

Mental Health and Addiction Services

Strategic Plan

Transforming Care Together

2007-2012



June 2007



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Acknowledgement

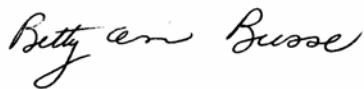
We are pleased to present the final draft of the 2007 – 2012 Fraser Health Strategic Plan for Mental Health and Addiction Services. Building on previous strategic and clinical planning, this plan identifies current strengths and successes, gaps and needs, and provides recommendations for a future comprehensive, integrated, and responsive system of care.

It is important to acknowledge contributions to the plan by our partners who are many; consumers, families, service providers and other key stakeholders. Stakeholders include not only those individuals and organizations within our region but partner health authorities and the Ministry of Health who are all working to ensure planning, service delivery, and policies are strategically aligned.

Mental Health and Addictions staff, physicians, and leadership are excited by the opportunity to seize the future by advancing these strategic directions and priorities. There is a great sense of optimism that in responding to the diverse needs of our population we will build and transform our programs and services, both along the hospital-community-residential continuum and across Fraser Health.

We know our success in meeting this strategic agenda over the next five years will be due to the commitment and passion of our mental health and addictions colleagues and partners. It is our hope that this plan will lay the foundation to enhance the service continuum, build effective and accountable programs, and improve system access and capacity for our clients and families.

Betty Ann Busse



Executive Vice President
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Executive Director
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Executive Summary

Mental Health is fundamental to health and human functioning. With proper treatment, the majority of people with mental illness and addiction can return to productive and engaging lives. Supporting good mental health of the population encompasses the continuum from health promotion, prevention, and supportive treatment to acute and long term rehabilitation. Although the focus of care is the individual, families and loved ones are key partners in recovery. Fraser Health's Mental Health and Addictions portfolio is responsible and accountable for partnering with clients, families and consumers, and other internal and external service providers to create more productive and rewarding lives for those who depend on its services.

The Fraser Health Mental Health and Addiction team is proud to continue to provide care within the system that has developed and at the same time is equally motivated to evaluate the need to change and transform the delivery system based on the population's changing needs. This high level strategic plan describes the current system, identifies the gaps, makes recommendations and will inform the team's work over the next five years.

This Strategic Plan, the result of an extensive process of review, research and consultation, outlines the priority recommendations essential to building a responsive, seamless, and effective continuum of care, now and through 2012. It was also developed to align with overall Fraser Health strategies, and to support the overall vision of 'Better Health, Best in Health Care'.

A driving factor for the need to evaluate and transform Mental Health and Addiction care is Fraser Health's population growth, and increasing numbers of people coping with serious mental illness and addictions. This population growth also involves a growing diversity, with its accompanying requirement to respond to a variety of sensitivities. There is no "one size fits all" treatment; rather, people need to have options available along the continuum of care to meet their clinical, developmental, gender and cultural needs at that moment in time.

The fundamental components of effective service delivery include integrated community based services, continuity of providers and treatments, family support services and culturally sensitive services. Effective service delivery for individuals with the most severe conditions also requires supportive housing and supported employment. For adults and children with less severe conditions, primary health care, schools and social services are key components of care. As senior health leaders reviewed the mental health system in Fraser Health, five strategic imperatives emerged as a framework to evaluate, plan and transform the continuum of care.

Strategic Imperatives

Five clear common themes emerged from the planning process. These require all future plans to:

- Address the changing needs of a diverse client population
- Transform the models of service delivery
- Enhance capacity and improve accessibility
- Strengthen coordination and integration
- Improve systems of information and performance monitoring

Principal Service Streams and Recommendations

The detailed recommendations in this Strategic Plan respond to the priority needs of thirteen client-centred service streams, and four supportive service streams. For quick reference, these service streams and recommendations are listed in Appendix 1.

Client-Centred Service Streams

Youth and Young Adult

Recommended priorities for this client group are built around the need to increase capacity. At the same time, the fact that mental illness frequently manifests in people before they reach the age of 24 drives the need to develop age-appropriate services.

Adult

Recommended actions for this largest group of clients recognize the need to transform how, when and where they receive services. Attention to best practices, along with the need to offer flexible options, is a priority in meeting the needs of these clients.

Older Adult

Seniors are a changing and diverse client group. Demographics clearly illustrate that the sheer numbers of future seniors will dramatically challenge the current system of services. Addressing this growth and diversity with flexible services is an urgent priority.

Specialized services and specific populations

Within each of MH&A's six main service streams are subpopulations who require additional attention because of some unique characteristics. Specific models of care have been developed and must be available to people with eating disorders, women with post-partum depression, individuals challenged by developmental disabilities along with mental illness, as well as mentally disordered offenders.

Some specific populations also need their unique needs addressed appropriately. Aboriginal communities; multicultural communities; the lesbian, gay, bisexual and transgendered population, as well as those who are homeless, face mental illness complicated by their differing issues.

Addictions

Recommended priorities for this group recognize the need to increase capacity, while at the same time actively seeking opportunities to strengthen coordination and integration. Individuals dealing with problematic substance abuse come into contact with many service providers and successes will increase when these agencies and groups cooperate to leverage their efforts.

Tertiary

Recommendations for this service centre on the need to increase capacity, while transforming models of care to respond to known and proven best practices.

Housing

Significant requirements to increase the capacity and scope of available housing resources drive the recommended actions for this service. A range of safe, affordable and suitable housing options is the first step in moving clients towards care and treatment services.

Supportive Service Streams

Providing care to such a varied client group requires a solid foundation.

Consumers and families have a significant and crucial role to play when someone deals with mental illness or substance abuse and their valuable contributions must be supported and encouraged.

As already noted, effective partnerships can greatly increase positive outcomes in most instances. Fraser Health itself, external organizations such as other Health Authorities, various government agencies, as well as with academic and research organizations are all sources of creative and innovative means of improving service delivery. Contracted service providers are also a key element in providing care and can play an important role in implementing proven best practices. Organizations which exist to provide support to and advocate on behalf of people dealing with mental health and addiction issues are another crucial source of partnership leverage.

Offering quality work environments and opportunities for growth and learning will create the essential workforce necessary for success. The ability to measure results and use data for future planning is another essential foundation on which to build quality Mental Health and Addiction services.

The ultimate success of this Strategic Plan lies in leadership. Within the Mental Health and Addiction portfolio, leadership is committed to achieving the key priorities of this plan. At the same time Mental Health and Addictions invites leaders both from within Fraser Health and all external stakeholders to become partners in the process of evaluating, developing and transforming mental health and addiction care for the residents of Fraser Health.

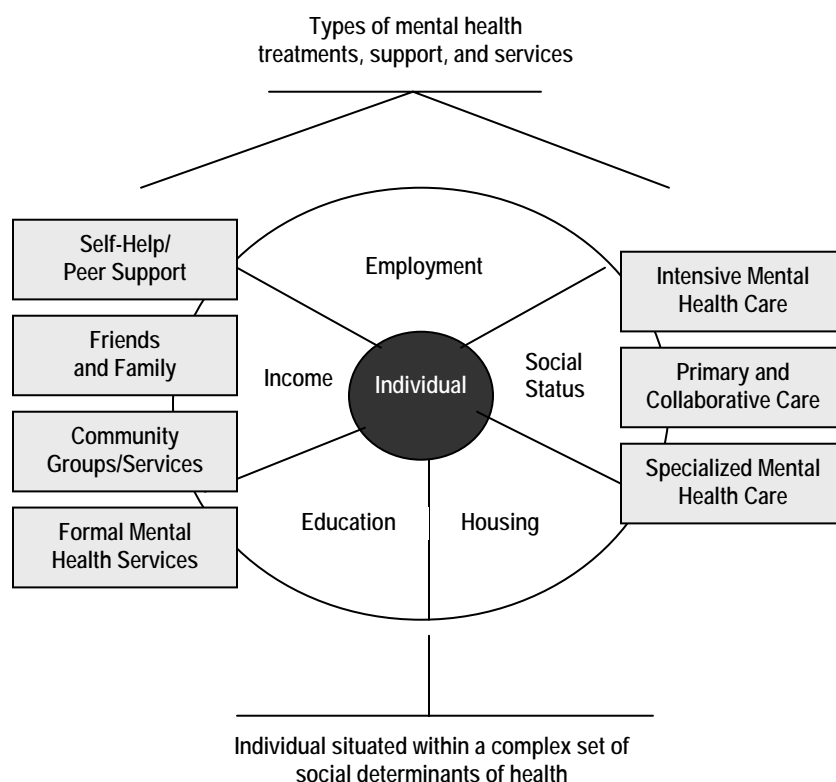
Introduction

Background

Mental illness and problematic substance use exact a staggering toll on millions of Canadians, as well as on their families and communities. In addition to the health-related impacts, enormous emotional, social and economic costs compound the issue. For those living with mental illness, appropriate interventions can alleviate, if not cure, the symptoms and associated disability of mental illness. With proper treatment and support, the majority of people with mental illness can return to productive and engaging lives¹. Likewise, for individuals who engage in problematic substance use, which has both mental and physical health implications, proper treatment can provide the opportunity to live a more productive and rewarding life.

A graphic illustration of the multiple complexities affecting mental health and addiction care is presented here, taken from a recently-published Federal report on mental health, illness and addictions.²¹

Figure 1: Mental Health Treatments, Supports & Services



Source: Final Report of Standing Senate Committee on Social Affairs, Science and Technology (2006) *Out of the Shadows at Last. Transforming Mental Health, Mental Illness and Addiction Services in Canada*.

¹ Appendix 3 outlines a useful glossary of mental health and addiction services

This diagram also highlights the situation that there is no “one size fits all” treatment option. Rather, individuals need to have continual access to a range of treatment options, and be able to choose the one that best suits their needs from a full continuum of services. The fundamental components of effective service delivery include integrated hospital and community based services, continuity of providers and treatments, family support and culturally sensitive services. Effective service delivery for individuals with the most severe conditions also requires supportive housing and supported employment. For those with less severe conditions, primary health care, schools, and social services are key components of care. While the focus of service delivery is on the individual, families are often key participants and important to recovery.

The provision of a continuum of mental health and addiction services is a continuing challenge, both within Fraser Health, and across Canada, as most types of services are consistently in short supply.

Purpose of the Plan

This plan document outlines the broad strategies recommended by Mental Health and Addiction Services as priorities for the next five years. When implemented, these actions will enhance the continuum of services and better meet the needs of consumers, families and communities.

In Fraser Health, the *2004-2006 Mental Health and Addiction Strategic Plan* has guided service delivery enhancements for Mental Health and Addictions (MH&A) over the past three years. This planning document outlined the principal goals and strategic directions for Mental Health and Addiction Services, and reflected the alignment of Addictions with Mental Health Services with the inclusion of the *Addictions Services Strategic Plan 2002-2005* as an appendix.

Mental Health and Addictions now has an exciting opportunity to further enhance its service direction with the development of an integrated MH&A Strategic Plan for 2007-2012 and an associated Service Plan.

Strategic Planning Process

Strategic plans are no longer created in isolation. Prior planning documents, feedback from internal and external stakeholders, clinical benchmarks, reference materials, and current issues all shape a collaborative and inclusive process to decide on future priority action plans.

The *2007-2012 Mental Health and Addiction Strategic Plan* was developed using a number of information gathering methods and sources. These included:

- Consultations with key stakeholders
- Information from MH&A Planning Documents
- Service Benchmark Analysis
- Extensive reference materials.

Consultations with Key Stakeholders

Key stakeholders across Fraser Health, both internal and external, were given every opportunity to participate in this planning effort. Their input and feedback dealt with strategic imperatives, service needs/gaps/barriers, and strategies for addressing these identified issues.

The process involved two steps:

- Internal consultations, involving MH&A Executive Director, MH&A Directors and Managers, and MH&A Medical Director and Chiefs of Psychiatry created the information necessary to develop a first draft of the Strategic Plan²
- The consultation working draft was then shared with Fraser Health staff and physicians³, service partners⁴, and consumers/families⁵ to gather their input.

Information from MH&A Planning Documents

Information was drawn from a number of previous MH&A Service Plans, Evaluations, and Reviews. These documents contributed substantially to the development of this Strategic Plan:

- The Acute Care Capacity Initiative (ACCI) Adult and Geriatric Psychiatric Clinical Service Plan (2006)
- The Acute Care Capacity Initiative (ACCI) Child and Youth Psychiatric Clinical Service Plan (2006)
- Mental Health 5 Year Housing Plan (2006)
- Community Residential Emergency Short Stay Treatment (CRESST) Utilization and Access Review (2006)
- Adult Community Support Services/Assertive Case Management (ACSS/ACM) Review (2005)
- Rehabilitation and Recovery Work Plan (2005 and 2006)
- Community Geriatric Psychiatry Services Strategic Plan (2002-05)
- CCHSA Mental Health and Addiction Survey (2004)
- Addiction Services Strategic Plan (2002-2005)
- MH&A Rehabilitation and Recovery Framework (2007 draft)
- Accreditation Documents (2004).

