, with better monitoring of client need and outcomes. In 2014/15, the Ministry of Health provided VCH with $2 million to be used to strengthen approved services for the SAMI population, and an additional $2 million to support two additional ACT teams.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 17, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services; March 21, 2017

[4] http://www.vch.ca/about-us/news/news-releases/new-substance-treatment-services-for-women-on-the-Downtown-Eastside

FACT SHEET

Existing and Emerging Virtual Supports for e-MHSU in BC

ISSUE

Accessing Mental Health and Substance Use (MHSU) services and navigating the system are two key issues identified by patients, families and service providers.

KEY FACTS

The Ministry of Health is bringing together innovative technology solutions to provide individuals and physicians with user-friendly, free access to reliable information, screening tools, and psychological support options. A provincial Virtual Care Strategy is being developed to guide the Ministry's investment in technologies to improve healthcare. Within that strategy, e-MHSU services have the potential to bridge existing gaps by providing timely access to appropriate interventions in BC, and helping people locate supports before they reach crisis.

Crisis Lines

- The Crisis Line Association of BC provides two provincial numbers for crisis lines: 1-800-SUICIDE and 310-Mental Health Support network. They facilitate provincial routing to the closest of the 10 regional health authority-funded crisis lines, and receive approximately 150,000 calls per year.[1]
- Crisis Intervention & Suicide Prevention Centre of BC offers online chat, from 12:00pm to 1:00am via CrisisCentreChat.ca and YouthInBC.com. Trained volunteers provide youth and adults with an opportunity to talk openly yet confidentially when in distress or crisis, seek emotional support, and to locate referral services in their community.

HealthLink BC (HLBC) - is the largest provider of on-demand virtual care in BC. They offer 24/7 access to BC specific health information and health resources (web, telephone, text), and provide clinical advice and care through their telephone help line (811). This service offers clinical support and navigation assistance from Registered Nurses, Licensed Pharmacists, and Registered Dietitians to almost half a million contacts per year. Currently HLBC is coordinating a project to update, integrate and facilitate access to current BC web resources related to mental health services in BC.

Digital Web Hub – Website Consolidation Project – A digital web hub is being developed that centrally references all information and government funded services are already available to help all BC residents streamline navigation to MHSU support. The web hub, hosted on gov.bc.ca, will bring together more than 6,000 services from over 450 providers, focused on areas that help with anxiety and depression, eating disorders, substance use and more; ultimately it will be a starting point for individuals and their families looking for services, regardless of where they live in BC.

Provider On-Demand Clinical Services for e-MH

- RACE Line: BC's Rapid Access to Consultative Expertise - is a telephone line and mobile application, allows primary care providers to access just-in-time support for clinical questions to specialists, including local Psychiatrists.
- BC Emergency Health Services - offers telephone-based physician-on-call services for paramedics, and are developing eAmbulance and Community Paramedicine Capacities.
- The Patient Transfer Network offers up-to-the minute insight into emergency and hospital availability and workflows, as well as repatriation planning services.

Examples of e-MH Assessment and Treatment Tools

Bounce Back - is an evidence-based program for adults experiencing symptoms of mild to moderate depression and anxiety that offers self-directed Cognitive Behavioral Therapy (CBT) with over the phone coaching. Bounce BackOnline, an online, fully automated version of the program, is now

[1] http://www.crisislines.bc.ca/

available without a doctor's referral to adults in BC. A new web resource – Youth Bounce Back – will be developed in 2017/18 based on the success of the adult-oriented program. Electronic CBT (e-CBT) modules will be provided online, by video.

MindHealthBC - is a tool to help identify MHSU symptoms and to connect users with available online and community resources. It offers a screening quiz that can help identify what users are struggling with, and provides highly targeted recommendation pages that offer the most relevant and trustworthy support options based on patients' quiz results (e.g., Bounce BackOnline).

MindCheck.ca - is a teen and young adult-focused interactive website, offering quick self-assessments and connections to early supports. In partnership with the Ministry, this site is being revamped to strategically align with the Foundry online portal, to better integrate care services in BC.

Strategic Investment Fund (SIF): MHSU Virtual Clinic, Limited Production Roll-out - The Ministry, in partnership with TELUS, is developing an e-MHSU platform that will support select cohorts suffering from mild to moderate MHSU issues using SIFs. The Virtual Clinic will offer e-CBT modules, counselling appointments via video chat, and online peer support forums through a customizable Personal Health Record. These supports will be accessible to clients via a secure log in at any time of day. With a projected launch for Winter 2018, this limited production rollout will be available to youth connected to the Foundry, and BC Emergency Health Services Paramedic employees. This service is anticipated to serve an additional 10-12,000 clients per year through online connections with clinicians tied to on-the-ground services in communities across BC.

Virtual Care for Residents in First Nations, Rural and Remote Communities - Since 2015, the First Nations Telehealth Expansion Project has engaged 70 new health care service providers, and provided over 45 First Nations communities with virtual capabilities. Telehealth has demonstrated that it can be used to provide improved access to physician services in a culturally sensitive manner. In June 2016, the Joint Standing Committee approved additional funding to assist Carrier Sekani Family Services to further develop this service for potential broader application.

FINANCIAL IMPLICATIONS

- Based on a 2013 report, the Ministry, through the health authorities provided approximately $2.1 million annually to support 12 regional crisis lines. In addition, PHSA provided $180,000 to the Crisis Line Association of BC in 2014/15 and 2015/16 to support 1-800-SUICIDE and 310-MENTAL Health Support networks.
- s.13,s.17
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Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 28, 2017
Daryl Conner, obo Manjit Sidhu, Finance and Corporate Services Division; May 15, 2017
Nancy South, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; June 15, 2017

[2] https://news.gov.bc.ca/factsheets/factsheet-comprehensive-mental-health-and-substance-use-services-in-bc
[3] As per e-mail from Gina Curran, Director Investment Management, Ministry of Technology, Innovation and Citizen's Services dated March 16, 2017
[4] s.13,s.17

FACT SHEET

Foundry Youth Service Centres

ISSUE

An overview of Foundry youth service centres, formerly the BC Integrated Youth Services Initiative (BC-IYSI).

KEY FACTS

- Foundry is a network of centres and e-health services co-created with health and social service partners, young people and families in communities across BC.
- Foundry youth service centres are intended to improve mental health, substance use and primary care access and care for youth and young adults in communities across BC.
- Foundry brings health and social services together in a single place to make it easier for young people to find the care, connection and support they need.
- Foundry is in the process of launching 5 integrated youth centres in BC – Kelowna, Campbell River, Prince George, North Shore Vancouver and Abbotsford – in addition to the existing Granville Youth Health Centre. Campbell River opened in March 2017, Kelowna opened in June 2017, and North Shore Vancouver opened in July 2017. Prince George expects to open by mid-September 2017, with Abbotsford slated to open late 2017.
- Funding is provided by public and philanthopic organizations to implement and support the 5 Foundry service centres in communities across BC, including:
    - Ministry of Health/regional health authorities
    - Graham Boeckh Foundation
    - St. Paul's Foundation
    - Michael Smith Foundation for Health Research
    - Pledge commitments from InnerChange Foundation
- Additional in-kind resources from the Ministries of Children and Family Development (MCFD), Social Development & Social Innovation, five lead agencies and their local governments, community and non-profit partners will also help support the centres.
- The Foundry Governing Council is co-chaired by the Ministry and MCFD, and includes members from the St Paul's Foundation, Graham Boeckh Foundation, and Michael Smith Foundation for Health Research.

<u>Background</u>

- A central "Backbone Organization" was created in October 2015 to support the development of 5 integrated health and social service centres. The Backbone Organization consists of 12 subject matter experts and has been funded through philanthropic organizations. In 2017/18, the Ministry is contributing to funding the Backbone Organization.
- The main functions facilitated by the Backbone Organization include: Clinical operations and planning, policy alignment and partnership development, knowledge translation, research and evaluation, communications, site development and fund raising.
- With the support of the Backbone Organization, lead agencies and their partners will be expected, as members of the Foundry network, to provide standardized services based on core care principles and practices.
- The Ministry, in partnership with TELUS, is working with Foundry to develop a virtual clinic to support the 5 sites. The virtual clinic will enable clients to access evidence-based interventions, including e-Cognitive Behavioural Therapy, self-management applications and health literacy tools. For individuals with the most intensive needs, supports will be available from a mental health and substance use (MHSU) counsellor or psychologist, with additional psychiatry, physician or nurse

practitioner back-up support also available through Foundry sites. The virtual clinic will be able to provide youth and young adults (YYA), familiar with online mediums and web-based services, an opportunity to receive MHSU care in a discreet and low-barrier point of engagement.

- In the fall of 2013, the Select Standing Committee on Children and Youth agreed to undertake an initiative to examine child and youth mental health in BC. The Committee released its final report *Child and Youth Mental Health in British Columbia: Concrete Actions for Systemic Change* in January 2016, and identified 23 recommendations to improve child and youth mental health services. Recommendations include making multi-year funding available for integrated service delivery programs, with a focus on "hub" site approaches, and targed plans for youth 16-24 yrs.

FINANCIAL IMPLICATIONS

The following funding has been or will be provided to support the development and implementation of integrated youth services and sites:

Integrated Youth Services Related Funding ($ Millions)	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20 and On-going
					s.13,s.17	
InnerChange Foundation (one-time funding)	3.0					
Regional Health Authorities (RHA base funding)			2.5	2.5		
Increase to RHA base funding				1.0		
Increase to RHA base funding						
Providence Health Care (BackBone support)				1.8		
PHC (continuing support for BackBone)						
Total Annualised Funding				**5.3**		

- The Ministry provided $3 million to the InnerChange Foundation in 2014/15 to develop and implement 5 integrated youth MHSU service hubs in communities across BC, in partnership with non-profit service delivery providers.
- In February 2017, the Province announced $8.4 million ($2.8 million per year s.13,s.17) to support up to 5 additional centres (see table above).
- s.13,s.17
-
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Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; July 12, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; July 13, 2017
Christine Voggenreiter, obo Teri Collins, Health Sector Information, Analysis and Reporting Division; July 17, 2017

FACT SHEET

Intensive Case Management Teams

ISSUE

People with severe substance use problems have difficulties living in the community, experience high rates of homelessness and overdose[1], and are frequently in contact with emergency services.[2] The Ministry of Health and the health authorities developed Intensive Case Management Teams (ICMT) to address the complex needs of this population.

KEY FACTS

- An estimated 130,000 people in BC live with severe mental illness and/or substance use disorders. These disorders have a significant impact on their ability to actively engage in personal, social, and/or occupational areas of daily life.[3]
- These individuals experience barriers in accessing existing health or social services. They have higher rates of poverty and challenges related to community living including housing and the criminal justice system.[4]
- In response to the complex needs of this population, the Ministry and the health authorities developed the ICMT model, an intensive community outreach-based model of wrap-around service provision for individuals and their families, impacted by problematic substance use (with or without mental illness).
- ICMTs engage clients by providing and coordinating direct community services and supporting individuals and families to navigate social support systems.
- ICMTs are comprised of nurses, clinical addiction specialists and peer support workers, with additional clinical support from general/nurse practitioners, addictions medicine specialists, and psychiatrists.[5]
- The goals of ICMTs are to improve health, social functioning, and access to care. ICMTs provide a low staff-to-client ratio (1:16 up to 1:20), frequent client contact, outreach-oriented services, and harm reduction approaches.[6]
- The *ICMT Model of Care: Standards and Guidelines (Standards and Guidelines)*, released by the Ministry of Health in 2014, provides a provincial framework outlining the requirements for an ICMT model of care for BC, based on evidence of the effectiveness and efficiency of intensive case management approaches.[7]
- The Standards and Guidelines apply to ICMTs targeting adults 19 years of age or older, with problematic substance use or chronic dependence (with or without mental illness), concurrent disorders (substance use and mental illness), or co-existing functional impairments.
- ICMTs have also been implemented for youth with moderate to severe substance use problems, concurrent disorders, and/or mental illness who are homeless or likely to become homeless. The Inner City Youth program and North Shore Intensive Youth Outreach Service in Vancouver Coastal Health Authority operate the only 2 youth ICMTs in the province. Island Health`s Mount Waddington ICMT also provides services tailored specific to youth.