² See Appendix 4: Consultation List – MH&A Staff

³ Working draft of the plan was circulated to Executive Directors and Directors of other Fraser Health portfolios (e.g., Acute Care, Health Promotion and Prevention, Home Health, Aboriginal, etc.).

⁴ See Appendix 5: Consultation List – External Stakeholders

⁵ See Appendix 6: Consultation List – Consumers and Families

External Reference materials

In addition to these internal documents, external sources, including reports such as those from the British Columbia Ministry of Health and the Federal Government served as useful references to guide plan development.⁶ Particular attention was paid to sources detailing best practices in Mental Health and Addictions, as well as reliable references detailing current thinking in evidence-based care.

Service Benchmark Analysis

Benchmarks establish the appropriate level of services and resources necessary to meet average demands for mental health and addiction services in any given community.

A comparative analysis was conducted of current MH&A resources with external benchmarks for each of the service components of the care continuum⁷. Unfortunately, few provincial benchmarks exist, but where they were available, these were used to draw comparisons between the level of service which should be available to Fraser Health residents and the actual level of service currently provided.

Where provincial benchmarks were not available, national and international benchmarks were considered. For example, the New Zealand Blueprint (1998) benchmarking for mental health services is the only benchmarking that encompasses the entire mental health and addiction system. These benchmarks have been accepted and applied by the WHO and by jurisdictions within the United Kingdom and Australia.

There were obvious limitations using benchmarks which were not locally developed, but the exercise provided a preliminary framework with which to identify service needs/gaps and to consider potential strategic directions.

Planning Documents

The extensive planning and consultation process outlined here resulted in three separate documents:

- ***Consultation Working Draft***

This evolving document captured the full input details, and was shared with all interested stakeholders to obtain their feedback throughout the process. This document will continue to exist as the **Strategic Plan Development Document** as it includes approved clinical information, recommendations, goals, objectives and outcomes.

- ***Strategic Plan***

This higher-level document provides an overview of the Mental Health and Addiction context, and lists recommended actions for the coming years.

⁶ Appendix 11 contains an extensive listing of external reference sources

⁷ See Appendix 7 for Benchmark Analysis

- ***Service Plan***

The Three Year Service Plan is a detailed document for moving plans forward and describes goals, objectives, implementation plans and outcomes. It is also the means of measuring progress during the term of the plan.

These three planning documents will serve to create a more accessible, seamless, and responsive system of mental health and addiction care for MH&A clients and their families.

Strategic Planning Context

Fraser Health Population Trends

Population Size and Demographics

Fraser Health is the largest and fastest growing health authority in British Columbia, serving approximately 1.49 million people, or one-third of the total provincial population. The expected annual growth between 2006 and 2020 is 1.8% bringing the population to 1.60 million by 2010.

Fraser Health faces the same major demographic issue as many other services: an aging population. The proportion of seniors is increasing much more rapidly than all other age groups. The population over 65 years of age is expected to grow from 185,227 in 2005 to 219,525 in 2010, an increase of 19%. Even more challenging will be the projected 77% increase by 2020.

Fraser Health also has a diverse population, with a large number of Aboriginal, Asian, Indo-Canadian, Korean and Philippine ethnic groups. Approximately 13% of FH residents have a home language other than English, the majority of which are Asian languages. Across the health authority, there are approximately 46,000 Aboriginal people.

Mental Health

In Fraser Health, it is estimated that by 2010 roughly 48,000 people will be coping with serious and persistent mental illness. Between 112,000-159,000 people will have moderate mental health issues that will require a range of secondary services.

Table 1: Projected Population Targets for Mental Health Services

| Prevalence of Mental Illness⁸ | 2006 | 2010 |
|--|-------------------|-------------------|
| Total residents ⁹ | 1,490,000 | 1,598,000 |
| 17-20% may experience mild to moderate mental health issues which can be appropriately addressed through access to primary mental health care services | 253,000 – 298,000 | 272,000 – 320,000 |
| 7- 10 % will require a range of secondary services to address moderate mental health issues (anxiety, depression) | 104,000 – 149,000 | 112,000 – 159,000 |
| Approximately 3% cope with serious and persistent mental illness (bipolar disorder , schizophrenia) | 45,000 | 48,000 |

It is estimated that 14% of children and youth experience mental health problems³, which equates to approximately 5,580 youth (13-18 yrs) in Fraser Health with significant mental health needs by 2010. For seniors, the prevalence rates for mental health issues have been cited as between 17 and 30 percent. Therefore, it is estimated that by 2010 between 37,319 and 65,858 of those over 65 years will have mental health concerns.

⁸ Source: World Health Organization

⁹ Source: PEOPLE 31

Addictions

Across Fraser Health, it is estimated that by 2010 approximately 192,000-240,000 people will be in need of withdrawal management and/or treatment services for substance misuse issues. Of those, between 29,000 and 36,000 individuals will seek assistance.

In addition, an analysis of recent BC mental health and addiction data suggests that between 50-80% of people aged 15 to 64 who are receiving addictions treatment services are also receiving mental health services⁴. It is estimated that by 2010, there will be roughly 47,400 – 79,500 people in Fraser Health diagnosed with a mental illness as well as a substance misuse problem.

Table 2: Projected Population Targets for Addiction Services⁵

| Fraser Health population | 2006 | 2010 |
|---|----------------------------------|----------------------------------|
| Total residents ¹⁰ | 1,490,000 | 1,598,000 |
| 12-15% are in need of withdrawal management and/or treatment services for addictions. Of these individuals, roughly 15% will seek assistance. | 179,000-224,000 27,000-34,000 | 192,000-240,000 29,000-36,000 |
| 30% of people diagnosed with a mental illness will also have a substance abuse problem (lifetime), & 37% of people who abuse alcohol (53% who abuse drugs) also have a mental illness. ⁶ | 43,800 – 73,460 | 47,400 – 79,500 |

- Medium-demand scenarios of addiction service estimates

Fraser Health Strategic Directions

Mental Health and Addictions is committed to ensuring that its services are developed in accordance with local Fraser Health and provincial BC imperatives, and are informed by national and international knowledge about best practices and optimal service delivery models within Addiction and Mental Health services.

The Fraser Health Strategic Plan (2003) sets out the four strategic directions which are identified as critical for long-term success:

1. Developing an **Integrated Health System**. This is our core business and other strategic directions will align with, and support, the development of a more integrated high quality system
2. **People development** that will provide a foundation of skilled, satisfied employees, physicians and volunteers
3. **Partnerships** with communities, advocacy groups, academic institutions, public and private sector partners that will create new opportunities, innovation, and revenues

¹⁰ Source: PEOPLE 31

4. **Performance improvement** that will provide the information required to set clinical priorities, and evaluate value and effectiveness.

Strategies aiming to address all four of these strategic directions are necessary in order to develop a health care system which is sustainable, responsive and moves our services towards achieving the vision of '*Better Health, Best in Health Care*'.

Mental Health and Addiction Vision and Principles

The Mental Health and Addiction Vision, Purpose, Values, and Guiding Principles were developed as part of the 2002 strategic planning process, and are aligned with the Fraser Health vision of 'Better Health, Best in Health Care'. The Purpose and Values are also aligned with the Ministry of Health and the Fraser Health Authority direction for care and services.

Vision

Best in Mental Health and Addiction services within a recovery-oriented system.

Purpose

To improve the overall health status of individuals and families in Fraser Health through health promotion and prevention, and the provision of accessible, acceptable, effective and integrated Mental Health and Addiction Services.

Values

Care is based upon respect, compassion, integrity, and accountability.

Guiding Principles

- Service is client-centered as evidenced by an increase in consumer input into planning and feedback from end users of the service
- Prevention and early detection/intervention are fundamental components of our health care delivery system
- Service delivery, treatment, and allocation of resources are based upon best available evidence and review mechanisms established to monitor and suggest future improvements
- Equity, accessibility, responsiveness and accountability are key determining factors in the provision of Mental Health and Addiction services
- Reducing harm in order to strengthen protective factors which build resiliency, reduce risk among population groups and mitigate potential threats to health must be a key element in service provision
- The establishment of collaborative working relationships among the formal Mental Health and Addictions sector, consumers, natural support systems such as family and significant others, key internal and external stakeholders, and the citizenship sector is the foundation of integrated, accountable service delivery systems
- Continuous professional development is central to the implementation of evidence-based practices and the realization of a recovery-based system of care.

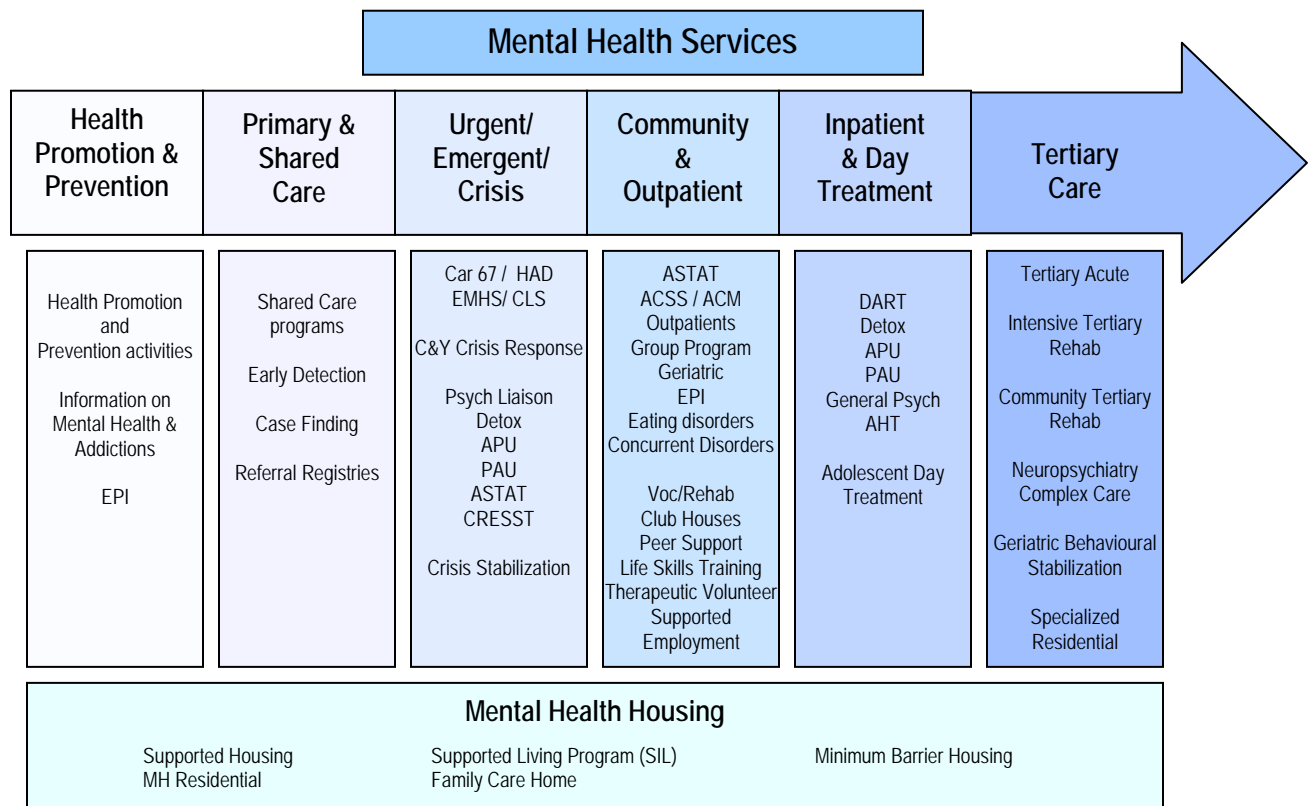
Current Mental Health and Addiction Services

Current Continuum of MH&A Services

Addressing the needs of a growing and diverse population involves developing a continuum of services that allows individuals to access a range of treatments and interventions, from health promotion, prevention and supportive treatment through to acute and long-term treatment and rehabilitation. Within such a continuum, the fundamental components of service delivery include integrated hospital and community-based services, continuity of providers and treatments, family support services and culturally sensitive services.

An overview of the current continuum of services for Mental Health and Addiction is presented in the diagrams below. Within Mental Health, a majority of current services fall within the categories of Urgent/Emergent/Crisis, Community/Outpatient, Inpatient/Day Treatment, and Housing. Fewer resources are currently dedicated to Prevention/Promotion, Primary Care/Shared Care, and Tertiary Care (see Figure 1).

Figure 2: Mental Health Services in Fraser Health



The Continuum of MH&A Services

Effective Mental Health and Addictions services are built on a comprehensive continuum of care. For the purpose of this Strategic Plan, the components listed below were used as a framework to guide future developments and investments. In each case, the description puts familiar health terms in the context of mental health and addictions.

Health Promotion and Prevention: Strategies to promote positive mental health evolve from the many personal, social, economic and environmental factors that are believed to contribute to both individual and community mental well-being⁷ and that are amenable to intervention and change by individuals and society.

Prevention of mental illness and substance misuse is about reducing the incidence and prevalence of these problems through public education, destigmatization activities and early detection and intervention. Mental Health has very limited resources dedicated to prevention and health promotion, but future initiatives could follow the innovative work done by Early Psychosis Intervention (EPI) with their advertising campaign of “Psychosis sucks”. This project aims to reduce barriers and encourage engagement with youth, so they may seek help with psychotic symptoms.

Health promotion and prevention is a complex and underserved area but research by the WHO has indicated that comprehensive programs for the detection and treatment of early psychosis can lead to: reduced duration of psychosis, reduced use of involuntary treatment, improved integration into work, training or school and improved consumer’s satisfaction with outcomes.⁸ Critical to these improved outcomes is the ability to reduce stigma associated with treatment, enhance knowledge transfer for families and clients and engage a wide range of providers and advocacy groups in the promotion of mental wellness. Fraser Health’s very successful engagement strategies during mental health awareness week are standards that need to be part of our every day work.

Within the Addictions sector, considerably more resources have been dedicated to prevention. Generally, Fraser Health outpatient services are required that 10-30% of clinical time is dedicated to preventative activities that directly address addiction issues. In addition to this, Fraser Health’s school and community based workers are involved in primary prevention aimed at strengthening protective factors and minimizing risk factors related to addictions.

Primary Care/Shared Care: The WHO states that “management and treatment of mental disorders in primary care is a fundamental step which enables the largest number of people to get easier and faster access to services. It needs to be recognized that many are already seeking help at this level.”⁹ Research estimates that 17-20% of a general community will experience mild to moderate mental health issues in any given year. These problem are ideally best addressed within a primary care setting. Currently, Fraser Health offers a full service Mental Health and Addictions Primary Care Clinic in Surrey, and supports 15 Shared Care programs across Fraser Health.

Within Addiction services, early identification and treatment which targets individuals showing early signs and symptoms of problematic substance use has been identified as important in slowing the progression of addiction, limiting harm, and promoting individual functioning.¹⁰ A future goal is that Fraser Health will develop more specific initiatives aimed at primary care providers who play a critical role in early identification and treatment.

Urgent/Emergent/Crisis: For Mental Health and Addictions services an urgent or crisis response often needs to be 24/7 or after hours and may take many forms:

- Psychiatric nurses in emergency departments to facilitate triage and crisis care planning
- Car 67 a partnership project based in Surrey, where first responders and clinicians provide outreach to individuals at risk to themselves or others
- CRESST (Crisis Response Emergency Short Stay Treatment) facilities providing crisis response and stabilization in a short-term residential setting
- Sobering Centers provide short term accommodation that allows inebriated persons to sleep off intoxication in a safe place, thus avoiding unnecessary visits to jail or hospital. A strategic recommendation is that Fraser Health implements a sobering centre in the future, as it provides clients opportunities to receive addictions services once sober.

All of these interventions seek to minimize the risk of harm to self or others, and offer short-term interventions including assessment, stabilization, and referral for follow-up services. Ideally, the goal of crisis intervention is to provide the right service at the right time to meet the client's needs during a crisis. It is by nature diverse, flexible, and timely and barrier free, and as a result often seeks to match the client's readiness to receive help.

Community and Outpatient Services: The Standing Senate Committee Report *Out of the Shadows At Last: Transforming Mental Health, Mental Illness, and Addiction Services in Canada* (2006)¹¹ refers to 'the Basket of Community or Outpatient Services' which are the core of a community-based mental health system. These include such services as assessments and referrals, individual and group therapy, Assertive Community Treatment (ACT) teams, and Case Management. Included in this service are the specialized services such as eating disorder programs, perinatal mental health services, developmental disabilities and mental illness treatment programs, many of which have long wait lists indicating the historical lack of expansion of these services within Fraser Health.

Community-based specialized Addiction services provide a range of outpatient treatment, assessment and referral, case management, monitoring and relapse prevention and education activities, through contracts with many Health Service Providers across Fraser Health.

The strategic plan clearly outlines that Fraser Health's "basket of services" related to community care, while serving the largest number of clients on the continuum has suffered from neglect related to capacity development. The plan outlines the need over the next five years to determine how to transform these services to ensure capacity development to meet the growing demand for care.

Inpatient/Day Treatment/Withdrawal Management: The Fraser Health acute care projected needs are determined in the Acute Care Capacity Initiative (ACCI) Clinical Service Plans for Adult/Geri-Psychiatry and Child/Youth with recommendations to increase bed capacity for PAU (Psychiatric Assessment Unit), Eating Disorders, Reproductive Psychiatry, as well as Secondary Acute beds.

In addition to inpatient bed capacity, there is an increasing focus on developing community-based alternatives to inpatient treatment, such as Acute Home-based Treatment, Day Hospital Services, and Intensive Day Evening Weekend addiction programs.

Within Withdrawal Management Services, it is important to expand service options and diversify in order to better address unmet demand. This includes establishing a comprehensive range of detox services from 'inpatient' detox and daytox through to home outpatient detox options and sobering centres. In addition to Withdrawal Management Services, there is a need to develop short term, assessment and stabilization beds for clients, known as the "secondary withdrawal management" system. These services support clients considered to be the most complex, multi-problem and marginalized.

Fraser Health provides low to moderate intensity residential treatment for adults 19+ in Stabilization and Transitional Living Residences (supported recovery). Intensive treatment is offered in three residential treatment facilities. Based on population projections, Fraser Health will need to increase the bed capacity for both recovery and treatment models.

Likewise, the youth residential treatment system does not have the capacity to meet the needs of those who require this intensive form of treatment. Planning is underway to develop the youth addictions continuum of care related to both long term residential services and shorter term wrap around services to support residential care.

Tertiary Services: Tertiary Care services are designed to serve clients whose needs are complex, refractory and cannot be met within the framework of primary and secondary mental health care. Planning commenced in 2002 with direction to redevelop the provincial tertiary Mental Health system in a manner that meets the unique needs of each local health authority population. Bed numbers were determined by the Ministry of Health in partnership with the health authorities. Fraser Health is expected to assume responsibility for 267 beds by 2010. Fraser Health is committed to developing new facilities and community resources to provide Adult and Geriatric Tertiary Mental Health services. Riverview Hospital has transferred over 63 beds to Fraser Health to date and both health authorities continue to work diligently toward meeting Ministry of Health performance targets over the next five years.

Housing: A guiding principle for Mental Health and Addictions is to provide a range of safe, secure and affordable housing options for clients. Appropriate housing allows clients with serious and persistent mental illness to live in an environment that increases possibilities to attain personal goals, by receiving appropriate mental health services while in stable housing.

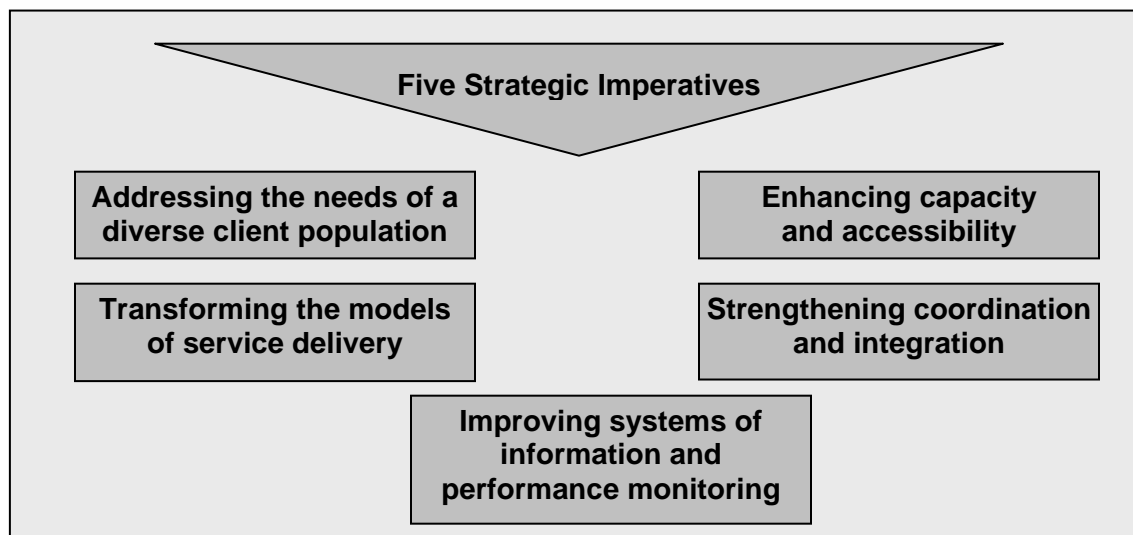
The Mental Health 5 Year Housing Plan (2006-2010) reviewed provincial averages across all health authorities as well as provincial benchmarks and made recommendations for three major areas of development to increase capacity and expand on the range of housing resources: specialized licensed residential beds, supported housing units, and subsidized rental units.

For Fraser Health Addiction services, there is a need to develop second stage housing. This type of “housing” allows individuals who have completed their primary level of addiction treatment to reside in time-limited housing supported by a case manager. Second stage housing builds on the hard work of recovery and prevents the likelihood of relapse, thus strengthening the better health of recovering Fraser Health clients.

Strategic Imperatives

Five clear common themes emerged from the planning process. These key strategic imperatives must drive system change for all Mental Health and Addiction service streams.

Figure 4: Strategic Imperatives for Mental Health and Addiction Services



Addressing the changing needs of a diverse client population

Fraser Health's population is changing more profoundly and more rapidly than at any time in the past. This change is reflected in the mental health and addiction issues facing local communities and residents. Future plans must recognize and continuously respond to this situation.

Examples illustrate this point:

- The growing population of older adults, both new and existing senior consumers, requires a more sustainable response from Mental Health and Addiction Services
- Services must respond appropriately to changing patterns of substance use/misuse
- Increasing complexity of diagnoses and co-morbidities demands increasingly complex solutions
- Fraser Health's diverse communities, including Aboriginal, visible minority, and gay, lesbian, bisexual and transgendered (GLBT) groups require health professionals to understand their unique issues and develop programs to meet those needs

- Some individuals are hard to engage in services – the homeless, those who have concurrent problematic substance use and mental illness, and/or have significant medical, social, financial and daily living problems. Assertive outreach interventions with strong partnerships to existing social, health, and community agencies are essential to respond effectively when individuals struggle with complex mental health and addiction problems.



Transforming the models of service delivery

Mental Health and Addiction Services are committed to a philosophy of care which emphasizes hope, recovery and self management, all which provide the least intrusive care options.

This philosophy manifests itself in a variety of ways:

- Within Addiction Services, adopting a Harm Reduction Framework will further shape the service delivery system. Harm reduction services focus on reducing the wider negative impacts and harm associated with problematic substance use, for those individuals not ready or unable to abstain
- There is an increasing call for a population approach to mental health care. This shifts service focus from longer-term interventions to enhancing treatment options for disorders which may be more amenable to short-term focused interventions
- Early identification, early intervention, and outreach and home based services, particularly to youth and specialized populations, have shown sufficiently positive results to justify continued use of these models of care
- Rehabilitation and recovery services are a significant component of a recovery-oriented system and currently under-available. Strengthening recovery-oriented practice involves being pro-active regarding housing, employment, education, and recreational opportunities for consumers. It also involves developing strong partnerships with many external stakeholders
- Health promotion activities and in the de-stigmatization of mental health and addiction offer potential for reducing the incidence and severity of illness, while encouraging individuals to seek assistance before their conditions become severe or chronic
- Strengthening consumer and family involvement in the planning, delivery and evaluation of services has also been shown to produce positive outcomes
- Training and education opportunities for workforce development need to be imbedded in overall action plans.

Enhancing capacity and improving accessibility

Quality mental health and addiction services are available in many communities throughout Fraser Health. However, they fail local residents when an individual needing care faces barriers such as insufficient capacity or restricted accessibility.

Service capacity does not meet current demand along many points of the continuum:

- Housing
- Community services
- Withdrawal Management
- Special populations
- Acute Care
- Urgent and Crisis Response Services.

The issue of inequitable access to services across the region must also not be ignored, and will likely require different solutions for different communities. Fraser Health's new organizational structure removes artificial geographic boundaries, making it much easier to reduce duplication, remove barriers, close system gaps, and make the overall menu of services more accessible.

Resolving capacity and accessibility issues also requires an increased ability to assess case weights – acuity and complexity – and caseloads. With this understanding, services can be tailored to known levels of need.

Establishing performance targets, and with known demand, decisions can be made as to whether services are provided locally or regionally.

Not unexpectedly, this strategic imperative drives the need to create a sustainable workforce and optimize recruitment opportunities.