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[1] BC Centre for Disease Control. (2014). *British Columbia Drug Overdose & Alert Partnership Report*. Retrieved from http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Publications/Epid/Other/FinalDOAPReport2014.pdf

[2] Vancouver Police Department. (2013). *Vancouver's mental health crisis*. Retrieved from: http://vancouver.ca/police/assets/pdf/reports-policies/mental-health-crisis.pdf.

[3] Patterson et al. (2008). *Housing and Supports for Adults with Severe Addiction and / or Mental Illness in BC*. Vancouver, BC: *Centre for Applied Research on Mental Health and Addiction*. pg. 8.

[4] British Columbia Ministry of Health. (2014). *Intensive Case Management Team Model of Care Standards and Guidelines*, page 5.

[5] British Columbia Ministry of Health. (2014). *Intensive Case Management Team Model of Care Standards and Guidelines*, page 42.

[6] Ibid.

[7] Ibid.

FACT SHEET

- Key provincial strategies have supported the development of ICMTs in recent years:
  - The November 2013 provincial action plan *Improving Services for Individuals with Severe Addiction and Mental Illness* supported the development of the Youth ICMT in Vancouver Coastal, and the 3 new teams each in Northern Health and Island Health.[8]
  - ICMTs in Interior Health were initially funded through the Acceleration funds linked to the Integrated Primary and Community Care initiative.
  - The Ministry's *Integrated Primary and Community Care* (2015) paper identifies ICMT as a best practice model.
- Intensive case management is effective for engaging clients with problematic substance use, and, in some cases, may be effective in reducing substance use.[9] Research has shown reductions in hospitalizations for participants with frequent use of the services of ICMTs.[10]
- The expansion of ICMT services aligns with provincial strategic directions to improve outcomes for individuals with moderate to severe MHSU conditions through increased integration of primary and community care.
- As of May 2017, there are 28 ICMTs across the province, located in the following health authorities: Fraser Health (3), Interior Health (6), Island Health (6), Northern Health (3), and Vancouver Coastal (10 including 2 youth teams).

Intensive Case Management Teams across B.C. (ICMT) May 2017[11]

Health Authority	Number of ICMTs	Location
Fraser Health	3	Surrey Maple Ridge Langley
Interior Health	6	Western region (Kamloops, Williams Lake) Central region (Vernon, Penticton) Eastern region (Cranbrook, Nelson)
Island Health	6	Victoria (2 teams) Nanaimo Comox Port Alberni Mount Waddington
Northern Health	3	Fort St. John Prince George Terrace
Vancouver Coastal Health	10	Vancouver (4 teams including 1 youth team) North Shore (6 teams including 1 youth team)
BC Total	**28**	

FINANCIAL IMPLICATIONS

N/A

Approved by:

Sharon Stewart, Primary and Community Care Policy Division; August 4, 2017

Aureleo Reyes, obo Manjit Sidhu, Finance and Corporate Services Division; August 9, 2017

[8] Ministry of Health. (2013). *Improving Health Services for Individuals with Severe Addiction and Mental Illness.*

[9] Sun, A.-P. (2006). Program factors related to women's substance abuse treatment retention and other outcomes: A review and critique. Journal of Substance Abuse Treatment. 30(1): p. 1-20.

[10] Sun, A.-P. (2006). Program factors related to women's substance abuse treatment retention and other outcomes: A review and critique. Journal of Substance Abuse Treatment. 30(1): p. 1-20.

[11] Ministry of Health. (2017). *ACT, ICM and AO Team Regional Breakdown Data.*

FACT SHEET

JUSTICE SYSTEM AND MENTAL HEALTH AND SUBSTANCE USE CLIENT POPULATION

ISSUE

Individuals with mental health and substance use (MHSU) problems are over-represented within the criminal justice system, requiring an integrated and collaborative response. The Ministry of Health (the Ministry) in partnership with the Ministry of Justice (MoJ) and Health Authorities (HAs) are working on key inter-ministerial initiatives to address the needs of individuals experiencing MHSU problems who are in contact with the criminal justice system, including police and correctional services.

KEY FACTS

- Individuals involved in the criminal justice system often have difficulty accessing and maintaining engagement with mainstream community MHSU services. Facilitating access to existing services and supports, and examining current outreach strategies are key priorities for this client population.
- Research shows a high prevalence of mental illness and/or problematic substance use within the population served by the criminal justice system.
  - Individuals with mental illness are three times more likely to interact with police than the general population,[1] are more likely to be victims of violence than perpetrators,[2] and approximately one-third of contact with police involves the use of substances.[3]
  - Sixty percent of adults in contact with BC Corrections (both in-custody and community corrections) have been diagnosed with a mental illness and/or substance use disorder.[4]
  - Individuals with substance use disorders (with or without a co-occuring mental disorder) have double the amount of convictions as those with mental disorders or no diagnosis, and are at increased risk of reoffending.[5] Individuals with MHSU disorders also make 2.5 times greater use of publicly funded services and health care services.[6]
  - Aboriginal people are associated with significantly higher levels of corrections involvement, and lower levels of health services utilization than non-Aboriginal people.[7]
- HAs provide a range of MHSU services for this client population including:
  - Community MHSU services for individuals not in-custody (e.g. on probation), and/or who do not require intensive interventions to safely manage their risk of violence.
  - The Provincial Health Services Authority (PHSA) is responsible for Forensic Services provided by six regional Forensic community clinics and the Forensic Psychiatric Hospital (190 beds).[8,9]
  - Responsibility for health services in BC Corrections (adult custody), including MHSU services is anticipated to be transferred to the PHSA in 2017/18. Health services are currently provided by a single private service provider.

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[1] Cotton, D. & Coleman, T. G. (2010) *Reducing Risk and Improving Outcomes of Police Interactions with People with Mental Illness*, Journal of Police Crisis Negotiations, 10:39-57, page 40.

[2] Mental Health Commission of Canada. (2012). http://strategy.mentalhealthcommission.ca/pdf/strategy-text-en.pdf, page 46.

[3] McCormick, et al. (2011). *Policing Persons under the Influence of Drugs and Alcohol in Vancouver, British Columbia*, page 24.

[4] Somers, J.M. (2015). *Mentally Ill Offenders: The Intersection of Public Health and Public Safety*. Somers Research Group, Facility of Health Services, Simon Fraser University. Page 46.

[5] Ibid.

[6] Somers, J.M., Cartar, L., & Russo, J. *Corrections, Health, and Human Services: Evidence-Based Planning and Evaluation.* (2008). Centre for Applied Research in Mental Health and Addictions at Simon Fraser University, page 3. Retrieved electronically on May 7, 2014 from http://summit.sfu.ca/item/11163

[7] Somers, J.M., Cartar, L., & Russo, J. *Corrections, Health, and Human Services: Evidence-Based Planning and Evaluation.* (2008). Centre for Applied Research in Mental Health and Addictions at Simon Fraser University, page 3. Retrieved electronically on May 7, 2014 from http://summit.sfu.ca/item/11163

[8] BC Mental Health and Addiction Services. (n.d.) Retrieved January 31, 2013 from http://www.bcmhsus.ca/forensic-psychiatric-hospital

[9] *Mental Health and Substance Use (MHSU) Bed Survey. (September 2016). Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health. Project: 2016-0202.*

FACT SHEET

- The Ministry, HAs, and the MoJ are committed to addressing the needs of individuals with MHSU problems in contact with the justice system through collaborative, integrated responses. The Ministry and MoJ are jointly engaged in several initiatives to improve prompt access to MHSU services, continuity of care and service linkages for this population, and to enhance community safety through a reduction in re-offending.
- **Current provincial and regional initiatives:**
  - Partners in Change: This project, an inter-ministry partnership initiative with MoJ, will improve the continuity of care for adults with MHSU problems in contact with Corrections, both in custody and community corrections. Deliverables include a provincial service framework (expected completion summer 2017), transition protocols and information-sharing protocols between HAs and BC Corrections.
  - Options for Involuntary Treatment under the *Mental Health Act (MHA)*: Work is underway between the MoJ and MoH to address the issue that a significant and increasing number of inmates with severe MHSU disorders do not have timely access to involuntary mental health treatment. The project will develop policy recommendations, and a proposed pilot for MoH and MoJ in 2017/18 to reduce the duration of untreated, severe mental disorders.
  - Interfaces between MHSU Services and Police Services: The MoH, in partnership with the MoJ, is developing a provincial toolkit to guide HAs and police agencies in the development of joint local protocols/agreements at several interface points, including:
    - Suicidal events: Police respond to calls about potentially suicidal individuals;
    - Wandering/elopement from a health care facility. For example, Island Health and the RCMP hold regular meetings to discuss drivers behind people going missing, review the physical layout of facilities, and identify a liaison person to facilitate response if needed. (Also, please see Fact Sheet: *Missing Seniors* for further details regarding provincial approaches addressing health and safety concerns concerning wandering among seniors);
    - Section 28 Apprehensions and Leave Recall situations under the Mental Health Act;
    - Joint MHSU-police response teams: (e.g. Car 87 in Vancouver);
    - Information sharing between police and health.

    Joint local protocols between HAs and police will facilitate effective, efficient and integrated responses to people with MHSU problems. Target completion of toolkit: June 2017.
- **Key collaborative initiatives between the MoJ and health authorities include:**
  - Joint Initiatives between Police and HA MHSU Services: In five BC communities, mobile response teams provide a joint health and police response to people in a mental health crisis with on-site crisis intervention, assessment, and referral to appropriate services (Kamloops, Prince George, Surrey, Vancouver, Victoria). There are also 20 Assertive Community Treatment Teams in BC that work in partnership with local police to support individuals with complex care needs. Vancouver Coastal Health, West Vancouver and Vancouver Police Departments, and the RCMP are collaborating to address the needs of MHSU clients in crisis when presenting to the emergency department. Island Health is also working on processes to ensure smoother transitions for individuals brought to emergency departments by police.
  - Downtown Eastside (DTES) Initiatives: Vancouver Intensive Supervision Unit, Drug Court, and Downtown Community Court address the complex needs of MHSU clients within the DTES.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 17, 2017

Christine Voggenreiter obo, Teri Collins, ADM Health Sector Information, Analysis & Reporting Division; March 17, 2017

FACT SHEET

MENTAL HEALTH ACT OVERVIEW

ISSUE

The *Mental Health Act* outlines the legislative requirements for involuntary care and those facilities in BC that have been designated to provide this level of care. The main purpose of the Act is to provide authority, criteria and procedures for involuntary admission and treatment, while safeguarding individual rights.