Strengthening coordination and integration

Successful health services are best created through collaboration, leading to improved coordination and consistent standardized practice. A well coordinated system will result in reduced wait times and eliminate barriers to service.

An important first step to attain this strategic imperative is improving the alignment between Addictions and Mental Health Services.

Another priority is to strengthen the linkages between all Acute/Inpatient, Outpatient, and Community sites and programs.

A number of successful initiatives have enhanced integration and coordination including:

- Providing Psychiatric Liaison Nurses in Emergency Departments
- Creating the new role of Concurrent Disorder therapists
- Centrally managing Youth and Young Adult services
- Expanding Shared Care initiatives.

Such initiatives demonstrate MH&A's ability to creatively solve barriers to care for clients and their families.



Improving systems of information and performance monitoring

All services must be held accountable through established standards and measures. Ready access to clinical and service information supports planning, decision-making, performance monitoring and evaluation. This is dependent on the establishment of compatible information systems, and ultimately an electronic health record.

Within MH&A, pilot projects and new initiatives currently have evaluation and monitoring processes built into service design. However, this practice is not in place for core services and programs, but can be enhanced in conjunction with greater involvement in research opportunities. A Service Score Card to monitor the performance of the Mental Health and Addictions system must be developed and include indicators to measure access, safety, efficiency, costs, and effectiveness.

Principal Service Streams

Mental Health and Addiction principal services are divided into the categories listed here:

Client-Centred Service Streams

- Youth and Young Adult Service Stream
- Adult Service Stream
- Older Adult Service Stream
- Specialized Services
 - Eating Disorders Services
 - Concurrent Developmental Disabilities Services
 - Reproductive Mental Health Services
 - Mentally Disordered Offenders' Services
- Specific Population Services
 - Aboriginal Communities
 - Diverse Communities
 - Homeless Population
- Addiction Service Stream
- Tertiary Service Stream
- Housing Service Stream

Support Service Streams

- Partnerships
 - Partnerships within Fraser Health
 - Partnerships with External Organizations
 - Partnerships with Primary Care
- Consumer and Family Involvement
 - Consumer Involvement
 - Family Involvement
- Workforce Development
- Information Systems and Performance Monitoring

Specific recommendations have been developed for each category, selected to best advance each service, given its particular context and stage of development.

Client-Centred Services

Youth and Young Adult Service Stream¹¹

International epidemiological studies estimate that 3 out of every 4 cases of mental illness have started by age 24, and that the highest rates of mental illness are found among 18-24 year olds. At the same time, early and appropriate interventions have been shown to significantly limit the long-term impacts of mental illness. Taken together, these two facts make a compelling case for effectively meeting the needs of people who develop mental illness before the age of 24.

In Fraser Health, the Ministry of Child and Family Development, (MCFD), and B.C.'s Children's Hospital share with Fraser Health the responsibility for serving young people with mental illness.

Fraser Health's responsibilities include:

- Crisis response
- Day treatment
- Inpatient psychiatry services
- Early psychosis intervention
- Addiction services

Some rehabilitation and housing services also fall under Fraser Health responsibility. In total, 10 separate programs and services are offered to Fraser Health's youth and young adults.

Specific statistics are not easy to identify for the target population because sources collect stats for differing age groups. However, these points illustrate the ever-increasing number of potential young clients who will depend on Fraser Health for care:

- In 2006, 26% of Fraser Health's 1.49 million residents are aged 20 or less – that's approximately 390,000 individuals
- Trend projections show a 4.1% increase in this population by 2020
- Taking the Canada-wide statistic that 14% of those aged 13-18 experience significant mental health problems, this means that 5,680 individuals in Fraser Health need care. However, less than 25% of these children receive specialist treatment
- An estimate of more than 30,000 youth in Fraser Health could benefit from services to address problematic substance use
- Projections estimate that up to 5,000 youth may require addiction treatment services by 2010.

In general terms, Fraser Health is currently providing only about 50% of the required day hospital and inpatient care required. MCFD indicates similar challenges to meet service

¹¹ "Youth" refers to individuals aged 13-18 yrs, and "Young Adult" refers to individuals aged 19-24 yrs.

benchmarks, with the result that their formal plans call for increased services in the coming years.

A challenge unique to this service is the fact that an individual's illness and age transitions are not well aligned with age-categorized services as they currently exist.



Recommendation: Improve coordination, integration and networking between mental health and addiction services for youth and young adults

Fragmentation of services has been clearly shown to reduce effectiveness and thus outcomes. Within Fraser Health, the recent appointment of a Youth and Young Adult Manager for MH&A will reduce fragmentation, as well as increased collaboration with MCFD and other partner providers.



Recommendation: Expand early intervention capacity

Allowing a mental illness or addiction to become chronic and complex is no benefit to clients, and places an additional burden on already-scarce services. Evidence points to the positive impact of early intervention in reducing personal, occupational and financial burdens. Fraser Health's existing early intervention efforts have shown sufficient success to justify expansion. This success will also be enhanced by collaboration with primary care, and health promotion and prevention.



Recommendation: Increase acute care capacity for children, youth and young adults

A child requiring inpatient psychiatric care in Fraser Health is admitted to a general pediatric unit because the region has no inpatient beds. Youth requiring hospitalization are likely to be admitted to an adult unit, given that the current capacity for Fraser Health consists of 10 beds at Surrey Memorial Hospital. There are limited consultation services for children and youth who are admitted to alternate services.

Difficulties in this area are compounded by the lack of child and youth psychiatrists and insufficient community alternatives to hospitalization. Acute Home Based treatment is currently being piloted, showing good potential for further development, for individuals aged 17 years and older.



Recommendation: Develop rehabilitation services for young adults

With recovery as a core goal, the need for rehabilitation services is essential to support clients so they develop self-esteem and independent healthy living skills. Rehabilitation services for Fraser Health's young population have yet to be fully developed, and clients will benefit greatly from giving this component of the continuum priority attention. It is essential to respond to the unique needs of specialized populations, such as those of varied ethnicities.

Recommendation: Develop specialized residential facilities for youth and young adults in partnership with MCFD

Many young clients cannot count on a place of their own which is affordable, clean, quiet and close to amenities, and at the same time appropriate for their age. Emergency short stay, supported independent living, foster care, and crisis foster placement are just examples of the necessary residential facilities which must be available to prevent unnecessary relapses.

Signs of Success:

The priorities identified here, when implemented, are intended to create positive outcomes for young clients, as well as the effective use of available Fraser Health Resources. They will:

- Improve transitions and collaborative care during transition to adult services
- Respond more effectively to youth with dual problems of mental health and addiction
- Build more effective partnerships with MCFD across Fraser Health
- Increase early detection and prevention strategies through public awareness and education
- Reduce burden of illness on clients and their families
- Reduce waitlists, readmissions, and congestion in emergency rooms
- Increased independent functioning and quality of life for young adults living with mental illness.

A Story of Success:

“Clubhouse Without Walls”

The “Clubhouse Without Walls” is a recent innovation to serve youth struggling with a mental health and/or addictions issue. Services include vocational, educational, and social/leisure rehabilitation. Services target youth and young adults, ages 16-25, living in White Rock/South Surrey, Langley, Surrey, and Delta and supports them as they integrate into available programs in the community.

The “Clubhouse Without Walls” initiative relies on the establishment of close partnerships with MCFD, Services Canada, community agencies, local businesses, and Parks and Recreation.

Anticipating approximately 100 clients each year, the “Clubhouse Without Walls” uses a recovery-oriented model which encourages independent functioning and improved quality of life. Offered in a variety of locations in the community on a 1:1 and group basis, the program aims to encourage independent functioning and quality of life in all aspects of the client’s life.

Adult Service Stream

Fraser Health clients look to Mental Health and Addiction Services to create hope and positive outcomes as each individual navigates the complex journey towards stable mental health. In practical terms, this means the right service in the right place at the right time. This is particularly essential because many clients experience some degree of relapse during their treatment for mental illness or addictions. To respond effectively to this situation, services along the continuum need to be flexible enough respond appropriately to clients' changing needs. An essential component of care is to also support to clients' families¹².

Integration and coordination between all inpatient, outpatient and community mental health sites, as well as between Mental Health and Addiction, is key to successfully meeting current and future demands. An ongoing priority need to build this coordination is a fact of life for Mental Health and Addiction Services.

Adult Mental Health and Addiction Services currently provide all communities' clients, aged between 19 and 64, with hospital-based, outpatient, and community mental health services.



Recommendation: Ensure that Community Mental Health Centers (CMHCs) are providing the best model(s) of care and are operating with appropriate resources

The population approach to mental health results in Mental Health and Addiction services expanding their focus so they are more responsive to conditions such as anxiety and depression which benefit from shorter-term interventions. In the past, more attention had been given to chronic and severe conditions, e.g. schizophrenia, requiring lengthy treatment.

This expanded mandate drives the need to review community services' capacity. The clinician-to-client ratio is known to exceed best practice guidelines; resource levels are not equitably distributed across the region; group therapy programs must become more accessible, and current service hours may not best meet clients' needs.



Recommendation: Incorporate rehabilitation and recovery core values and practices throughout Mental Health Services

Recovery-oriented care is "person-centered," so clients can build strengths and skills to manage their illness and function with greater independence.

These core services are known to achieve beneficial and effective rehabilitation:

- Peer delivered services
- Clubhouse, drop-in and community rehabilitation centers
- Specialized rehabilitation funds

¹² For the purposes of this document, the term "families" is used to refer to both traditional and non-traditional members and significant others

- Rehabilitation specialists - Occupational and Recreational Therapists, Vocational Rehabilitation and Educational Counselors
- Access to psychologists for diagnostic testing related to client vocational/educational goals.

An increased complement of skilled staff is required so they can be deployed across the service continuum and offer recovery-oriented rehabilitation services.

Addressing Needs

Recommendation: Improve service engagement with individuals who are hard to reach

Hard-to-reach persons are homeless, have inadequate housing choices, have concurrent problematic substance use and mental illness, and/or have significant medical, social, financial and daily living problems. In addition, some individuals may fall into the hard-to-reach category as a result of cultural barriers, e.g. Aboriginal population. Assertive outreach interventions with strong partnerships to existing social and health agencies are crucial to improving responsiveness to this population.

Currently, clinical case loads for this most complex, vulnerable, and at risk client group are outside established benchmarks and this gap will increase as population grows.

It is important to develop Outreach models of service delivery especially for those individuals who are street entrenched.

Transforming Services

Recommendation: Expand implementation of early intervention strategies

As already noted in the Youth and Young Adult section, early intervention is proven to increase successful outcomes. Resources for Early Psychosis Intervention services are inequitably distributed across Fraser Health, despite increasing demand for this successful service delivery model.

Enhancing Capacity

Recommendation: Increase acute care capacity

The Acute Care Capacity Initiative (ACCI) *Clinical Service Plan* estimated that Fraser Health currently requires an additional 121 inpatient acute beds. Future demands put the requirement by 2010 at 231 additional beds, for a total of 408 beds.

Increased acute capacity must also be addressed with additional day hospital places, more assessment beds, acute home treatment options, and specialist beds for such conditions as eating disorders and reproductive programs.

Pressures on psychiatric beds and shortened lengths of stay have made it difficult for patients to access hospital admission in a crisis. This intensive treatment approach may not be the best setting to address the social causes of the crisis and some patients and families would prefer to avoid a hospital admission if possible. For this reason, alternatives to hospitalization are an important part of a flexible and comprehensive mental health system.

Three alternatives to hospitalization exist -- crisis residences, acute day hospitals and acute home treatment – with the latter most recently developed by Fraser Health. Acute Home Treatment, the

least restrictive and the least stigmatizing form of acute treatment, is consistent with principles of recovery. Evaluations have shown that acute home treatment can reduce rates of involuntary admission and that most patients and their families prefer it.



Recommendation: Improve crisis/emergency services

There is a clear need to re-evaluate whether Emergency Departments are the best entry point into inpatient mental health services. Currently, 78% of clients are referred through the Emergency system.

Urgent/Emergent service capacity needs to be enhanced and consistently available across Fraser Health in order to mitigate demand for Inpatient Psychiatry Unit beds. With the exception of the Emergency Room Psychiatric Liaison Nurses, there are only limited and inequitable After-hours Mental Health services.

Recommendation: Expand health promotion and prevention activities



From a population approach to health care, promotion of mental health and well-being is about reducing the incidence and prevalence of mental health problems through public education, destigmatization activities, and early detection and intervention.

Given the recognized long-term benefits of health promotion and prevention, Mental Health needs to build on and expand its health promotion and prevention activities across the health authority. Such efforts should be in partnership with other Fraser Health portfolios and with external organizations who have already dedicated significant resources to this issue.

Signs of Success:

These recommended priorities in Adult Services are intended to respond more effectively to client and family needs, and achieve these benefits:

- Improve match between services and client needs
- Improve access to community services through better coordinated intake processes
- Limit harm associated with problematic substance use
- Decrease the need for more intrusive interventions
- Reduce hospital admissions and/or length of stay
- Improve access to consistent after-hours services
- Increase community awareness of the potential to prevent or minimize mental illness.

Stories of Success:

Acute Home-based Treatment

The pilot Acute Home-based Treatment (AHT) Program provides home based psychiatric treatment, as an alternative to in-patient hospital treatment, for individuals with acute mental disorders, who would otherwise need admission. The AHT program offers short-term, intensive home-based treatment, with staff available seven days a week.

Based on national and international models, this innovative service is provided by a specialist team of psychiatric nurses working with referring psychiatrists, and can serve between eight and twelve patients at any one time.

The program's clients are suffering with acute psychiatric illness, are aged 17 years and older, and live in Langley and White Rock/South Surrey. They must be agreeable to receiving care in their home environment and can be safely managed. Patients are initially seen twice daily with frequency of visits decreasing as the patient improves.

The key elements and principles of home treatment are: home visiting, the services of a psychiatrist, rapid response, and rapid access to medication, engaging the help of families and other care givers, availability of help at least daily, and remaining involved until the crisis resolved.

Chilliwack General Hospital Outpatient Partial Hospitalization Program

The Chilliwack General Hospital Partial Hospitalization Program provides treatment for adults experiencing varying degrees of situational, mental, behavioral or emotional problems, which interfere with their daily living but do not require full hospitalization.

The treatment focus is primarily on psycho-educational, cognitive-behavioral and process-oriented group therapy. Referrals to this program are through family physicians, psychiatrists, inpatient psychiatry unit, emergency mental health services, Psychiatric Liaison Nurses or the community mental health centre.

The Partial Hospitalization Program consists of three components. A three-week Day Hospital Program operates Monday-Friday, while two Depression Groups and a "Managing Difficult Emotions" group are also offered. Patients attending the Partial Hospitalization Program must have a history and physical completed by a physician prior to entering the program.

This program has been successful as a step-down resource for discharged patients who require short term intensive support. It also serves as an alternative to hospitalization.

Older Adult Service Stream

The older adult population is recognized as one of the more underserved client groups in Fraser Health, and this deficit will increase as the population grows. Given this, geriatric mental health and addiction services will require considerable service enhancements over the next several years. Coordinated approaches to care that include strong partnerships with community resources that serve the older adult population are essential, such as home care, chronic disease management, and community residential services. Families can also play an important role and need to be part of the treatment team.

Planning to provide geriatric mental health services must take into account a number of issues specific to this particular population:

- Major population and societal changes for the older adult population are anticipated in the coming years. Across Canada, the proportion of seniors is increasing more rapidly than all other age groups. The greatest impact on services will be the increase in elderly patients who have complicated co-morbid medical conditions along with mental health concerns. From 1991- 2001, the 80+ population grew by 41.2% and from 2001-2011 an additional increase of 43% is expected¹²
- The increasing older adult population will not only place more demands on mental health services, but will increase the need for culturally responsive services
- Mental health is an often neglected senior's issue. The two most common mental health problems are cognitive impairment and depression. The rate of mental health issues for seniors has been cited as between 17 and 30 percent)¹³
- While the older adult population includes people from 65 years + years, the health and mental health needs of the sub-population of younger active and healthy seniors will differ noticeably from the older sub-group of seniors who have complex health and disability issues. For example, dementia becomes more prevalent with increasing age
- The impact of age associated diseases often complicates the presentation and treatment of mental health conditions. For some of the communities, lack of appropriate public transportation is a significant barrier to accessing services
- Literature suggests that there are four main psychosocial factors that impact substance abuse by seniors: the death of spouse, family, friends; retirement; losses in the social network; and enabling attitudes and behaviors.



Recommendation: Determine the best model of care for community older adult mental health services

Current resources for community geriatric mental health services will not be able to meet the projected demand for mental health services required by the older adult population.

A standardized model of care, consistent with Best Practice guidelines, and associated core level of service, must be identified and implemented across Fraser Health. A flexible model/continuum of care will range from one time consultative assessments to intensive client treatment and follow-up

and extensive case management to other forms of collaborative/shared care. Planning for this model must include an analysis of resources required for implementation.

Strengthening
Coordination

Recommendation: Improve coordination and collaboration with health care providers serving the older adult population

To effectively address the complex interaction between medical and mental health needs within the older adult population, especially the frail elderly population, will require Mental Health and Addictions to build stronger links with related Fraser Health programs.

Earlier Fraser Health planning recommended a multi-disciplinary approach to care with family physicians functioning as the primary care providers and coordinators of healthcare, even though the specialist mental health and addiction professionals may be providing intensive follow up to the individual. Collaborative and shared care services are vital to successfully provide mental health services for geriatrics.

Strengthening
Coordination

Recommendation: Ensure alignment with the Provincial Dementia Strategy

It is important for MH&A, in partnership with other portfolios within Fraser Health, e.g. Home Health, and Geriatric Services, to move forward with the implementation strategy for the Provincial Service Framework for Dementia.

Enhancing
Capacity

Recommendation: Build the continuum of older adult acute care services

No Fraser Health communities have fully developed secondary psychiatry services for older adults. These mental health and addiction consumers often end up receiving treatment in general medical/surgical units or Emergency Departments.

This lack of dedicated secondary inpatient psychiatry beds for the older adult population results in less than optimal care with a significant impact upon the flow through and utilization of acute care resources. The exceptionally large projected increase for this population will result in a significant need to provide acute care geriatric psychiatry services.

The estimates for secondary geriatric psychiatry bed requirement ranges from a low of 16 to a high of 45 beds.

The BC Ministry of Health Services promotes seniors day hospitals as an alternative to inpatient hospitalization, which will facilitate early discharge and prevent unnecessary inpatient admissions. Fraser Health's ACCI plan recommends the specialized geriatric psychiatric day hospital service which would serve patients who could remain in their own homes but receive acute treatment during the day.

In addition to day hospitals, Acute Home Treatment has been identified as a promising approach to expand the acute care service options for older mental health consumers.

Recommendation: Increase housing options for older adult mental health and addiction consumers

Specialized residential care for older mental health and addiction consumers is essential to more appropriately meet their changing physical and mental health needs. Over the past few years, work has begun on planning and developing housing options for seniors with mental health concerns. Purpose-built aging-in-place residential facilities have been established in some areas within the Fraser Health region. These facilities successfully provide supportive care for consumers experiencing co-existing mental health and early dementia (see Story of Success below).

Signs of Success:

Mental health and addiction services to seniors will benefit in a number of ways from implementing these recommendations, which will:

- Improve coordination, organization, delivery and capacity of MH&A services for the senior population
- Increase number of health professionals with expertise in Geriatric Mental Health
- Ensure the implementation of a comprehensive dementia strategy for Fraser Health
- Support successful interagency and interdepartmental collaboration
- Provide access for seniors to appropriate inpatient services
- Increase access to safe residences for Mental Health and Addiction clients as they age.

A Story of Success:

Topaz Place

Topaz Place is a 12-bed mental health residential facility designed to meet the changing physical and mental health needs of residents as they navigate the aging process. The facility is the result of partnerships between the provincial government, Fraser Health, the City of Chilliwack and MCC Supportive Care Services.

The 12 residents of Topaz Place are primarily elderly mental health clients requiring 24/7 care in a group home facility. These residents require both mental health as well as physical care. Topaz Place is unique for two reasons. It is:

- The first purpose-built community mental health facility designed for aging in place in the Fraser Health region (i.e., single level facility, wheelchair accessible, assistive devices/equipment, etc.).
- The first community mental health facility to incorporate “green building technology” in the Fraser Health region and the first to be certified under “Energuide 80”.

Specialized Services

Best practice suggests that people with complex mental health problems are best served by specialist teams of professionals with specific skills and experience. These services can either provide consultation to other health and mental health professionals or directly assist consumers.

Eating Disorders Services

Eating Disorders are estimated to affect up to 5% of the population, and are associated with both high morbidity and mortality. Best Practice supports access to a comprehensive continuum of specialized Eating Disorder services.

Eating Disorders services currently provided within Fraser Health include outpatient services, limited group programs, limited community support and professional consultation. A recent needs assessment identified gaps in the service continuum. For example, no outpatient services are available for clients residing in Fraser East, there are no designated promotion/prevention activities, and only limited access exists to residential and inpatient treatment.

Fraser Health requires an integrated continuum of care for eating disorders, incorporating some of the components of the Calgary Eating Disorder Program. This model should include the following elements:

- Inpatient care for medical and psychiatric stabilization
- Residential care for both adult and youth clients
- Day treatment program for clients who require more intensive treatment than can be offered through an outpatient program.
- Crisis response for clients who become more seriously ill and/or go into crisis.

Enhancing
Capacity

Recommendation: Develop inpatient capacity for treatment of eating disorders

Currently within Fraser Health, there are no specific inpatient facilities for medical and psychiatric stabilization and tertiary treatment beds for eating disorders. Emergency medical stabilization is *only* available at the Tertiary Treatment Centers, St. Paul's and B.C. Children's Hospital, which have very limited bed capacity. All medical stabilization of eating disordered clients who live outside Vancouver must be provided in the community in which they reside.

It has historically been difficult to admit eating disorder clients to medical or psychiatric beds within Fraser Health, indicating a need for specialized designated beds for patients with eating disorders. Initial estimates were for 2-3 dedicated beds¹⁴.

Enhancing
Capacity

Recommendation: Enhance community outpatient treatment capacity

The 2005 Needs Assessment of the Fraser South Eating Disorders Program concluded that the waiting time to access the outpatient treatment program is too long, potentially taking many months after referral before a client is admitted to the program. Moreover, only those with Anorexia Nervosa, Bulimia Nervosa and EDNOS (Eating Disorders not otherwise specified) are able to be assessed in the Fraser South program. There is a lack of services to address the needs of those with Binge Eating Disorders. Similarly, Fraser South lacks capacity for early intervention with children and youth with EDNOS. Again, there is no equivalent community service for clients residing in Fraser East.

Addressing
Needs

Recommendation: Provide support to clients waiting for treatment

While on the waitlist for outpatient treatment, referred clients typically receive little or no contact or support from the outpatient programs. Some clients may experience a significant deterioration in their health during the lengthy wait for treatment, while others may change their mind about entering treatment. Family physicians are placed in the difficult position of managing complex and time consuming cases without expert advice from the programs.

Strengthening
Coordination

Recommendation: Increase community and service provider awareness/understanding of eating disorders and available programs

In general, family physicians, counselors, school administrators, community service agencies, as well as consumer and family organizations have limited understanding of eating disorders and lack awareness of treatment programs available through Fraser Health.

Signs of Success:

Fraser Health's increased focus on the specialized services needed by those with eating disorders will lead to:

- Improved access to specialized inpatient treatment
- Reduced waiting time for range of community services
- Increased consultation with mental health centers, hospitals and family physicians
- Earlier interventions and treatments
- Increased public awareness and health promotion.

A Story of Success:

Group Benefits

The increasing number of people dealing with eating disorders, and the challenge in providing timely appropriate care inspired an innovative pilot project in Fraser South.

Through a collaboration of the Psychiatric Outpatient programs at Langley, Peace Arch and Delta hospitals, ED clients were offered the support of participating in a psycho-educational group. Both individuals awaiting access to treatment, and those in the general mental health system were able to avail of this service.

Fraser South Eating Disorders Program staff noted a number of benefits from their efforts. These included enhanced relationships with community partners and an increase in their awareness of and ability to work with eating disorder clients, as well as greater support for clients on the program's waiting list.

With additional training, the program can further strengthen community partners' capacity for early intervention.

Concurrent Developmental Disabilities Services

In the general population, approximately 1% will be identified as having a developmental disability, and of these, approximately 30 - 40% will experience mental health disorders. Based on these estimates and using the population projections for 2006, approximately 8,000 to 10,000 people living in the Fraser Health and Vancouver Coastal catchment area will have both an intellectual disability and a mental health disorder.¹⁵

The West Coast & Fraser Health Mental Health Support Teams (MHSTs) support people with developmental disabilities and mental illness across the Vancouver Coastal Health (VCHA) and Fraser Health Authorities. The program serves clients who are 14 years of age or over; have an IQ of 70 or less; have a mental disorder and/or challenging behaviour; and have developed their intellectual disability before the age of 18. The MHST, although assessment/consultation focused, provide many other treatment and support services:

- medication treatment and follow up
- behavioral intervention
- counseling, art and music therapy
- direct short term crisis support
- education and in-service training

Improving
Access

Recommendation: Improve access to tertiary acute care for individuals with concurrent developmental disabilities

Hospital psychiatric inpatient units are often reluctant to admit clients with both developmental disabilities and severe mental illness due to a lack of understanding of the sometimes unusual presentation of psychiatric symptoms, as well as the tremendous support that some individuals require while hospitalized. The MHSTs have made a concerted effort, particularly during the past year, to visit emergency and psychiatric units and provide educational sessions to staff.