KEY FACTS

- The Act, updated in 2005, sets out the authority, criteria and procedures for involuntary admission and treatment of people with mental disorders in designated mental health facilities. The Act also contains protections to ensure these provisions are applied in an appropriate and lawful manner.
- Facilities designated under the Act as of February 16, 2016, include:
  - 23 Provincial mental health facilities, providing specialized inpatient treatment, tertiary care, and/or treatment of sub-populations such as forensic clients;
  - 38 Psychiatric Units located in acute care hospital, providing inpatient treatment; and
  - 10 Observation Units providing short-stay in rural hospitals, for stabilization and/or transfer.[1]
- In 2015/16, a total of 25,780 individuals admitted to BC hospitals received health care for mental illness and substance use problems, an increase of 36 percent since 2006/2007. Of these individuals, a total of 11,415 (44 percent) received voluntary mental health treatment, while 14,455 (56 percent) received involuntary mental health treatment. The number of individuals receiving voluntary treatment increased by 7 percent, while those receiving involuntary treatment increased by 72 percent over the eight-year period from 2006/2007 to 2015/16[2].
  - The involuntary treatment rate per 100,000 BC residents grew from 193 to 309 from 2006/07 to 2015/16 (61 percent).[3] These increases may be impacted by increased patient complexity including those with concurrent disorder and severe substance use problems, the aging population of those with mental illness, as well as initiatives to help reduce stigma, resulting in proper identification of individuals requiring treatment.
  - During this time period, average length of stay has decreased slightly for involuntary patients from 17 to 14 days, while increasing for voluntary patients from 10 to 12 days.[4]
- In 2015/16, 2,382 people discharged from hospital were on Extended Leave provisions under the Act. This number has increased by 1,538 (282 percent) since 2008/09.[5] Clients on Extended Leave over 12 months are informed of their right to a review at least once a year.
- A person can only be involuntarily admitted under the Act if all four admission criteria are met:
  - Is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment, or to associate with others;
  - Requires psychiatric treatment in or through a designated facility;
  - Requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration, or for the person's own protection or the protection of others; and
  - Is not suitable as a voluntary patient.
- To provide legal authority for an involuntary admission for an initial 48-hour period, a medical certificate must be completed by a physician. The completed medical certificate provides authority to take the person to a designated mental health facility.

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[1] http://www.health.gov.bc.ca/healthy-minds/pdf/designations-list.pdf
[2] Hospital Discharges with MH Dignosis Treated Involuntarily 2006-2014 - with Age Category-by case count.xlsx; BASO Project2016-0164; Data extracted on January 2016
[3] ibid.
[4] Ibid.
[5] Hospital Discharges with MH Diagnosis Treated Involuntarily 2002-2014 - with Age Category-by case count; Extended Leave Table 1 PID; PAS2016-0164; Extracted January 2016.

- A second medical certificate by a different physician must be completed within 48 hours of admission; otherwise the patient must be discharged or admitted as a voluntary patient. Subsequent medical certificates must be renewed by the end of the first, second and fifth month of admission; and then at subsequent six month intervals.
- Section 37 of the Act permits the director of the designated mental health facility to place an involuntary patient on Extended Leave from the facility. Leave means that a patient is authorized to be absent from the facility to live in the community providing appropriate support services exist to meet the conditions of Extended Leave.
- The Act also contains protections to ensure that the provisions are applied in an appropriate and lawful manner. For example, hospital staff must inform involuntary patients verbally, and provide written notification of their rights promptly upon admission, including the right to have their involuntary admission reviewed by a Review Panel and the right to retain legal counsel.
- The Mental Health Review Board is an independent, quasi-judicial administrative tribunal, established in April 2005, which conducts review panel hearings under the Act upon request by the client. It is made up of a chair and members appointed by the Minister under the Act. The Board conducts hearings to review and decide whether persons detained in or through any designated mental health facility in the province should continue to be detained, based on criteria in the Act (for further information, see the Fact Sheet entitled *Mental Health Review Board*).
- The Ministry developed a Guide to the Act which answers common questions about the Act. It is available at: www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf.
- In 2011, the Ministry and health authorities conducted the first BC Mental Health and Substance Use Survey of individuals who experienced a short-stay inpatient service. Feedback was provided by 6,615 people (65 percent response rate) who were recently discharged from one of 102 short-term mental health or substance use treatment facilities in BC.[6] While there are some areas for improvement, 87 percent of mental health patients and 95 percent of substance use clients rated the overall quality of their care as good, very good, or excellent.[7]
- In September, 2016 the Attorney General of BC received a Notice of Constitutional Question and a Notice of Civil Claim questioning the constitutional validity of sections of the Mental Health Act, the Health Care (Consent) and Care Facility (Admission) Act and the Representation Agreement Act that concern the ability of involuntarily detained patients to consent to treatment. The plaintiffs consist of two individuals and the Council of Canadians with Disabilities who are represented by the Community Legal Assistance Society (CLAS). The Ministry of Justice, in partnership with the Ministry , will be defending the legal challenge. A response to the Notice of Civil Claim was filed in November 2016, and Ministry document search and disclosure meachanisms are underway. It is expected that the litigation process will take about two years (2018) until the Supreme Court will hear the case.

FINANCIAL IMPLICATIONS

s.13,s.14,s.17

Approved by: Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 15, 2017
Nancy South obo Teri Collins, ADM Health Sector Information, Analysis & Reporting; July 5, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services; July 13, 2017

[6] R.A. Malatest & Associates Ltd. *Patient Experiences with Short-Stay Mental Health and Substance Use Services in British Columbia: 2010 -2011*. p. 6. November 1, 2011. Retrieved electronically June 24, 2013, from: http://www.health.gov.bc.ca/library/publications/year/2011/BCMHSU-DescriptiveReport-2011.pdf
[7] Ibid. For survey results, see p. 7.

FACT SHEET

Mental Health and Substance Use Crisis Intervention Services

ISSUE

Police agencies throughout BC are reporting increases in the number of police calls due to mental health and/or substance use (MHSU) crisis (a MHSU crisis is defined as an acute disturbance of thinking, mood, behaviours or social relationships that requires an immediate intervention). Health authorities and police departments are increasingly developing protocols and guidelines to ensure a more integrated approach to MHSU crisis intervention.

KEY FACTS

Current Array of Health Authority Crisis Intervention Services

- **Crisis lines** are a telephone service provided by paid and volunteer staff, operating 24/7, offering emotional support, crisis and suicide assessment/intervention and resource information. Health authorities provide funding to support 10 regional crisis centres. In addition, the Provincial Health Services Authority (PHSA) provides funding support to the Crisis Line Association of BC in the operation of the 2 provincial network lines (1-800-SUICIDE and 310-Mental Health Support). The 10 regional crisis centres in the province collectively answer over 120,000 MHSU calls each year.
- **Mobile crisis outreach** consists of partnerships between health authority MHSU services and local police departments to provide outreach to individuals experiencing mental health crises. There are 5 joint MHSU-Police mobile crisis response teams based out of Kamloops, Prince George, Surrey, Vancouver, and Victoria (e.g., Integrated Mobile Crisis Response Team serves southern Vancouver Island).
- **Community Crisis Stabilization Units** are licensed facilities under the *Community Care and Assisted Living Act* and provide 24/7 assessment, treatment, stabilization, and referral for follow-up services, with a primary focus on psychiatric treatment. There are 62 community crisis stabilization beds in BC[1] (e.g. Surrey Community Residential Emergency Short Stay Treatment).
- **Crisis Residential Care Units** provide short-term crisis stabilization services for people with MHSU problems who are having acute psychosocial crises, such as eviction, job loss, or substance use overdose temporarily impacting their daily functioning. MHSU staff (available 24/7), assist clients in resolving their immediate crises. Currently there are 54 beds that provide this crisis stabilization.[2]
- **Sobering and Assessment Beds** provide short-term (< 24 hours) safe places for people under the influence of substances to receive observation, supervision and support while sobering up and linking to appropriate supports for housing and treatment services. There are 60 sobering and assessment beds in the province (25-Quibble Creek, Surrey, 20-Victoria, and 15-Vancouver Detox Centre).[2]
- **MHSU services in hospital emergency departments** provide specialized assessment, treatment, crisis intervention and linkage to community resources to emergency department patients. Care is provided by MHSU staff such as psychiatric nurses and social workers (e.g., about 7,500 patients a year are assessed and treated at the emergency department[2] in Surrey).
- **Acute Care Short-Term Assessment Units** within a hospital (up to 48 hours) provide specialized assessment and crisis intervention for people who require a brief inpatient stay in order to stabilize (e.g., psychiatric emergency services at Archie Courtnall Centre in Victoria includes 4 brief-stay inpatient rooms).[2]
- **Designated Observation Units** in rural hospitals designated under the *Mental Health Act* to stabilize and treat involuntary patients for up to a maximum of 7 days. If more time is needed, patients may

[1] MHSU Bed Survey. (March 2016). March 2016 submissions to Community MHSU Bed Inventory, Business Analytics Strategies and Operations Branch, Health Sector Information, Analysis and Reporting Division, Ministry of Health. Project: 2016_0202

[2] Retrieved from: http://www.fraserhealth.ca/about-us/media-centre/news-releases/news-releases-archive/-0/surrey-memorial-hospital-s-new-mental-health-and-substance-use-emergency-zone April 27 2015

be transported to the nearest designated mental health facility for completion of treatment (e.g., Fort Nelson General Hospital and Wrinch Memorial Hospital in Hazelton).

- **Discharge planning from hospital-based services** is completed in all hospitals with clients and their families to assist them in avoiding and/or handling future crisis situations. Fraser Health offers classes run by trained peer facilitators who assist people to create their own recovery and crisis plans.

Provincial Ministry Initiatives to Enhance Current Continuum

- Enhanced crisis response services as part of the provincial action plan "Improving Health Services for Individuals with Severe Addiction and Mental Illness", such as:
  - An Acute Behavioural Stabilization unit at St. Paul's Hospital with 5 beds and 4 secure rooms.[2]
  - An Assertive Outreach Team, in partnership with the Vancouver Police Department, offers outreach for patients with the most severe and complex needs from St. Paul's and Vancouver General Hospitals' emergency departments.
  - Psychiatric Nurse Liaison Programs, established in Northern Health and Fraser Health emergency departments,[3] provide assessments, interventions, and linkage with community resources.
- The development of new guidelines to improve the interfaces between MHSU and police services. The Ministry of Health, in partnership with the Ministry of Justice, is developing a provincial toolkit to guide health authorities and police agencies in the development of joint protocols/agreements at various interface points, such as situations where an individual has wandered from a health care facility, or when a family calls police due to concerns about a potentially suicidal individual. Joint MHSU-police response teams and information sharing are overarching interface points. The establishment of local protocols between health and police agencies is expected to strengthen the use of effective, efficient and integrated responses to support people with MHSU problems who come into contact with police. Target completion of guidelines - June 2017.
- Enhanced crisis lines in BC - The Ministry has established a provincial advisory committee consisting of the PHSA , regional health authorities, the Ministry of Children and Family Development, Crisis Line Association of BC and regional crisis centres to follow through on actions identified in *An Implementation Plan for the Establishment of an Enhanced and Efficient Provincial Network*. Progress includes the development of a unified call record for use in all of the regional crisis centres, and creation of common training modules and standards for crisis line workers.

FINANCIAL IMPLICATIONS

- s.13,s.17

- In addition, PHSA provided $180,000 to the Crisis Line Association of BC in 2014/15 and 2015/16 to support 1800SUICIDE and 310MENTAL Health Support networks, which use routing technology to direct calls to the nearest crisis line network partner.

Approved by:
Sharon Stewart, obo Doug Hughes, Primary and Community Care Policy Division; February 28, 2017
Gordon Cross, obo Manjit Sidhu, Finance and Corporate Services Division; March 9, 2017

[3] Retrieved from: http://www.fraserhealth.ca/about-us/media-centre/news-releases/news-releases-archive/-0/surrey-memorial-hospital-s-new-mental-health-and-substance-use-emergency-zone April 27 2015

s.13,s.17

FACT SHEET

Mental Health and Substance Use Expenditures

ISSUE

BC has made mental health and substance use services a priority, as evidenced by a commitment to best practices, a significant increase in total financial expenditures for the mental health sector and the provision of protected capital funding for the redevelopment of the province's tertiary mental health resources.