The ACCI examined future resource requirements for specialty beds for adults with developmental disabilities with a 70 IQ cut off. Their estimates ranged from a low volume estimate of 2 beds to a high volume estimate of 6 beds.

Strengthening
Coordination

Recommendation: Build collaborative working relationships in order to better serve/support individuals with concurrent developmental disabilities

In order to effectively work with individuals with co-existing health challenges and their families/caregivers, strong relationships must exist between service providers and with the wider community.

It is important for MHST to forge relationships with principal partner agencies. Currently, collaboration and mutual understanding must occur among eight different agencies in order to provide appropriate and improving services to this special population. MHST must work in partnership with MCFD to ensure that the youth with mental illness and intellectual disabilities receive the services they require.

Enhancing
Capacity

Recommendation: Enhance capacity and continuum of community-based services

Mental health service teams for individuals with developmental disabilities were created throughout the province of B.C. in 1991 as a result of the closure of the institutions in the province that housed and provided mental health services to many of these individuals. Until 2004, no new financial resources were added to the service, making it increasingly difficult to provide support to the growing population.

The Mental Health Support Teams Three Year Strategic Plan (2005) identified three strategic priorities for the service:

1. To increase clinical services to clients in order to meet the demand created by a growing population and increased focus on community intervention in health care.
2. To build relationships with VCHA to determine a formula for increasing the resources of the West Coast Mental Health Support Team.
3. To decrease waitlists and provide mental health services to individuals with intellectual disabilities in a timely fashion.

Enhancing
Capacity

Recommendation: Provide increased training and education about concurrent developmental disabilities

One of the key services provided by the MHST program is education and training to health care providers, clients, families, care providers, teachers, etc. Two part time employees are dedicated to this important task. All other clinical staff and contractors provide some education and training as part of their job description. This component of the program is vital to ensure that there is a greater understanding of the needs of this client group.

Signs of Success:

The recommendations in this section are designed to lead to improved outcomes including:

- Increased access to specialty tertiary care beds
- Appropriate referrals to the MHST
- Increased understanding, acceptance and integration of individuals with developmental disabilities and mental illness.

A Story of Success:

First Person Unique

Challenges and triumphs, and years of distinctive experiences, became an anthology of stories, each created and submitted by patients and their families. What made the stories different was that they gave a voice to a unique group of people: those who deal with the combined challenges of developmental disability and mental illness. These stories are collected in the book: "Success Stories from the Frontline".

The West Coast and Fraser Health Mental Health Support Teams care for these patients, supporting their many and complex needs. The collection of stories, spelling out an unfiltered reality, is a testament to the team's success with their clients.

Reproductive Mental Health Services

Data suggests that 40% of perinatal women in B.C. see a physician for mental health support, and about one-third of those specifically for depression. However, it is believed that only a third of women experiencing depression seek professional help.

In 2006/07, the Ministry of Health directed the Health Authorities to develop regional plans to strengthen perinatal depression services. Post partum depression is planned to become a MOH performance target in the 2007/08 fiscal year.

A Reproductive Psychiatry Clinic has been established at Royal Columbian Hospital. This clinic provides psychiatric services during pregnancy planning, during pregnancy, and for one year post-partum for patients needing psychiatric assessment and/or follow-up (medication management, counseling). Referrals to the clinic are made by the patient's family physician, and assessment and follow-up services are provided by a psychiatrist and a nurse counselor.

Enhancing
Capacity

Recommendation: Develop a Fraser Health Reproductive Mental Health Implementation Strategy

The B.C. Ministry of Health in partnership with the B.C. Reproductive Mental Health Program released a provincial *Perinatal Depression Framework* in (2006).¹⁶ This document provides guidance to Health Authorities in improving responsiveness to women with perinatal mental health difficulties. The Framework details four pillars for effective services:

- Education and prevention activities
- Universal screening and diagnosis
- Treatment and self-management initiatives
- Development of coping and support networks¹⁷

Mental Health services have an important role to play, in partnership with Maternity and Public Health Nursing Services in the development and implementation of a Fraser Health Reproductive Mental Health Strategy to provide specialized mental health services to new mothers. The Strategy must address the development of both community and inpatient specialist reproductive services. In addition, the establishment of reproductive psychiatry clinics must involve partnership with the B.C. Perinatal program.

Signs of Success:

A Reproductive Mental Health program will create improved outcomes such as

- Earlier identification, assessment, and treatment of women experiencing post-partum depression
- Physicians, staff, care providers and residents benefit from education offered by Fraser Health, thus becoming more aware of post-partum depression and its prevention strategies.

Services for Mentally Disordered Offenders

Research shows that there is a relatively high prevalence of substance misuse and mental disorders among offenders in the criminal justice system, thus indicating that many clients of Mental Health and Addiction services are or are at risk of becoming involved with the law.



Recommendation: Strengthen partnerships aimed at promoting a coordinated approach to the delivery of services to mentally disordered offenders

A coordinated approach to the delivery of health and social services to mentally disordered offenders will reduce the risk of their initial contact with the criminal justice system and reduce the risk of recidivism following sentencing. Given this, there is a need for MH&A to coordinate and collaborate with various agencies to meet the needs of this population, including RCMP/Police, Forensic Psychiatry Services, Ministry of Employment and Income Assistance (MEIA), BC Housing, and BC Corrections Services.

Signs of Success:

Following action on this recommendation, positive outcomes will include:

- Addiction Services are increasingly involved for consultation and services to this group
- Formal agreements and established communication links exist between health, social and law enforcement agencies
- Mental health clients when in conflict with the law receive improved care.

A Story of Success:

Partnerships and the “one stop shop”

Mentally disordered offenders can successfully reduce their risk of recidivism, thanks to a partnership effort by MH&A, the Ministry of Employment and Income Assistance, Ministry of Public Safety and Solicitor General, Corrections Branch, and Community Corrections.

All it now takes is one visit for a client to report to the Probation Officer, see the MH&A counsellor, and touch base with the Employment Assistance Worker.

The pilot project's initial success led to annual funding for the liaison program and creation of six full-time liaison workers to serve communities across Fraser Health. In addition to providing integrated service and removing system barriers, the program results in all partners gaining a greater understanding of mental health and addiction issues.

Specific Populations

Mental Health and Addiction services have a commitment to ensure equity of access to all community residents, including those who create the region's unique diversity.

Fraser Health is home to one of the most ethnic and culturally diverse populations within British Columbia. These statistics tell the story¹³:

- Fraser Health has the second largest population of visible minorities (27.1%) in the province
- Twenty-nine percent of the Fraser Health population is foreign-born
- The largest visible minority groups in Fraser Health are South Asian (136,280 or 10.4%) and Chinese (107,185 or 8.2%)
- Other visible minority groups include Filipino (25,695), Korean (20,255), South East Asian (13,805), Black (12,285), Latin American (10,880), Japanese (9,880), West Asian (8,545) and Arab (3,205)
- Across the health authority, there are approximately 46,000 Aboriginal people
- According to the 2001 Census, about 13% (142,950) of Fraser Health residents have a home language other than English, the majority of them Asian languages. Punjabi (44,585) and Cantonese (16,970) were the two top most spoken languages at home

Due to the cultural diversity within Fraser Health many residents have a unique perspective on how extended family, support systems and significant others engage in the delivery of an individual's health care. This diversity requires MH&A employees to continually ensure their services are accessible to and engage with cultural or ethnic minorities. For example: same sex couples may encounter unnecessary barriers to ensuring next of kin status or there are complex implications for staff who work to involve large extended families in health care decision making. Additionally, there will be a need to ensure that the workforce has sustainable cultural responsiveness training and support to work most effectively with the evolving ethnic population.

¹³ Source: Census 2001

Aboriginal Communities

In Fraser Health, there are approximately 46,000 Aboriginal people, including Status and Non-Status First Nations, Métis and Inuit.

Table 5: Distribution of Fraser Health Aboriginal Population¹⁴

| Health Area | Aboriginal Population | | Non-Aboriginal Population | |
|--------------|-----------------------|---------|---------------------------|---------|
| | Number | Percent | Number | Percent |
| Fraser North | 14,335 | 31.1 | 500,660 | 38.2 |
| Fraser South | 17,305 | 37.6 | 588,708 | 44.9 |
| Fraser East | 14,385 | 31.3 | 222,310 | 16.9 |
| Total | 46,025 | 100.0 | 1,311,675 | 100.0 |

The key characteristics of the Aboriginal population in Fraser Health relating to health status include:

- The Aboriginal population is younger and has lower levels of education than the general population. Lack of education in early years translates to lower incomes and higher rates of unemployment and poverty than for non-Aboriginal residents of Fraser Health, which impacts health and well-being
- Centuries of disadvantage show up in significantly poorer mental and physical health, and ultimately earlier death. For example, a Status Indian in Fraser North has an average life expectancy of 16.5 years less than the general provincial population
- Injury deaths are a significant factor in the potential years of life lost statistics, and account for one quarter of Status First Nations deaths (e.g., suicides, motor vehicle crashes, accidental poisoning, falls, fires and drowning)
- Addictions are a continuing problem in the aboriginal population. Alcohol-related deaths are increasing and are more than six times the rate for the general population
- While HIV/AIDS deaths in the general population are declining, the trend is going in the opposite direction for Status First nations, thus increasing the health status gap
- Status First Nations patients are three times more likely than the general population to be admitted for manageable chronic conditions, such as diabetes, asthma, hypertension, neurosis, depression or alcohol and drug misuse.¹⁸

Despite these concerns, Aboriginal people present to and engage with health care services, including mental health and addiction services, in lower numbers than anticipated given the size of the population. This is likely due to a number of factors:

- Diverse size, nature and needs of aboriginal communities
- Geographical distance from services and lack of available services at community level
- Gaps in cultural awareness and sensitivity of mainstream service providers

¹⁴ Source: 2001 Census

- Lack of aboriginal service providers and programs
- High incidences of substance abuse
- Complex maze of funding arrangements for Aboriginal health care services.

In order to promote better access and engagement by the Aboriginal population, MH&A needs to make some key changes, in terms of both its service philosophy and service continuum. These are:

- **Service Philosophy:** the Aboriginal community holds a holistic and integrated view of health care that includes the physical, mental, emotional and spiritual aspects of being. This is graphically represented by the Fraser Health Aboriginal Logo, inspired by the traditions of the Medicine Wheel (Figure 6). While the population-based approach of Fraser Health is consistent with this view, MH&A needs to incorporate the important aspects of spirituality of the individual, family and community into its service delivery model.

Figure 6: FH Aboriginal Health Logo



- **Service Continuum:** while MH&A aims to provide a comprehensive continuum of services to the Aboriginal population, and key initiatives have improved services in recent years, significant gaps remain in the service continuum for Aboriginal clients. Attention must be paid to improving both the accessibility and the capacity of mainstream and Aboriginal-specific services to ensure they are accessible and acceptable to Aboriginal residents.

Strengthening
Coordination

Recommendation: Strengthen relationships, linkages and partnerships with Aboriginal service constituents

One strategic priority for Fraser Health generally is to enhance collaboration with Aboriginal communities so planning, implementing and delivering services results in improved health outcomes.

Addressing
Needs

Recommendation: Develop an Aboriginal mental health and addiction action plan

In order to facilitate the implementation of the service priorities identified in this Strategic Plan, there is a need to work in partnership with key Aboriginal service constituents. The reference for this initiative will be the Fraser Health Aboriginal Health Plan and Adaptation Plan which outlines specific actions related to building capacity, engagement and strengthening community initiatives¹⁵.

¹⁵ Appendix 10 summarizes the Fraser Health Aboriginal Health Services Adaptation Plan

Enhancing
Capacity

Recommendation: Enhance the continuum of mental health and addiction services for the Aboriginal population

Across Fraser Health, MH&A aims to provide a comprehensive continuum of services that ranges from health promotion, prevention, and supportive treatment through to acute and/or long term treatment and rehabilitation. While there have been key improvements to services for the Aboriginal population in recent years, significant gaps remain in the service continuum for Aboriginal clients. There is a need to enhance both the accessibility/acceptability and the capacity of mainstream as well as Aboriginal-specific services for the Aboriginal population of Fraser Health.

Addressing
Needs

Recommendation: Improve access to mental health and addiction services by the Aboriginal population

In general, Aboriginal people do not access or engage with mainstream mental health and addiction services in proportion to their population. Among those working in mental health and addiction, there is a very real sense that current services fail to adequately serve Aboriginal people.

In order to be more responsive and acceptable, MH&A needs to provide services which are meaningful to Aboriginal people, which acknowledge the particular issues facing Aboriginal people, and which incorporate a broader, more holistic view of health. In that regard, services need to incorporate western as well as traditional aboriginal approaches to mental health and addiction care/service.

To support this, there is a need to increase the number of Aboriginal professionals working in mental health and addiction services. Increasing the cultural competence of mainstream staff will improve their understanding of Aboriginal approaches to health care, and the most effective ways to engage Aboriginal people in services.

Signs of Success:

Positive outcomes from implementing these recommendations will include:

- More collaborative projects between MH&A and Aboriginal communities, including a jointly endorsed action plan
- Increased number of Aboriginal service providers
- Increased use of mainstream MH&A services by Aboriginal residents
- Reduced cultural and geographic barriers to service.

A Story of Success:

Communicating Culturally

Since earliest times, the Aboriginal people have placed great importance on passing on traditions and wisdom through the ages, sharing experiences through story telling, song and dance. Fraser Health recently developed a new Aboriginal Mental Health DVD that embodies the essence of this oral culture and tradition.

'Aboriginal Journeys in Mental Health – Walking the Path Together', is a documentary that provides personal insights from aboriginal persons recovering from depression, bipolar illness and schizophrenia. This culturally appropriate and sensitive tool supports Aboriginal people who are dealing with the issues of mental illness. The DVD features a collection of courageous and inspiring sharing of personal struggles, pain, frustrations, sadness, recovery and hope by Aboriginal people including those living with mental health issues, as well as some partners and caregivers. The hope is that through their personal stories, others in their culture will learn and find hope for recovery.

As well as the potent messages offered by these individuals, the film captures the importance of a balance of conventional and spiritual approaches to assessment, treatment and healing for the Aboriginal people through information shared by a psychiatrist, Dr. Soma Ganesan and Mali-hat-kwa, a nationally recognized Elder, Healer, Secwepemc Sundancer, Pipe Carrier and Samahquam Elder Mother.

The project's partners include Fraser Health's Mission Mental Health, Mission Indian Friendship Centre Society, Sto:lo Nation Health Support Services, BC Partners for Mental Health and Addictions Information, and Bear Image Productions.

Diverse Communities

Multicultural population

By 2017, visible minorities are expected to comprise the majority of the Greater Vancouver population, and one in three people in British Columbia are expected to be people of colour. South Asians and Chinese are expected to be the most numerous visible minority groups, and West Asian, Korean and Arab populations will be growing more rapidly.

Within the visible minority sub-population are three distinct groups. Each group is likely to have unique mental health needs.

- **Settled migrants** are often a mix of first generation with second and third or more generation migrants, and a “clash of cultures” can occur when older first generation family members have differing cultural and social expectations than the younger generation. This can lead to family conflict between the generations and can result in anxiety and depression
- **New or landed immigrants** have re-settlement and acculturation issues. Often they find that their hopes of life in Canada have not been realized, so that qualified people are unable to gain employment or wealthy business people find themselves underemployed, and these experiences can result in depression and isolation
- **Refugees** typically take 3-5 years to regain their sense of confidence and control of their new lives. Their imperatives are practical living issues and addressing mental health needs may be low in priority. Refugees may also have different beliefs about utilizing mental health services and do not access such services, yet they may display symptoms of trauma, torture, and/or profound loss in physical manifestations.

A number of issues have been identified in relation to the multicultural population of Fraser Health:

- Although Fraser Health has a large and varied visible minority population made up of immigrants and refugees, the region does not currently have an accurate multicultural profile of those accessing mental health and addiction services or the degree to which visible minority consumers and their families are under-represented
- Currently, there are problems with accessing services in a timely manner and engaging with services. Outreach, translated material, and multi-lingual staff are necessary to facilitate access and engagement with mental health and addiction services. Providing education and awareness in multicultural communities may be one strategy towards facilitating access
- Unique and creative solutions are required that will include outreach to multicultural communities. This will include outreach for inclusion in planning, as well as outreach as an essential component in service delivery. Due to issues of different cultural beliefs about mental health, the ongoing stigma of mental illness, and for some, traumatic experiences with authorities and political/religious conflict in their countries of origin, solutions will need to come from the multicultural communities
- Choice in services and service providers is an important component in service delivery for multicultural consumers. There are individual differences in preferences regarding services provision by those from the same cultural group. Some multicultural consumers prefer

mainstream services due to acculturation with many years or generations in Canada, having English fluency, or concerns about shame/exposure or political/religious differences originating in their homeland. MH&A must provide a variety of service delivery approaches in order to address cultural and ethnic differences among providers and consumers

- Dislocation from family and natural support networks may isolate multicultural individuals and families. The experience of racism can undermine self-esteem as well as impact upon the identity development of young people and cause great distress in older individuals. Furthermore, social and economic hardships and inadequate housing present challenging life circumstances, and may complicate mental health and addiction issues.

Lesbian, Gay, Bisexual and Transgendered (LGBT) Population

Prevalence rates for Lesbian, Gay, Bisexual and Transgendered (LGBT) individuals are estimated at about 5-10% of the Canadian population while 0.5% of couples identified themselves as same-sex.

Although the Canadian Charter of Rights and Freedoms and the BC Human Rights Code guarantee that the LGBT population be treated as equals, they continue to be subject to widespread discrimination. This population faces a number of issues which affect their mental health:

- Meta-analysis of several studies suggests that LGB individuals have a higher prevalence of mental disorders than heterosexuals¹⁹
- LGB individuals are at elevated risk for mood, anxiety and substance abuse disorders and have a greater prevalence of co-morbid disorders
- LGB individuals also have higher rates of mental health service utilization, suggesting a high frequency with which mental health service providers either knowingly or unknowingly provide care to LGB persons²⁰
- LGB youth also have a unique health status compared to heterosexual youth. They are more likely to report problems with depression, suicide, substance abuse, homelessness and school drop out²¹. They are also at risk for HIV infection, becoming victims of violence, and resorting to prostitution. In BC, prevalence of suicide attempts and injuries as result of attempts was higher among LGB youth²². A recent pilot survey indicated that LGB youth, particularly girls, are also at increased risk for reported use of crystal meth, ecstasy, ketamine, and GHB²³
- Other factors that may be related to mental health and substance abuse concerns for the LGBT population may include the “coming out” process, loss of family support, isolation and alienation, threats to economic security due to discrimination, gender transition, the impact of HIV and AIDS. Clients in mainstream mental health and addiction settings may not be open about their sexual orientation or gender identity and may not self-disclose due to concerns about negative responses, and therefore tend to delay or decline necessary health care.

Strengthening
Coordination

Recommendation: Form a Cultural Diversity Advisory Committee

In December 2005, Fraser Health and Ministry of Children and Family Development (MCFD) formed a joint Multicultural Competence Task Group. This task group began the process of informally reviewing the status of multicultural services within MH&A and MCFD Child and Youth Mental Health. The task group also conducted a needs assessment and began the development of a multicultural competencies training program for staff. At that time, the task group has had an informal reporting relationship within Fraser Health and MCFD and has focused on planning staff training.

In order to support Fraser Health's responsiveness to cultural diversity, a committee that has substantial interface with the MH&A leadership and operations team needs to be reconfigured and given the mandate to identify and make recommendations for improvements in services. Furthermore, the LGBT population needs to be included as part of the committee's mandate.

Transforming
Services

Recommendation: Develop a sustainable cultural competency training program (in partnership with MCFD)

Cultural competence is essential to providing effective consumer-oriented services for diverse populations. A cultural competence training program for MH&A service providers will include training in all three aspects of cultural competence:

- Awareness of personal beliefs and/or attitudes about culturally diverse clients
- Knowledge about diverse cultures
- Ability to use intervention skills or techniques that are culturally appropriate

Addressing
Needs

Recommendation: Improve accessibility of Mental Health and Addiction services for multicultural and LGBT consumers

In order to better serve and ensure engagement in services from all cultural groups, services, facilities and providers must be accessible and appropriate. When services and facilities are geographically, linguistically, and culturally accessible, consumers from multicultural and LGBT communities are more likely to respond positively to treatment and services.

Strengthening
Coordination

Recommendation: Develop culturally specific direct services in partnership with community agencies who work with visible minorities and the LGBT population

Collaboration allows organizations to leverage scarce resources, reduce costs, link complementary competencies, and increase speed and flexibility. Utilizing this strategy ensures a comprehensive level of services across communities in Fraser Health. Working in partnership with experts in the community ensures a continuous quality of culturally competent services to consumers of all ethnic groups, sexual orientation, and gender identity.

Signs of Success:

Successful implementation of these recommendations will result in:

- Increased cultural competence by Mental Health and Addiction Services
- Improved employee ability to provide culturally competent services
- Increased utilization of services by multicultural and LBGT consumers
- Expanded language options provided by MH&A employees.

Homeless Population

Despite significant investments by the federal and provincial governments, the problems of homelessness continue to grow. Given the size and complexity of this issue, it will require collaboration and commitment from all levels of government as well as from non-governmental agencies to identify and implement effective solutions.

Homeless studies over the past few years within the Greater Vancouver and Fraser Valley areas indicate increasing numbers of homeless people as noted in the following table:

Table 6: GVRD Homeless Counts 2002 & 2005²⁴

| Municipality | Homeless 2002 | | Homeless 2005 | | Total Change | Percent Change |
|-----------------------|---------------|-------------|---------------|-------------|--------------|----------------|
| | Number | Percent | Number | Percent | Number | Percent |
| Burnaby | 17 | 2% | 40 | 2% | +23 | 135% |
| Coquitlam | 3 | <1% | 3 | <1% | 0 | 0% |
| Delta / White Rock | 10 | 1% | 11 | 1% | +1 | 10% |
| Langley | 17 | 1% | 54 | 3% | +37 | 218% |
| MR / Pitt Meadows | 62 | 6% | 42 | 2% | -20 | -32% |
| New Westminster | 69 | 7% | 92 | 4% | +23 | 33% |
| North Van Dist / City | 31 | 3% | 83 | 4% | +52 | 168% |
| Port Coquitlam | 10 | 1% | 35 | 2% | +25 | 250% |
| Port Moody | 0 | 0 | 0 | 0 | 0 | 0 |
| Richmond | 29 | 3% | 33 | 2% | +4 | 14% |
| Surrey | 160 | 15% | 371 | 18% | +211 | 132% |
| Vancouver | 628 | 60% | 1,291 | 63% | +663 | 106% |
| West Vancouver | 13 | 1% | 2 | <1% | -11 | -85% |
| Total | 1,050 | 100% | 2,057 | 100% | +1007 | 96% |

A homelessness count focusing on the eastern Fraser Valley in August, 2005 showed a similar pattern of increasing homelessness. Within Fraser Health, communities that experienced the largest growth included Surrey, Langley, Port Coquitlam, Burnaby and New Westminster.

Table 7: Fraser East Homeless Count 2005²⁵

| Municipality | Number | Percent |
|--------------|------------|-------------|
| Abbotsford | 226 | 55% |
| Chilliwack | 87 | 21% |
| Mission | 75 | 18% |
| Hope | 19 | 5% |
| Agassiz | 1 | 0% |
| Boston Bar | 3 | 1% |
| Total | 411 | 100% |

In terms of the characteristics of the homeless population, local studies indicate that many homeless people have both mental health and substance use problems. These statistics are relevant for those planning Mental Health and Addiction services:

- 39% of the 864 homeless surveyed reported an addiction to alcohol and/or drugs, while 23% reported a mental health problem.²⁶
- In the 2005 GVRD homeless count, 48% of the 1,731 homeless surveyed reported an addiction problem, while 22% indicated they had a mental illness.²⁷
- In the 2005 Fraser East homeless study, more than 27% of the 411 homeless persons indicated they had an addiction problem, and over 7% reported an emotional or mental health problem.²⁸
- Along with mental health and addiction concerns, homeless individuals have a high incidence of medical problems as well. The “3 Ways to Home” report indicated that 35% of the homeless persons surveyed in 2005 reported a medical condition. In Fraser East, the 2005 homeless count identified more than 18% of 219 respondents as having a medical condition.

Thirteen priorities²⁹ have been identified that if addressed would significantly alleviate the issues of homelessness. Although all 13 priorities do not fall within the mandate or scope of Fraser Health services, there are a number of areas which Fraser Health could work towards in partnership with other community agencies to reduce or alleviate the issues and problems associated with homelessness.

Recommendation: Finalize the homelessness strategy for Mental Health and Addiction

Strengthening
Coordination

Addressing
Need

Over the past year, work has been undertaken to begin formulating a homelessness strategy for Mental Health and Addictions. Priority steps are to complete the draft homelessness strategy; work with key partners, both government and non-government, to finalize the strategy; and then develop an implementation action plan. This evolving strategy incorporates the three essential components that combat homelessness: housing, income, and support.

Enhancing
Capacity

Recommendation: Develop “minimal barriers” housing projects for the homeless

With the growing number of homeless individuals with mental illness, addiction and other health conditions in Fraser Health, housing and associated support services need to be considered as part of the overall response. One potential housing option is to develop flexible, non-judgmental and accessible “minimal barrier housing”.

Although there are no official benchmarks available to estimate minimal barrier housing needs, development of this type of housing is important, given the statistics noted above and the behaviour and lifestyle associated with this population.