KEY FACTS

- In November 2010, the Province released a 10-year plan to address mental health and substance use with a focus on prevention of problems, early intervention, treatment and sustainability. To ensure mental health and substance use services are evidence-based and cost-effective, BC is focusing on delivering programs more efficiently and effectively.
- Mental health and substance use services are delivered by the health authorities. The integration of the continuum of community and hospital mental health services at the health authority level reflects best practice recommendations, and the alignment of substance use services with mental health services offers new opportunities for improving service access and responsiveness.
- Expenditures related to the Mental Health and Substance Use service sector occur across the health care systems' continuum of care, including:
    - acute care services;
    - the continuum of community-based mental health and substance use services;
    - specialized services managed by the Provincial Health Services Authority (Riverview Hospital[1] and Forensic Psychiatric Hospital and community clinics);
    - PharmaCare;
    - physician services (general practitioners and psychiatrists, salaried and sessional); and
    - work being undertaken with the Centre for Addictions Research of BC to develop evidence-based information to support health authorities in the ongoing implementation of mental health and substance use reform.

FINANCIAL IMPLICATIONS

- The mental health and substance use sector operating expenditures for 2015/16 were approximately $1.45 billion[2]. This equates to an increase of more than 71% over the 2000/01 total of $851.4 million.
- In addition, capital funding is provided to support provincial tertiary redevelopment, as well as other mental health projects.

[1] Riverview Hospital ceased operations in July 2012.

[2] Includes estimated expenditures incurred by the Ministry of Health / Health Authorities only (i.e. excludes MHSU expenditures incurred by the Ministry of Children and Family Development).

FACT SHEET

s.13,s.17

Approved by:
Gordon Cross, Regional Grants and Decision Support Branch; October 18, 2016
Manjit Sidhu, Finance and Corporate Services Division; October 31, 2016

FACT SHEET

Mental Health and Substance Use Services Overview

ISSUE

Overview of provincial and regional mental health and substance use (MHSU) services in BC.

KEY FACTS

- The Ministry of Health is responsible for community, acute and tertiary child, youth and adult MHSU services, as well as Ministry programs (i.e. Medical Services Plan, PharmaCare), and services provided by physicians (general practitioners and psychiatrists).
- Services funded by the Ministry are provided generally through provincial and regional health authorities, and contracted service providers. Child and youth community mental health services are provided by the Ministry of Children and Family Development.
- The MHSU system is comprised of a broad range of service providers including psychiatrists, family physicians and nurse practitioners, registered nurses, social workers, psychologists, MHSU clinicians, support workers, and a range of allied health professionals.
- An estimated 12.6 percent[1] of children and youth in BC at any given time, and approximately 19.6 percent to 26.2 percent[2] of BC adults annually will experience a MHSU disorder.
- Available Ministry utilization data[3] indicates that there are approximately 814,000 individuals (children, youth and adults) in BC that have accessed MHSU services from a physician or hospital (including emergency departments) in 2013/14. Approximately 8 percent were ages 0-18; 22 percent were ages 19 – 35; 51 percent were ages 36 – 65; and 19 percent were 66 years and older.
- In 2015, the Ministry released *Primary and Community Care in BC: A Strategic Policy Framework* identifying individuals with mental health and/or substance use problems as a priority population. A core component of the Ministry's strategic agenda is to improve integration of MHSU services, particularly with primary care, through the use of interdisciplinary teams. Work is ongoing to develop an integrated system of community-based MHSU 'specialized community services programs' across all Health Geographic Service Areas.
- MHSU services and supports in BC are provided along a continuum from health promotion and prevention through to early intervention and treatment, and are represented by a five-tiered model (see figure 1). The tiers represent levels of service need according to the acuity, chronicity and complexity of an individual with mental health and/or substance use problems.

Tier 1 "Mental Health & Wellness Promotion/Problematic Substance Use Prevention" services are designed to build the capacities of all British Columbians, individuals and families, to improve their ability to cope with adversity and to create supportive community environments. Programs and services include health promotion, health literacy activities and resources that aim to help achieve and maintain positive mental wellbeing, healthy lifestyles, and effective approaches to stress management, supportive social networks, and stigma reduction. For example mincheck.ca and heretohelp.ca provide navigational and informational resources.

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[1] Waddell et al. (2014). *Child and Youth Mental Disorders: Prevalence and Evidence-Based Interventions*. A Research Report for the British Columbia Ministry of Children and Family Development. Children's Health Policy Centre, Simon Fraser University.

[2] Bijl, R. V., de Graaf, R., Hiripi, E., Kessler, R. C., Kohn, R., Offord, D. R., & Wittchen, H. U. (2003). The prevalence of treated and untreated mental disorders in five countries. *Health Affairs, 22*(3), 122-133.;Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005b). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617-627.;Slade, T., Johnston, A., Oakley Browne, M. A., Andrews, G., & Whiteford, H. (2009). 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australasian Psychiatry, 43*(7), 594-605.

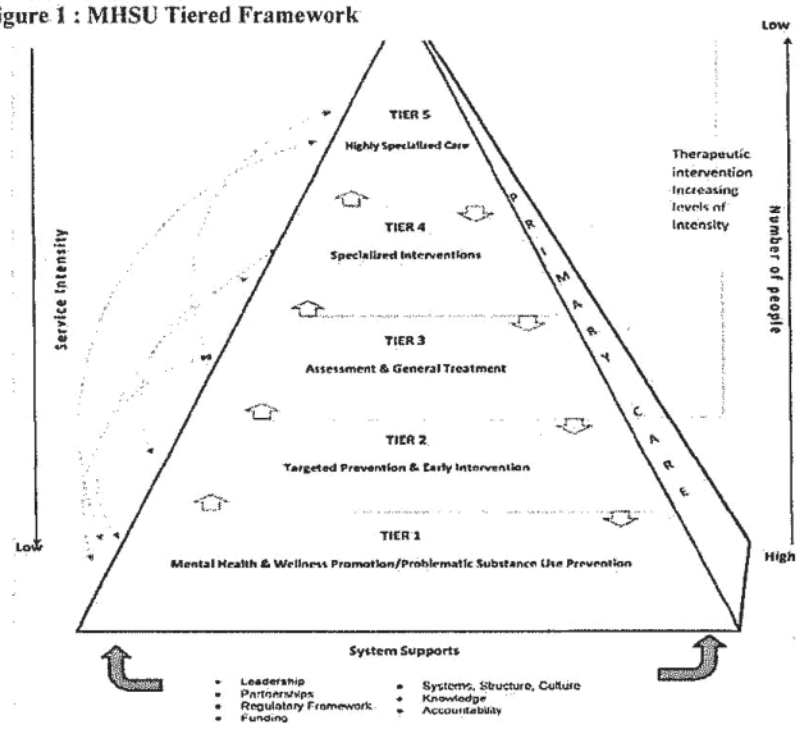
[3] **Mental Health and Substance Use – Updated Patient Population Cohort (January 7, 2016).** Prepared by: Business Analytics Strategies and Operations Branch, Health Sector Information Analysis and Reporting Division

FACT SHEET

Tier 2 "Targeted Prevention & Early Intervention are activities focused on vulnerable populations at risk of developing MHSU problems, with the goal of identifying issues and providing links to appropriate support at an early stage. Current examples include targeted prevention and risk/harm reduction strategies, such as the Early Psychosis Intervention program and the Healthy Minds/Healthy Campuses initiative.

Tier 3 "Assessment & General Treatment" is focused on individuals with identified MHSU use problems, but who may not necessarily require intensive services. This tier may serve as a linkage to higher tier services. Activities include comprehensive assessment and diagnosis, risk/crisis management, and care planning. Other Tier three services include integrated primary and community MHSU care teams, and a range of community-based services, such as supportive counselling, sobering services, withdrawal management and MHSU outreach services.

Figure 1 : MHSU Tiered Framework



Tier 4 "Specialized Interventions" are targeted to individuals who require treatment or specialized approaches for diagnosed disorders and substance dependence, delivered by regulated professionals with appropriate training. Activities include but are not limited to acute inpatient services, intensive outreach, medically managed withdrawal management, and crisis intervention/emergency response. Specific program examples include intensive case management teams; day treatment; supportive recovery services; residential SU treatment; psychosocial rehabilitation services; mobile crisis response units, and crisis stabilization beds.

Tier 5 "Highly Specialized Care" is designed for individuals who are experiencing highly acute, chronic and/or complex mental illness and/or substance dependence. Examples include tertiary care assessment and rehabilitation, Assertive Community Treatment, and forensic psychiatric services (in-patient and outpatient clinics).

FINANCIAL IMPLICATIONS

The MHSU sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71 percent over the 2000/01 total of $851.4 million.

Approved by:
Sharon Stewart OBO Doug Hughes, ADM Primary and Community Care Policy; February 28, 2017
Gordon Cross, obo Manjit Sidhu, ADM, Finance and Corporate Services; November 15, 2016

FACT SHEET

OFFICE OF AUDITOR GENERAL REPORT
ACCESS TO ADULT TERTIARY CARE
MENTAL HEALTH AND SUBSTANCE USE SERVICES

ISSUE

The Office of the Auditor General (OAG) of British Columbia has conducted an audit to determine whether the Ministry of Health (the Ministry) and the six health authorities adequately managed access to adult tertiary care for individuals with serious mental health and substances use (MHSU) problems. The final Report with ten recommendations was released in mid-May, 2016.

KEY FACTS

- The OAG assessed four key aspects of managing access to adult tertiary care including: Ministry stewardship; health system planning to meet needs; health authority management of patient access and flow; and health system accountability.
- The audit object and criteria used by the OAG was based on the Ministry ten-year MHSU plan *Healthy Minds, Healthy People,* previous Ministry service plans, government letters of expectations, the *Health Authorities Act*, and consultation with subject matter experts and staff from the Ministry and health authorities.
- The audit period started with the end of the Riverview Hospital devolvement to regional health authorities in 2012 to March 31, 2015.
- The work for the audit was completed on November 30, 2015.
- The final draft report "*Access to Adult Tertiary Mental Health and Substance Use Services*" was released in May, 2016 and contains the following 10 recommendations:
  1. The Ministry collaborate with the health authorities to clarify roles and responsibilities, and set province-wide direction, including a refreshed vision, goals and objectives for adult tertiary care.
  2. The Ministry collaborate with the health authorities to implement a province-wide performance management framework for adult tertiary care, including performance measures and targets.
  3. The Ministry clarify roles with the Provincial Health Services Authority to finalize and implement the adult tertiary care standards.
  4. The Ministry collaborate with the health authorities to improve long-term planning, including improving information-sharing to better identify long-term risks and gaps in services.
  5. The health authorities regularly identify adult tertiary care population needs and determine whether they have the right mix of current and future services.
  6. The health authorities periodically evaluate the effectiveness of their adult tertiary care programs, and share lessons learned with the Ministry and other health authorities.
  7. The Ministry and health authorities work with key stakeholders to address the gaps in services for individuals whose needs are beyond the threshold of services currently funded and available.
  8. The Ministry and health authorities collaborate to create a consistent and documented approach to active waitlist management, including waitlist tracking, acceptance and prioritization of patients, and declination practices.
  9. The Ministry and the health authorities further analyze barriers to adult tertiary care access and flow and work with each other and relevant stakeholders to address them.
  10. The Ministry and the health authorities collaborate to develop appropriate measures to report publicly on access to adult tertiary care.

FACT SHEET

- The Ministry and health authorities have been fully engaged with the OAG in the development of the audit report and confirmed that they are in full agreement with the above recommendations.
- The Ministry is working closely with health authorities and key service partner's to clarify their roles and responsibilities; set province-wide direction, including a refresh of the vision, goals and objectives of adult tertiary mental health and substance use care; develop a provincial tertiary care performance management framework; finalize the tertiary care standards including a phased-implementation work plan; provide best practice guidelines regarding information-sharing, and develop appropriate measures to report publicly on adult tertiary care.
- On an ongoing basis, the Ministry in partnership with health authorities and stakeholders will review the needs of the adult tertiary care client population, including potential barriers to access such as waitlist management; determine whether the tertiary care services have the right mix of current and future services; and periodically evaluate the effectiveness of adult tertiary care.
- The PHSA will take on a lead role in supporting the Ministry in coordinating the implementation of the OAG recommendations.
- On October 5, 2016, Ministry representatives presented the 24 month action plan to the Select Standing Committee on Public Accounts.
- As of October 31, 2016, a detailed 24 month work plan has been completed by the Ministry; a Memorandum of Understanding has been signed off by the Ministry and the PHSA to clarify the roles and responsibilities of the PHSA, regional health authorities and the Ministry of Health in addressing the OAG recommendations; staff have been hired by the PHSA to support this initiative; the provincial tertiary care advisory committee has been formed and has held monthly meetings since October, 2016.
- The Provincial Framework and Standards for Tertiary Care are near completion and are expected to be completed by May 2017.

FINANCIAL IMPLICATIONS

s.13,s.17

Approved by:

Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 7, 2017

Gordon Cross obo Manjit Sidhu, ADM Finance and Corporate Services; March 31, 2017

FACT SHEET

PSYCHO-SOCIAL REHABILITATION (PSR) AND CLUBHOUSE SERVICES

ISSUE

Individuals with mental health and/or substance use (MHSU) issues and their families are increasingly requesting more access to psychosocial rehabilitation (PSR) approaches to support their education, employment, leisure, wellness, and basic living skills goals as part of their ongoing recovery. The Ministry of Health (the Ministry), in partnership with health authorities (HAs), the Ministry of Social Development and Social Innovation (MSDSI), and other stakeholders are committed to providing a range of PSR supports to facilitate ongoing recovery.

KEY FACTS

- Development of life skills, completion of education, and achievement of employment are integral to treatment and recovery for people living with MHSU problems.
- It is estimated that 70 percent of MHSU problems have their onset during childhood or adolescence.[i] This interrupts the development of skills in key life domains such as: Employment, education, leisure, wellness and basic living skills.

The following PSR services are offered within HAs in BC:

Clubhouses

- Clubhouses are community centres, where individuals with MHSU problems participate in educational, vocational, social and recreational programs. The International Center for Clubhouse Development provides accreditation for clubhouses based on an evidence based fidelity model.
  The Richmond Pathways Clubhouse is an example of an accredited clubhouse funded as part of a $1.4 million contract between the Vancouver Coastal Health Authority (VCHA) and the Pathways Clubhouse Society of Richmond to deliver a range of psycho-social rehabilitation services.
- Connections Place Society, formerly "Moms Like Us" (MLU, www.momslikeus.ca), is a group of parents of adult children living with serious mental illness which has been advocating for the development of an accredited Clubhouse in Victoria to provide improved access to PSR services, especially increased access to supported education and employment support for young adults.
  The Vancouver Island Health Authority (VIHA) developed a South Island PSR Advisory Team with a broad range of stakeholders, involving representation of family members (including MLU members), contracted providers, and IH staff to review the greater Victoria area PSR and Recovery-oriented services. The review included external experts and consultation with the Provincial PSR Advanced Practice, a provincial community of practice supporting PSR services throughout BC.
  The IH PSR Advisory Team is recommending the development of a wide range of PSR services to remove barriers and improve the engagement of youth and young adults through the Early Psychosis Intervention Program, and young adult services at Gateway to Resources and Options for Wellness (GROW), an agency funded by VIHA. Considering the high costs of accredited Clubhouses, VIHA is not considering the development of an accredited clubhouse at this time, but is reviewing the concept of a clubhouse as a social gathering place.

Supported Employment

- Supported employment services aim to improve basic work habits, skills and behaviours, increase individual and employer job satisfaction, and increase economic independence.
- HAs provide a range of Supported Employment services for people with MHSU problems across the province, including pre-employment supports, therapeutic work contracts, transitional employment, and supports for competitive employment such as Individual Placement and Support (IPS) services.
- During 2014-15, HAs had a total of 2,745 participants in Supported Employment programs, and 782 participants (28 percent) obtained or maintained employment.[ii]
- IPS is an evidence-based Supported Employment model that helps people with mental illness and other disabilities acquire and maintain competitive jobs of their choice in the community, through rapid job-search and time unlimited, individualized follow-up services.[iii] Employment specialists are

embedded in the mental health teams, and work closely with the individual and other team members to find solutions for issues that affect work and recovery. The full IPS model of Supported Employment is provided by two HAs (VCHA and Fraser Health Authority (FHA)) through contracts with the CMHA, who indicate that 60-70 percent of new clients in their IPS program obtained employment in their first year.[iv]

Supported Education

- Supported Education (SE) refers to supports which assist individuals with MHSU to achieve their desired educational goals. The core components of SE include career planning, academic survival skill building, and connection to academic and mental health/substance use supports and services.
- Several SE studies have demonstrated increases in enrolment in post-secondary education as well as increased course completion, and greater likelihood of re-enrolment in the following academic year.[v]
- In 2014-15, HA funded SE programs supported 2,236 people and 375 individuals (17 percent) to either obtain or maintain their education.[vi]

Supported Leisure

- Supported leisure services assist individuals to explore healthy leisure options, build their knowledge and use of community resources, and strengthen social networks. Some evidence is emerging that supported leisure participants are showing improvements in terms of reduced MHSU symptoms, better self-esteem, and overall functioning.[vii]

Basic Living skills

- Basic living skills assists individuals to live more independently, such as managing their finances, shopping, meal planning, personal hygiene, use of public transportation, personal safety, home maintenance, and making friends. HAs provide a variety of basic living supports through the various MHSU supported housing options.

Wellness Support

- Wellness support addresses a person's desired state of physical, mental, social and spiritual well-being. These programs assist people to identify their strengths, set their own goals, build knowledge about their illness, integrate medication management into their routines, and strengthen ways of coping with stresses in their lives.
- Wellness support programs include the Illness Management and Recovery (IMR)[viii] program, and the Wellness Recovery Action Plan (WRAP).[ix]
- FHA has integrated use of WRAP into their services using peer led workshops to support individuals to establish their plans for achieving wellness goals.

FINANCIAL IMPLICATIONS

The mental health and substance use sector operating expenditures for 2015/16 were approximately $1.45 billion. This equates to an increase of more than 71 percent over the 2000/01 total of $851.4 million.

Approved by: Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 16, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services Division; April 11, 2017

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[i] Government of Canada (2006). The human face of mental health and mental illness in Canada.
[ii] Labour Market Agreement for Persons with Disabilities Annual Report, (2015)
[iii] Drake RE, Bond GR, Becker DR. IPS supported employment: An evidence-based approach to supported employment. (2012).
[iv] http://vancouver-fraser.cmha.bc.ca/how-we-can-help/employment-services
[v] Mowbray, C., Collins, M E, Bellamy, C D, Megivern, DA, Bybee, D, & Szilvagyi, S; Supported education for adults with psychiatric disabilities: An innovation for social work and psychosocial rehabilitation practice. *Social Work* (2005).
[vi] Labour Market Agreement for Persons with Disabilities Annual Report, (2015).
[vii] Davidson, L, Shahar, G, Stayner, DA, Chinman, M J, Rakfeldt, J, & Tebes, J; Supported socialization for people with psychiatric disabilities: Lessons from a randomized controlled trial. *Journal of Community Psychology* (2004).
[viii] Mueser, KT, Meyer, PS, Penn, DL, Clancy, R, Clancy, DM & Salyers, MP; The illness management and recovery program: Rationale, development, and preliminary findings. *Schizophrenia Bulletin, (2006).*
[ix] Sterling, EW, von Esenwein, SA, Tucker, S, Fricks, L, & Druss, BG; Integrating wellness, recovery, and self-management for mental health consumers. *Community Mental Health Journal,* (2010).

FACT SHEET

RIVERVIEW LANDS REDEVELOPMENT – BURNABY CENTRE FOR MENTAL HEALTH AND ADDICTION

ISSUE

Over the last two years, the Province of British Columbia has engaged and consulted with individuals, groups and key stakeholders on the future use of the Riverview Lands in Coquitlam. A Vision for renewing the Riverview Lands has been developed which lays out a master development plan for a comprehensive mixed-use community, including the relocation of the Burnaby Centre for Mental Health and Addiction to the Riverview lands. The Honourable Minister Coleman, Minster of Natural Gas Development and Minister responsible for Housing is leading the redevelopment of the Riverview Lands.

KEY FACTS

In 2013, the Province of British Columbia announced a vision consultation process on the future of the Riverview lands and entrusted BC Housing to lead this process.

- Two years of consultation with thousands of British Columbians and multiple stakeholders resulted in *A Vision for Renewing Riverview Lands*, released in December 2015.
- Establishing mental health care facilities at the Riverview Lands received strong public and stakeholder support.
- *A Vision for Renewing Riverview Lands* lays out a master development plan for a comprehensive mixed-use community that will include a healthcare district as well as market and supportive housing.
- The approach is designed to balance the priorities and objectives of a wide range of stakeholders in the community, non-profit and health care sector, Kwikwetlem First Nation and the Province.
- The Vision highlights five key themes – mental health and substance use care, heritage and environment, a complete community, housing and economic development – that emerged during the consultation process.
- As a first step, the Province will be relocating three programs to the Riverview Lands, currently located on the Willingdon Lands in Burnaby.
    - Burnaby Centre for Mental Health and Addiction operated by the Provincial Health Services Authority (PHSA).
    - Maples Adolescent Treatment Centre operated by the Ministry of Children and Family Development (MCFD).
    - Provincial Assessment Centre operated by Community Living British Columbia (CLBC).
- The new Centre for Mental Health and Addictions (CMHA) will be a 105-bed, 20,800 square meter mental health facility to replace the BCMHA, and a second new facility will be built by the Ministry of Technology, Innovation and Citizens' Services to accommodate the 28-bed Maples Adolescent Treatment Centre and the 10-bed Provincial Assessment Centre.
- The CMHA is expected to be completed in 2019 and will increase bed capacity from 100 to 105 beds, and replaces the existing BCMHA located on the Willingdon Lands in Burnaby, a site that was sold as part of the provincial government's Release of Assets for Economics Generation initiative.[1]

[1] The 88 beds at the Burnaby CMHA were to include a new 14-bed high intensity treatment unit. PHSA has been unable to secure a building permit from the City of Burnaby for the needed renovations for these beds. As a short term alternative, 20 acute stabilization beds are expected to be operational on the Burnaby site by April 2016. This will bring the total number of beds in operation at the Burnaby site to 94. The high intensity beds will be incorporated into the replacement CMHA as planned.

FACT SHEET

- Shared Services BC has negotiated lease back arrangements for the Willingdon Lands. There is a three year lease back for the BCMHA to March 31, 2017 with an option to extend the lease for two more years to March 31, 2019. PHSA has requested Shared Services BC negotiate a further extension to the Willingdon lease.
- In the interim, the BCMHA is expected remain at the current site until accommodation is finalized and a full transition plan is implemented.
- When a new site is finalized, the PHSA, regional health authorities and health care staff will work closely with the patients and their families to develop a thorough transitional care and communication plan that will ensure that patients receive consistent services.
- For further details, see:
  - Fact Sheet: Burnaby Centre for Mental Health and Addiction
  - Fact Sheet: Centre for Mental Health and Addiction Replacement Project Coquitlam (Capital Plan)
  - Fact Sheet: Severe Addictions and Mental Illness (SAMI) Action Plan

FINANCIAL IMPLICATIONS

In October 2015, Government approved the CMHA Project with a total capital budget of $100.86 million, including a project reserve of $3.32 million. The capital funding for this project will be provided entirely by the Province.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 28, 2017
Joel Palmer obo Manjit Sidhu, ADM Finance and Corporate Services; March 6, 2017

FACT SHEET

SECURE CARE

ISSUE

In BC, as in other jurisdictions, there are youth who engage in a range of behaviours, including problematic substance use, commercial sexual exploitation, and high risk behaviour due to mental health issues, that are harmful to the youth themselves and/or the public. Parents, police, social workers and health care professionals have expressed concerns about an apparent lack of legal authority to intervene when such youth are unable or unwilling to engage in voluntary services. There have been repeated calls for new secure care legislation to support involuntary treatment to minimize potential harm to themselves and/or the public.

KEY FACTS

- Secure care refers to the involuntary detainment of youth engaged in serious self-harming behaviours, including problematic substance use, commercial sexual exploitation, and high risk behaviour due to emotional and/or mental health issues.
- A 2014 report[1] by the BC Representative for Children and Youth (RCY) contained a recommendation for the Ministry of Children and Family Development (MCFD) "to explore the creation of a form of secure care".
- In BC, the issue of secure care has been considered on previous occasions. In 2000, the *Secure Care Act* focusing on intervention and assistance to children under 19 years of age was passed but never brought into force. In 2009, *Safe Care Act* legislation, focusing on youth experiencing sexual exploitation and/or severe substance misuse, was drafted but never tabled. A number of concerns associated with the use of an involuntary residential model care have been raised in consultations. MCFD has conducted further research and investigation into Secure Care legislation since 2009.
- In BC, the Ministries of Children and Family Development (MCFD), Education and Health are responsible for the delivery of services for children, youth and families. As such, a variety of voluntary services are in place that address the needs of youth engaged in serious self-harming behaviours. These include acute and tertiary care and community-based outpatient counselling, withdrawal management, residential treatment, outreach services, emergency shelters, and child welfare services. While services exist, there continue to be gaps (services not available in all communities where they are required) and shortfalls (insufficient capacity, resulting in lengthy waits) affecting availability of voluntary services.

Current Policy and Legislation: Policy and legislation in BC that support compulsory or involuntary treatment services for youth include mandated services through youth justice (federal *Youth Criminal Justice Act)* and options for interventions for children and adolescents involved in dangerous circumstances through the *Child, Family and Community Service Act.* Judges can mandate substance use treatment in a youth custody facility as a condition of a sentence, or can order treatment in a residential substance use treatment program as a condition of probation.

Additionally, in circumstances set out in the *Mental Health Act (MHA),* individuals with both mental health and substance use issues may be admitted to a psychiatric facility for assessment and involuntary treatment if they meet four admissions criteria (see MHA Fact Sheet for more information). Children under the age of 16 can be involuntarily admitted under the *MHA* with consent from a parent or guardian. Going beyond the limitations of currently available options (i.e. through the justice system, the *MHA*, child protection legislation and voluntary services) would require the enactment of specialized legislation authorizing the involuntary detainment of youth.

Evidence Regarding Secure Care: While there is widespread recognition of the negative impacts of problematic substance use, including increased morbidity and mortality rates,[2] there is no clear evidence that compulsory or involuntary treatment, such as those proposed under secure care legislation, improves treatment outcomes.[3,4]

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[1] BC Representative for Children and Youth (2014). *Paige's Story: Abuse, Indifference and a Young Life Discarded.*

[2] Urbanoski, K. A. (2010). Coerced addiction treatment: Client perspectives and the implications of their neglect. Harm Reduction Journal. 7:13, doi: 10.1186/1477-7517-7-13.

FACT SHEET

A systematic review of research on compulsory addiction treatment found little evidence of its effectiveness in the short-term, and no evidence of improved long-term outcomes.[5] The researchers recommended that in the absence of clear evidence, voluntary services should be prioritized as the first-run response to problematic substance use.[6]

Canadian Legislative Context: The majority of provinces across Canada have legislation allowing for the involuntary treatment of youth in at least one of the following three categories:

1. Youth with severe substance use problems – Alberta, Saskatchewan and Manitoba
2. Youth who are sexually exploited – Alberta, Quebec
3. Youth who are deemed at risk to themselves or others, which could include severe mental health and/or substance use issues – Ontario, Quebec, New Brunswick, PEI and Nova Scotia.

Of note, the third category of legislation is more encompassing than the specific criteria in BC's *MHA*. The *MHA* recognizes that involuntary treatment must strike a balance between an individual's health and wellbeing, and their individual rights and autonomy.

Current Approach:

Government is exploring the potential need for implementation of secure care in BC, including reviewing the various approaches to secure care in other jurisdictions.

MCFD and Health recognize gaps in the current system of care for high risk youth. Both MCFD and Health have responded to the RCY's report *Paige's Story: Abuse, Indifference and a Young Life Discarded* and other reports calling for expanded substance use services for these youth.[7] Both Ministries are committed to bolstering voluntary services prior to enacting coercive legislation.

Examples of current health initiatives to improve substance use treatment services for youth include:

- Actions from the *120 Day SAMI Action Plan*: Six new youth group home beds at Renfrew House in Vancouver and the new Youth Intensive Case Management Team in North Vancouver.
- The BC-Integrated Youth Service Initiative will implement 5 Integrated Youth Service Centres, integrating primary care with MHSU support services for youth and young adults ages 12 to 24. The five sites, one in each HA, will be announced in April 2016.
- The *Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative* works to improve access to CYMHSU services, and includes a Substance Use Working Group.
- Approximately 20 percent of the planned 500 substance use spaces will be dedicated to youth.

MCFD, in partnership with numerous partners, has implemented a Rapid Response Team in the Downtown Eastside of Vancouver to provide intervention to youth experiencing high risk.

FINANCIAL IMPLICATIONS

N/A

Approved by:

Sharon Stewart OBO Doug Hughes, ADM Primary and Community Care Policy; February 28, 2017

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[3] Lundgren, L., Blom, B., Chassler, D. & Sullivan, L. M. (2015). Using register data to examine patterns of compulsory addiction treatment care in Sweden: Program planning and methodological implications. Evaluation and Program Planning. 49, pp. 149-152. doi.org/10.1016/j.evalprogplan.2014.12.012.

[4] Urbanoski, K. (2016, January 29). Compulsory Addiction Treatment: What does the evidence tell us? CARBC Lecture Series. Victoria, Canada: Centre for Addictions Research of BC, University of Victoria.

[5] Werb, D., Kamarulzaman, A., Meacham, M.C., Rafful, C., Fischer, B., Strathdee, S.A. & Wood, E. (2016). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*. 28, p. 1-9.

[6] Ibid.

[7] Other reports include: *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*by the Representative for Children and Youth, *Becoming Whole* by the McCreary Centre Society, and *Taking the Next Step Forward Building a Responsive Mental Health and Addictions System for Emerging Adults* by the Mental Health Commission of Canada.

FACT SHEET

Substance Use Hub/Spoke Model
Consolidating Substance Use Services and Strengthening the Network

ISSUE

Substance use services are currently fragmented and do not respond adequately to the immediate needs of people seeking help.

KEY FACTS

- Substance Use Hubs/Spoke models will be implemented to:
  - Improve quick access to integrated mental health and substance use treatment and support, including opioid agonist treatment (OAT) across all communities of BC;
  - Increase the capacity of primary and community care providers to identify and care for individuals with problematic substance use;
  - Increase retention in treatment and retained connection to care providers; and
  - Increase public understanding of where and how to access treatment.
- Specialized substance use centres (the 'hubs') will provide
  - A one-stop shop for individuals to get fast access to assessment and treatment, including services that address physical, mental health and substance use needs as well as other health determinants (e.g. housing, income, employment, etc.); and
  - A one stop for providers to access substance use expertise; professional consultation and support, and additional services and supports for their patients as needed.
- Primary and community care providers (the 'spokes') will care for individuals with substance use concerns across all communities in BC, with enhanced support from the hubs. This will enable more stable individuals to be supported in their home community with the ability to access more specialized care if and when they need it.
- Formalized relationships between hubs and spokes will reduce provider isolation by providing fast and easy access to specialist consults and enhanced supports for patients with more complex needs.
- Fully realized hubs will provide integrated, team-based care including:
  - Prevention & Education (e.g. family and community members)
  - Assessment on a walk-in basis
  - Mental health and primary care supports
  - Support for all substance use (not just opioids)
  - Harm reduction supplies and education
  - Same day OAT initiation & support during stabilization
  - Medication management support to optimize pain management and substance use treatment
  - Connection to social supports (housing, income assistance)
  - Accelerated linkage to other MHSU programs and supports (treatment programs, intensive case management, counselling)
  - Peer support
  - Support for or connection to pain management services
  - Connection with ED/Acute for expedited referral/transfer of care
  - Connection and referral to primary care spokes once stabilized
  - Training, mentorship, professional and patient care support for spoke providers in primary, community and acute care settings
- Foundry youth sites will be hubs for youth and young adults.

FACT SHEET

- Implementation will occur in a phased approach, building on services that are already available (e.g. rapid access addiction clinics) and scaling up quickly where possible. A balance will be struck between establishing provincial standards and consistent public expectations for core services, and enabling flexibility for regional implementation.
- Next steps in the development and implementation of substance use hubs and spokes:
  - Conduct a literature review of evidence-based models and approaches, identify critical components for success;
  - Consult with health authorities and providers to determine how to leverage existing services and how best to structure and resource hubs and spokes to best support providers and individuals accessing services; and
  - Work with Ministry of Health to align with integrated primary and community care, including urgent care centres. Substance use hubs and spokes will be an accelerated component of the overall vision for integrated, team-based care, reflecting the urgent need and response to the overdose emergency.

FINANCIAL IMPLICATIONS

Funds from the 2017 Budget Update will establish specialized substance use centres and support delivery of care in the community via hub and spoke service delivery model.

Funds Requested:

s.13,s.17

Approved by:

FACT SHEET

SUICIDE OVERVIEW

ISSUE

Suicide and suicide-related behaviours affect the lives of all British Columbians — irrespective of age, culture, status, or background. Recent events, including a number of high profile suicides and a growing awareness of the disparity in suicide rates between Aboriginal and non-Aboriginal populations has raised awareness around suicide, as well as highlighting suicide prevention as an important public health issue within BC and across Canada.

KEY FACTS

- Over a ten year period from 2006-2015, an average of 528 British Columbians died by suicide each year. In 2015, 614 British Columbians died by suicide, a rate of 13.1 per 100,000.[1] The World Health Organization estimates that the ratio of the number of suicide attempts to the number of suicide deaths may be as high as 20 to 1.[2]
- On November 24, 2016, the Government of Canada released the Federal Framework for Suicide Prevention, which provides guiding principles for the Government's ongoing work with all sectors to help prevent suicide. This includes raising public awareness and reducing stigma associated with suicide, disseminating information and data to help prevent suicide, and promoting the use of research and evidence-based practices in suicide prevention.
- The Framework was followed by the release of the 2016 Progress Report on the Federal Framework for Suicide Prevention on December 14, 2016. The Progress Report highlights a number of federal government actions including the establishment of the national toll-free First Nations and Inuit Hope for Wellness Help Line in October 2016, and a $2 million Public Health Agency of Canada investment over five years to support the Canadian Distress Line Network to develop a national suicide prevention service.
- Suicide and suicidal behaviours have complex underlying causes such as mental illness, substance use problems, a family history of suicide, childhood abuse, and/or social isolation.[3]
- Protective factors that reduce vulnerability to suicide include: Resilience and strong coping skills; social connectedness (especially with family and friends); robust support networks; stable personal relationships; connections to cultural practices and traditions; and opportunities to explore and practice spirituality — all achieved through comprehensive action to promote mental health and prevent mental illness.[4]

Prevention

- Gatekeeper training aims to equip key individuals that have contact with many people in the community to independently and pro-actively assess people at risk, determine the corresponding level of risk, and make appropriate referrals.[5]
- In March 2015, the Ministry of Health (the Ministry) provided funding of $3 million to the BC Division of the Canadian Mental Health Association (CMHA) to coordinate delivery of evidence-based Gatekeeper Training across BC.
- Regional coordinators for the project are based in five communities: Nanaimo, New Westminster, Salmon Arm, Prince George and Cranbrook.
- To date, 84 communities across BC have benefitted from gatekeeper training.[6] These numbers continue to grow as more communities are engaged.

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[1] BC Coroner's Service (2017). *Suicide Deaths 2006-2015*. Retrieved Apr 7, 2017.

[2] Joshi, P., Damstrom-Albach. D., Ross. I., & Hummel, C. (2009). *Strengthening the Safety Net: A summary on the suicide prevention, intervention and postvention initiative for BC*. Vancouver BC.

[3] World Health Organization (2012). *Public Health Action for the Prevention of Suicide*. Geneva: WHO Press.

[4] Ibid.

[5] Ibid.

- Additionally, the Ministry of Health, the First Nations Health Authority and Health Canada's First Nations and Inuit Health Branch have developed *Hope, Help and Healing*, a suicide prevention toolkit for First Nations communities. This toolkit was pilot tested by five First Nations communities across the Province, and the finalized resource was released on April 14, 2015.

Intervention

- The Suicide Prevention, Intervention and Postvention Initiative for BC's *Strengthening the Safety Net* (2009) provides guidance for Health Authorities to coordinate strategic, evidence-based suicide prevention, intervention, and postvention activities across the province.[7]
- All health authorities have implemented best practice organizational standards for suicide risk management in clinical settings, as laid out within the *Provincial Suicide Clinical Framework* (2011)[8], developed by the Provincial Health Services Authority.
- The Centre for Applied Research in Mental Health and Addiction (CARMHA) at the Simon Fraser University, commissioned by the Ministry, has developed resources related to suicide for use in HAs:
  1. *Coping with Suicidal Thoughts: A Resource for Patients*[9] is designed to offer resources, information, support, and practical steps to help cope with suicidality.
  2. *Working with the Client Who is Suicidal: A Tool for Adult Mental Health and Addiction Services*[10] provides an overview of recommended practices in assessing/treating suicidal behaviour in adults.
  3. *Working with the Suicidal Patient: A Guide for Health Care Professionals*[11] is a useful tool for assessment and management of suicidality for providers without a mental health background, including those that may be working in an acute care/emergency setting.
  4. *Hope and Healing: A Practical Guide for Survivors of Suicide*[12] is a guide that focuses on the practical matters that survivors need to deal with after a loved one has died by suicide.
- Coroners' reports following suicide deaths are carefully reviewed by the Ministry to identify areas for improvement in service delivery.
- In response to the issues identified in the Coroners' reports, the Ministry is working with CMHA and the HAs to review current practices, to consider the emerging evidence regarding Zero Suicide and other approaches, and to identify improvement opportunities and regional action plans. Terms of Reference for a Provincial Working Group are near completion.
- Overall responsibility for Child and Youth Mental Health services – including suicide prevention and intervention – resides within the Ministry of Children and Family Development.

FINANCIAL IMPLICATIONS

- The Ministry provided $3 million to the CMHA in March 2015 to support coordinated delivery of evidence-based Gatekeeper Training across BC.

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; March 16, 2017
Arlene Paton, ADM, Population and Public Health, May 16, 2017
Nancy South obo Teri Collins, ADM Health Sector Information, Analysis & Reporting; April 11, 2017
Gordon Cross obo Manjit Sidhu, ADM, Finance and Corporate Services, March 24, 2017

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[6] Dammy Albach, Manager, Gatekeeper Training Project, Canadian Mental Health Association-BC Division, personal communication, January 16, 2017.
[7] https://suicidepipinitiative.wordpress.com/publications/
[8] *Provincial Suicide Clinical Framework (2011)*
[9] https://www.sfu.ca/carmha/publications/coping-with-suicidal-thoughts.html
[10] http://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf
[11] http://www.health.gov.bc.ca/library/publications/year/2007/MHA_WorkingWithSuicidalClient.pdf
[12] http://www.health.gov.bc.ca/library/publications/year/2007/HopeandHealing.pdf

FACT SHEET

SUPPORTIVE RECOVERY HOMES

ISSUE

Supportive recovery homes are non-medical residences that offer support to people recovering from substance use problems. Currently, supportive recovery homes are unevenly distributed throughout the Province, with the majority located in Surrey. While most supportive recovery homes are legitimate and registered, some unregulated homes have been problematic, and may pose a risk to the clients and the neighbourhoods in which they reside.

KEY FACTS

Background

- Supportive recovery homes are regulated under the *Community Care and Assisted Living Act* (CCALA).
- Supportive recovery homes offer hospitality and psychosocial supports, or other personal assistance services to individuals who are experiencing substance use problems.
- Supportive recovery homes are designed to provide access to low to moderate substance use services and supportive housing for people who are preparing to enter residential treatment, or those who have left more intensive residential treatment but who require additional support to reintegrate into the community, or for those requiring a longer term structured environment while preparing to transition into a more stable lifestyle.

Registration/ Assisted Living Registrar

- In 2012, the Ministry of Health and the Ministry of Social Development and Social Innovation (MSDSI) introduced a co-ordinated approach to identifying and registering supportive recovery homes, and the Ministry of Health (the Ministry) began formally registering supportive recovery homes through the Assisted Living Registry. Lists of the registered homes are available on the Ministry of Health website.
- Registration requirements include offering at least one assisted living service, such as psychosocial supports or addictions meetings, and five hospitality services (meals, housekeeping, laundry, social or recreational opportunities, and a 24-hour emergency response).
- Some supportive recovery homes offer a higher level of services and supports, and are licensed under CCALA.
- Houses that are providing fewer services than required for registration are still bound by municipal and criminal laws and regulations.
- There are 108 registered supportive recovery homes across the province. The Ministry is in the process of registering an additional 30. Of the 108 registered supportive recovery homes, 48 are in Surrey.[1]
- Recovery homes receive a $30.90 per diem from the Ministry of Social Development and Social Innovation (MSDSI) for each client who is in receipt of income assistance benefits from MSDSI. Per diems help cover the cost of food, shelter, programs, or service on behalf of clients.
- Health authorities are also able to provide an accommodation fee subsidy (per diem) for individuals who are not on social assistance, and do not have the financial resources to pay for their stay in a licensed or registered residential substance use program.
- The Assisted Living Registrar can inspect a home if there is reason to believe an operator is offering the level of service which requires assisted living registration, or if the health and safety of residents is at risk. According to the *Community Care and Assisted Living Act,* if an operator does not register when required to, fines can be imposed through a court process.

[1] Assisted Living Registry database February 16, 2017

FACT SHEET

- In 2016, government amended the CCALA to increase flexibility and protections for residents of assisted living by including enhancements to the registrar`s inspection and enforcement powers. These changes enable greater powers to protect individuals with substance use problems from abuse, neglect, and unsafe living conditions.
- The amendments to the CCALA also allows for more than two assisted living services to be provided in a registered residence. The amendments will be brought into force, once the assisted living regulations have been developed and are ready to be implemented.
- Drafting of the new assisted living regulations is currently underway with guidance from a Mental Health and Substance Use advisory committee that has expertise in working with substance use recovery home providers.

Ministry of Justice

- There have been reports of the justice system referring clients to supportive recovery homes that are not registered.
- The Ministry has provided ADMs in the Ministries of Justice, and Social Development and Social Innovation with a link to the Ministry of Health's list of registered supportive recovery homes.
- The Ministry has also worked with Justice to educate the courts, police, and parole officers about supportive recovery homes, and have provided them with a list of registered homes.

FINANCIAL IMPLICATIONS

- N/A

Approved by:
Sharon Stewart obo Doug Hughes, ADM Primary and Community Care Policy; February 28, 2017

FACT SHEET

Mental Health and Substance Use
Residential Care and Treatment User Fees

ISSUE

Throughout BC, Client User Fees are applied for publicly funded, licensed or registered MHSU residential care and treatment facilities.

KEY FACTS

User Fees

- Fees are regulated by the MoH and administered by regional health authorities.

Type of facility	Daily User Fee rate	Monthly User Fee rate
a) Licensed Mental Health and Substance Use - Residential Care Facilities	$30.90	$939.87
b) Mental Health and Substance Use - Family Care Homes	$30.90	$939.87
c) Provincial Mental Health and Substance Use Facilities - Residential Care Units	$30.90	$939.87
d) Registered Mental Health and Substance - Assisted Living Units;	$20.75 (single) $28.20 (couple)	$631.00 (single) $857.00 (couple)
e) Registered Adult Supportive Residential Units (Supportive Recovery)	$30.90	$939.87
f) Licensed Adult Residential Substance Use Treatment Facility Units	$40.00	$1,216.67
g) Licensed Adult Supportive Residential Units (Supportive Recovery)	$40.00	$1,216.67

- User fees cover the cost of room and board in the above facilities and do not include transportation costs, toiletries or other personal effects.
- For psychiatric units and provincial MH facilities designated under the *Mental Health Act*, a daily rate of $35.43 for voluntary patients is prescribed in the *Mental Health Regulation*; however, health authority practice has been to charge $30.90.
- For SU residential treatment facilities, health authorities apply the $40 per day fee set by the 1999 Alcohol and Drug Services policy.
- For supportive housing a per diem rate is not applied; instead, the rate is based on the current Ministry of Social Development and Poverty Reduction (MSDPR) shelter allowance. MH supported housing is based on a model that encourages the client's ability to enhance independent living skills. The Ministry, BC Housing, MSDPR and health authority's agree that it is inappropriate for MH supported hosing residences to charge a per diem as it would eliminate almost all of an MSDPR client's discretionary spending.
- As of summer 2013 the Ministry of Social Development paid the per diem for approximately 85% of clients in MHSU facilities.

User Fees for Voluntary versus Involuntary MH Patients

- There is no User Fee for any voluntary or involuntary patient accessing a designated tertiary acute care or tertiary rehabilitation facility (e.g. Acute Care Hospitals, South Patient Care Centres at Royal Jubilee Hospital, Seven Oaks, Cowichan Lodge etc.).
- A $30.90/day user fee is applied to all patients, whether voluntary or involuntary accessing tertiary care residential facilities (designated or otherwise) or a residential care facility licensed under the *Community Care and Assisted Living Act (CCALA)*

Legal Authority to Charge Fees

- Section 9 of the *Mental Health Act* authorizes the Lieutenant Governor in Council to "prescribe daily charges for care, treatment and maintenance provided in a provincial mental health facility," and the *Mental Health Regulation* does prescribe fees payable by voluntary patients.

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- Section 37 of the *Mental Health Act* gives the director of designated facilities authority to release involuntarily-admitted patients on leave. Under section 39(1), the authority to detain the involuntarily-admitted patient continues upon release under section 37. Under section 31(1), if treatment while on leave is authorized by the director, it is deemed to be consented to by the patient. If an individual is deemed to provide consent, then a daily charge for care, treatment and maintenance provided in a provincial mental health facility can be applied.
- Mental Health and Substance Use is a "type of care" provided in a community care facility which is licensed under the CCALA and is described as residential care for persons who are in care primarily due to a mental disorder, substance dependence or both, and is prescribed in s. 2(2)(b) of the *Residential Care Regulation* to the CCALA. The *Continuing Care Act (CCA)* applies in situations where operators of MH and SU Residential and Treatment facilities have entered in to agreements with the province to provide provincially funded continuing care services. The *CCA* provides legal authority for the Lieutenant Governor in Council to prescribe rates that HAs may charge for providing continuing care services.

Background

- Until 2010, most MHSU facility client fees were aligned with the *CCA's* minimum rate in the *Continuing Care Fees Regulation (CCFR).*
- In 2010, the rates in the *CCFR* were changed as part of a seniors care rate restructuring initiative which resulted in a reduction in the lowest daily rate from $30.90 to $29.40. The Ministry of Health made a decision to not continue aligning MHSU facility client fees with the lowest rate to protect existing funding.
- Although the CCA, *Mental Health Act* and their regulations are silent on charging fees for children and youth in MHSU facilities, health authority practice is no to apply charges, which is also consistent with MCFD policy and practice.

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Ted Patterson, Primary and Community Care Policy Division; October 11, 2017

FACT SHEET

Youth and Young Adults with Mental Health and/or Substance Use Issues

ISSUE

Youth and young adults with mental health and or substance use issues have been identified as a priority population for enhanced policy and programming. The Ministry of Health is responding to the needs of this population by working collaboratively with key partner ministries and organizations.

KEY FACTS

An estimated 70% of mental health problems in Canada have their onset during childhood or adolescence[1]. Research indicates that half of all cases of mental disorder begin by age 14, and three-quarters by age 24, while half of all people with a substance use disorder will have experienced substance use issues before the age of 20.[2]

Youth and Young Adult Services

- In BC, the majority of mental health and substance use supports and services for youth and young adults and their families and/or caregivers is provided by the Ministry of Children and Family Development (MCFD), the Ministry of Health through the health authorities, as well as general physicians who provide screening and assessment, and referrals to services.
- MCFD and the health authorities work with the community, education, justice, employment, and housing systems to provide a full range of services for youth and young adults.
- MCFD provides prevention, early intervention, treatment and support for youth with mental health problems up to 18 years of age, and their families. Services also include the Maples Adolescent Treatment Centre, a designated, tertiary mental health facility under the *Mental Health Act* for youth 12-18 years of age, youth forensic services and youth justice substance use programs.
- Health authorities provide all other MHSU treatment and supports including mental health promotion and mental illness prevention, community-based substance use treatment for youth and adults, and acute and tertiary level mental health and substance use treatment for children, youth and adults.

Challenges

- Despite needing mental health and substance use (MHSU) supports, youth and young adults (YYAs) tend to access help through primary care, or other social supports such as education, housing, and vocational services.[3] This is largely due to stigma, and because MHSU services often do not respond to the distinct needs of YYAs.[4]
- Reports highlight the system challenges facing YYAs struggling with MHSU issues in BC. The Representative for Children and Youth's April 2013 report, *Still Waiting: First-hand Experiences with Youth Mental Health Services in B.C.*[5], and the November 2014 Select Standing Committee on Children and Youth *Interim Report: Youth Mental Health in British Columbia*[6], identify the difficulty navigating services across the child and youth, and adult systems.
- The 2016 Select Standing Committee on Children and Youth final report identified 23 recommendations including making multi-year funding available for integrated service delivery programs, focusing on "hub" site approaches, and developing a specific plan for transition-agedYYAs.

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[1] Government of Canada (2006) The human face of mental health and mental illness in Canada. Retrieved from http://www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php

[2] Kessler, 2005; Davis, 2003; Vander Stoep A. et al, 2000; Carter EW & Wehby JH, 2003.

[3] Mental Health Commission of Canada (2015) *Taking the Next Step Forward: building a responsive mental health and addictions system for emerging adults*

[4] Dooley & Fitzgerald, 2013; Casanueva et al, 2011; Manion, Davidson, Clark, Norris & Brandon, 1997.

[5] Still Waiting: First-hand experiences with youth mental health services in BC. April 2013. BC Representative for Children and Youth.

[6] Select Standing Committee on Children and Youth released their *Final Report: Youth Mental Health in British Columbia*

- In 2013/14, approximately 130, 000 children and youth aged 0 – 25 accessed hospital and physician services for MHSU in BC.[7] Recent analysis indicates 19 – 25 year olds make up approximately half of these help-seeking individuals aged 0 – 25.[7]
- Between 2009 and 2013 BC saw an increase of 43% in the number of MHSU hospital visits by children and YYAs aged 0-24. Hospital visits by individuals with anxiety and depression concerns was highest in 15-19 year olds, with visits for substance use concerns becoming more frequent in older age groups.[8]

System Level Improvements

- The Ministry, along with cross-ministry and community partners, and regional and provincial health authorities, has embarked on a number of initiatives to improve services for YYAs.
  - The Youth Mental Health Transition Protocol, being implemented across all regions, aims to ensure youth beyond 19 years of age are effectively transitioned to appropriate adult services using the principle of "best-fit", rather than chronological age.
  - The Child and Youth Mental Health and Substance Use (CYMHSU) Collaborative, operating since June 2013, brings together youth with lived experience and their families, care providers and decision makers to address important local, regional and provincial issues (see CYMHSU Collaborative Fact Sheet).
  - Foundry brings health and social services together in a single place to make it easier for young people to find the care, connection and support they need. Foundry is being implemented in up to 11 communities across the province. (see Foundry Fact Sheet)
  - MCFD has expanded the Agreements with Young Adults program to include youth and young adults up to age 26 up 48 months of financial support if they choose to access postsecondary, life skills training or mental health and substance use supports.
- Improving services for YYAs has also become a priority across Canada. In September 2015, the Mental Health Commission of Canada released *Taking the Next Step Forward Building a Responsive Mental Health and Addictions System for Emerging Adults*, outlining a number of recommended principles to improve services for YYAs.
- In 2015, at the direction of Canadian Health Ministers, a Provincial Territorial (P/T) Working Group on MHSU was established. Chaired by BC and comprised of experts from every P/T, developed two documents to support innovative practices in the provision of services to YYAs.
  - *Towards Integrated Primary and Community Mental Health and Substance Use Care for Youth and Young Adults: A Compendium of Current Canadian Initiatives and Emerging Best Practices.* This report was provided to the provinces and territories for their use.
  - *Integrated Mental Health and Substance Use Services for Youth and Young Adults: A report on emerging practices and potential enablers to integrated service provision.* This report is currently being finalized.

FINANCIAL IMPLICATIONS

- The mental health and substance use sector operating expenditures for 2016/17 were approximately $1.52 billion.
- The following funding has been or will be provided to support the development and implementation of integrated youth services (Foundry and sites):

[7] Carolyn Bell, Planning and Innovation Division, Ministry of Health to the CYMHSU Collaborative Learning Session 5, April 8,9 2015.
[8] BC Ministry of Health. Analysis of the Utilization of Acute Care Mental Health and Substance Use Services in British Columbia by Children and Youth (Description of results and recommendations). April 2015. Discharge Abstract Database, Health Sector Planning and Innovation Division, Ministry of Health. Project # 2015_0010 Filename: *Hospital Services for BC MHSU Patients 0910 to 1314.xlsm*

FACT SHEET

s.13,s.17

Integrated Youth Services Related Funding ($ Millions)	2014/15	2015/16	2016/17
InnerChange Foundation (one-time funding)	3.0		
Regional Health Authorities (RHA base funding)			2.5
Increase to RHA base funding			
Increase to RHA base funding			
Providence Health Care (BackBone support)			
PHC (continuing support for BackBone)			
Total Annualised Funding			

- Per the Committee's audited financial statements, as at March 31, 2017, $18 million has been invested in the CYMHSU Collaborative. The following table depicts the funding allocated up to 2017/18:

Fiscal Year	Expenditure
2012/13	-
2013/14	753,058
2014/15	3,661,635
2015/16	5,804,965
2016/17	7,761,394
Subtotal	17,981,052
2017/18	s.13,s.17
Total	

Approved by:
Sharon Stewart obo Ted Patterson, Primary and Community Care Policy Division; October 11, 2017
Gordon Cross obo Manjit Sidhu, Finance and Corporate Services Division; October 12, 2017

FACT SHEET

Child and Youth Mental Health and Substance Use Beds

ISSUE

A range of mental health and substance use community residential treatment, residential care, and supported housing options are available for children and youth with mental health and/or substance use problems in order to respond appropriately to an individual's service needs.

KEY FACTS

- A stable, supportive living environment is an important determinant of both physical and mental health and well-being. People who are struggling with substance use or their mental health require options to support their recovery and live effectively in their communities.
- Bed-based services are a part of a full continnum of mental health and substance use services provided to children and youth for children and youth include short-term, intensive residential programs such as withdrawal management, residential treatment, and supportive recovery and longer-term supported housing.
- While beds are a part of the continuum of care, it is important to note that not all treatment services require a bed, and that beds are needed by people who don't have safe, stable housing or need a higher-level of care and observation.
- Many bed-based services, such as residential treatment, are available to all children and youth in the province, regardless of their physical location and home health region.
- Substance use beds are for youth with a primary substance use problem. Mental health beds are for youth with a primary mental health problem. However, each service has the capability to respond to the unique needs of the youth, which may include access to mental health or substance use care. Some mental health beds are dedicated to youth to treat a particular diagnosis, i.e., eating disorders.
- As shown in Table 1, health authorities provide 224 community, acute and tertiary treatment and support beds for children and youth.

Table 1: MHSU Child and Youth Beds[1]

Health Authority	Community	Acute	Tertiary	Total
IHA	13		8	21
FHA	10	10		20
VCHA	36		10	46
VIHA	33	14		47
NHA	8	6		14
PHSA	36		40	76
BC Total	**136**	**30**	**58**	**224**

Community Beds (136 beds total)

These treatment and intervention beds are provided in a variety of community residential settings, and include a range of services.

- Mental Health Beds (14)
    - Eating disorder treatment beds at Looking Glass Residence – 14 beds
- Substance Use Beds (122)
    - Withdrawal management (detox) – 41 beds

[1] *MHSU Bed Survey, March 31, 2017, Project 2017_0213, HSIARD*

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- Residential Treatment – 42 beds
    - Supportive Recovery – 32 beds
    - Transitional Services – 4 beds
    - Supported Housing – 3 beds

Acute Beds (30 beds total)
Health authorities provide acute care inpatient treatment to youth experiencing mental illness and concurrent MHSU problems.These specialized MHSU hospital inpatient beds are usually short-term in nature providing assessment, treatment and stabilization; most are located in facilities designated under the *Mental Health Act*.

Tertiary Beds (58 beds total)
Tertiary care beds meet the needs of youth who require more intensive, long-term and/or specialized treatment, and have not been successfully treated in the primary and secondary mental health system. Services include: Assessment, treatment including stabilization of acute symptoms not resolved in other settings, and rehabilitation focusing on psychosocial rehabilitation and recovery.

- Child and youth psychiatric – 34 beds
- Eating disorder – 14 beds
- Concurrent mental health and substance use – 10 beds

FINANCIAL IMPLICATIONS

N/A

Approved by:
Sharon Stewart obo Ted Patterson, Primary and Community Care Policy Division; October 11, 2017
C. Voggenreiter obo Teri Collins, Health Sector Information, Analysis and Reporting Division ; October 12, 2017