Enhancing
Capacity

Recommendation: Partner with community agencies / ministries in the development of “transitional housing” resources

Transitional housing assists clients to improve their independence-related skills and has been identified as an important component of the housing continuum, especially for homeless youth or youth at risk of being homeless.

Within this type of housing, youth can learn and develop necessary skills to increase chances of success in more independent living arrangements in the future. Others who would benefit are individuals with complex needs, which would include individuals with serious mental illness and / or substance use issues. For these individuals, a transitional living environment may assist with illness stabilization and skill development.

These new transitional housing resources could be located in the same building as supported housing, allowing for staffing expertise to be available for both programs.

Enhancing
Capacity

Recommendation: Develop “supported housing” resources in priority communities for individuals with complex mental health and substance use needs

Supportive housing is permanent housing where individuals live in self contained apartments either in purposely designed buildings or scattered site apartments. These individuals generally require ongoing supports and services and are not expected to become fully self-sufficient. Support may be provided on site or through outreach. A supported housing model of care works well when providing housing for individuals with complex mental health and/or substance use issues.

Specially designed supportive housing developments could be targeted to homeless individuals or individuals at risk of homelessness who have significant impairments due to their mental illness and substance use behaviours.

Many of the clients entering into supported housing will continue to have substance use issues. This is one of the reasons why homelessness continues to be an issue with them and should not be a limiting factor in their housing placement. The “harm reduction” approach to housing for persons with concurrent disorders is an important policy to implement in this model of housing.

All communities within Fraser Health would benefit from having purposely designed residential resources for individuals with complex mental health and addiction needs. Unfortunately, due to the significant cost of designing and operating these types of resources, priorities for communities must be established based on need and an ability to serve as a regional resource.

Addressing
Needs

Recommendation: Utilize assertive outreach strategies to engage the homeless population

Enhancing
Access

Homeless individuals, for a number of reasons, often do not receive ongoing support and treatment from Mental Health and Addiction services. Unfortunately, without adequate follow-up and support, these individuals continue to find themselves homeless with untreated mental illness and substance abuse problems.

Assertive outreach is an effective strategy for “reaching out” and making connections with homeless individuals living on the streets or in emergency shelters³⁰. Outreach workers have the ability to seek out and engage and build relationships with homeless individuals. As relationships and trust are established, outreach workers can provide crucial linkages to services and other resources that may assist in getting homeless off the streets and into more suitable living situations.

Signs of Success:

Given the increasing incidence of homeless people through Fraser Health, the implementation of these recommendations are important to the overall efforts to reduce this problem. They can:

- Increase Fraser Health's ability to provide a range of permanent, safe, and affordable housing options
- Offer specific housing options for hard-to-reach individuals, and those homeless or at risk to be homeless.
- Reduce the demand for emergency support and shelter beds
- Improve access to health care and increase the chance of improving physical health.

A Story of Success:

Making hard to reach easier to reach

For people who have never been homeless, the idea that it's tough to go from homeless to permanent housing might be hard to understand. But that fact is one of the major issues of resolving homelessness, especially when the homeless are challenged with mental health and addiction issues.

Housing with "low barriers" is an essential first step away from homelessness, and is now provided in a motel near Surrey Memorial Hospital. The housing is accessible, and in an area frequented by at-risk populations – those hard-to-reach people.

Working in partnership with community agencies, Fraser Health MH&A provides clients with mental health support seven days a week, along with assertive case management through the Surrey Mental Health centre. Those who avail of this stable accommodation and MH&A services ultimately benefit from improved health.

Addictions Service Stream

In Canada, the social and economic costs of substance use are staggering and well-recognized. In 2002, the overall cost of substance use in Canada was estimated to be approximately \$40 billion, including health care and law enforcement costs. The overall cost of substance use in British Columbia was estimated at just over \$6 billion in 2002.³¹

The literature states that about 15.5% of the population need some form of service to deal with problematic substance use. Of those, around 15% will access the 'professional service system'. The remaining 85% are either not yet ready to seek help or seek services through other venues. Roughly 13.6 % of all Canadian are considered high-risk drinkers.³²

In British Columbia, Addictions Services have undergone a somewhat bumpy and often uncertain journey since its grassroots beginnings in the 1960s. In 2002, addiction services became the responsibility of the health authorities and are continuously developing new partnerships both within Health and more specifically Mental Health. As an evolving service stream, it continues to capture the attention and passion of consumers, families and carers, communities, service providers and elected officials across Fraser Health.

One of the primary objectives for Addiction Services is to build and stabilize services across a continuum of care, and to ensure these services are well coordinated and integrated with Mental Health services. Since becoming part of the health authority in 2002, Fraser Health has focused effort and funding in this area but there remain significant gaps in service and unmet needs.



Recommendation: Expand withdrawal management services

Detoxification is recognized as an important step in the recovery process for individuals living with addiction.

Within Withdrawal Management Services, it is important to expand service options and diversify in order to better address unmet demand. Research has concluded that inpatient detox is about 10 times the cost of community-based detox with no difference in effectiveness. However, for clients with acute withdrawal symptoms and co-existing medical complications, inpatient detox is the preferred service type.

Daytox and Home Detox

Expanding the currently available community-based options, such as daytox and home outpatient detox, will reserve available inpatient detox facilities for those individuals who most need this level of care. In addition to being shown to be as effective as inpatient detox, the home service is considered more appropriate for youth and seniors.

Sobering Centres

Sobering centres provide accommodation for inebriated persons to sleep off their intoxication in a clean and safe environment, thus diverting their demands on emergency and police services. Clients are typically given nourishment and low level drug and alcohol intervention, with an average length of

stay of 12 hours. Sobering centres are considered essential service components of an effective continuum of care, and already exist in both Victoria and Vancouver.

Recommendation: Build the continuum of youth and young adult addiction services

The need to build the continuum of services is clearly illustrated by this picture of problematic substance misuse among youth and young adults³³:

- Youth aged 15-24 are the most likely population group to suffer from substance dependence issues
- Approximately 1 out of every 3 individuals between the ages of 15 and 24 exceeded Health Canada's low-risk drinking guidelines
- Approximately 1 out of every 2 individuals between the ages of 18 and 24 report monthly heavy drinking, while more than 1 in 3 will have five or more drinks in a sitting
- The 15-17 age range is when an increased use of cannabis is reported, suggesting fertile ground for prevention activities
- In Fraser Health, cannabis and cocaine are drugs of choice (after alcohol)
- Aboriginal youth are significantly more at risk of alcohol-related problems than their non-aboriginal counterparts
- One in five Aboriginal youth have used solvents, with almost half of those starting before age 11.

Most young people will reduce or cease their substance misuse as they move into adulthood. However, certain risk factors contribute to ongoing problematic substance use. These include physical, sexual or emotional misuse; growing up with a parent who is mentally ill, suicidal, in prison, addicted or absent; having a concomitant mental illness; and/or having no or limited social supports or a social group which is typified by substance use.

Young people require a different model of Addiction services. The recommended continuum of addiction services for youth includes:

- Prevention initiatives
- Early intervention and treatment initiatives
- Harm reduction initiatives
- Community-based outpatient/outreach counseling
- Withdrawal Management services
- Day Treatment services
- Residential treatment facilities.

Currently within Fraser Health, direct and contracted outpatient counseling services provide assistance to both youth and adults. In addition, a number of exciting and innovative projects have

been initiated to better address the needs of young people with substance use problems. Examples of these innovations include:

- The DEWY program, providing day, evening and weekend treatment services
- An Intensive Residential Treatment Program, in collaboration with VCHA, responding to the need for more residential treatment options for youth
- Dedicated Youth Concurrent Disorder workers
- The Matrix Youth Addictions Program (see Story of Success).

Enhancing
Access

Recommendation: Expand pilot of the Early Discharge Follow-up Program

An Early Discharge Follow-up Program was piloted at Maple Cottage Detox Centre in 2005/06. The benefit of this program was to reduce length of stay and improve access to appropriate and timely detox services for clients by providing follow-up and support after discharge.

Enhancing
Capacity

Recommendation: Develop second stage housing for addiction clients

Second stage housing is important for clients who have completed detox and treatment and who need a stable and safe environment in order to continue their recovery and prevent relapse. This supported housing is viewed as an extension of treatment with clients typically remaining in such facilities for 12-18 months.

Enhancing
Capacity

Recommendation: Expand the range of older adult addiction services

Geriatric clients with addictions require different services to effectively meet their particular medical and support needs.

Factors such as loneliness, loss, decline in physical capabilities and many psychosocial factors can contribute to alcohol abuse. It is estimated that 18% of hospitalized seniors are admitted because of alcohol abuse. Geriatric individuals are more likely to use prescription medications than illicit drugs.

In Fraser Health, there are currently no designated geriatric residential treatment beds, and no services for concurrent disorders that take into account the differing needs of this client group.

As a first step to developing services for geriatric clients, a Needs Assessment must be undertaken, which includes gathering information regarding prevalence and identifying Best Practice guidelines.

Transforming
Services

Recommendation: Initiate development of low threshold / harm reduction interventions

Low threshold services include interventions that aim to reduce substance-related harm for those engaging in problematic substance use but who are not yet ready to engage in treatment services. Harm reduction services include needle exchanges, supervised/safe injection sites, and low threshold housing. Those ready to receive help they can access addiction, mental health, medical and social services.

Enhancing
Capacity**Recommendation: Improve services for clients with concurrent disorders**

Research indicates that the likelihood of having a mental health disorder increases with the number of substances used, and that there are high (and increasing) rates of concurrent substance use and mental health problems among people who are homeless.³⁴

Table 3: Prevalence of Concurrent Substance Use & Mental Health Disorders¹⁶

| Mental Health Disorder | Lifetime Prevalence of Mental Health Disorder | Lifetime prevalence of substance use disorders among people who have mental health disorders |
|------------------------|---|--|
| Anxiety disorder | 10-25% | 24% |
| Major depression | 15-20% | 27% |
| Schizophrenia | 1% | 47% |
| Bipolar disorder | 1-2% | 56% |

Clients who have co-occurring substance use and mental health needs frequently have high and complex needs which cannot readily be met by existing services. Typically, individuals with concurrent disorders have been poorly served by both Mental Health and Addiction services receiving either partial treatment (only one problem is addressed), or being shifted between the services in an attempt to have their needs met sequentially or in tandem.

There is an urgent need to further develop services specifically for this client group. Best practice supports the provision of effective and routine assessment/screening for both problems by mental health and addiction service staff.

Strengthening
Coordination**Recommendation: Improve crisis care and response services to individuals living with an addiction**

Across Fraser Health, individuals present to Emergency Departments for medical assistance due to the consequences of substance misuse. In the context of inconsistent linkages between specialist addiction services and Emergency Departments, these individuals may not receive the most appropriate interventions. There is a need to develop integrated systems between Emergency services and other first responders, and addiction services.

Addressing
Needs**Recommendation: Improve the responsiveness of Addiction Services to special populations**

It is important for Addiction services to be able to better respond to those sub-populations and groups within Fraser Health who have heightened vulnerability or who may not readily engage in services.

These include:

- Women, especially those with children

¹⁶ Source: Concurrent Disorders Ontario Network

- Culturally diverse populations, such as South Asian, Chinese, First Nations, Inuit and Métis
- People with disabilities
- Gay, lesbian, bisexual and transgendered individuals

Transforming
Services

Recommendation: Expand addiction prevention and health promotion activities

Successful prevention and health promotion programs require strong collaboration and partnerships with a range of different ministries and agencies including, health, education, social services, police, courts, Aboriginal and local government.

Fraser Health Addiction Services have an important role to play in partnering with Prevention and Promotion portfolio and other agencies/services which are active in providing health promotion (i.e. public education regarding HIV/AIDS, tobacco), in assisting to expand targeted and universal preventative activities. Central to these activities should be the goals of reducing stigma and of encouraging the view that addiction is a health issue.

Enhancing
Capacity

Recommendation: Expand addiction outpatient activities

Outpatient services need to be viewed as the preferred option for treating addiction clients. This approach, offering a variety of interventions, is considered by expert sources to be less intrusive than residential care.

MH&A's 19 addictions clinics offer screening, assessment, treatment planning, counseling, referrals, and prevention services. Some clinics focus on the needs of special client groups such as youth, First Nation, seniors and multicultural. Family counseling and education form an important element of outpatient services.

Adopting more current and evidence-based practice approaches, enhancing components of existing programs, advancing staff competency, and developing more specialized clinics will all contribute to creating more positive outcomes for outpatient clients.

Signs of Success:

The priority recommendations for Addictions Services are selected to alleviate the more pressing issues facing this portfolio. Once implemented, they will achieve:

- Reduced ER congestion, more fast-track options, more knowledgeable ER staff
- Reduced harm, increased harm prevention initiatives
- Fewer relapses or readmissions to detox units
- Safer, available second stage housing units
- Increased family engagement

- More timely access to more appropriate services
- Increased age-appropriate continuum of services
- Fewer youth electing to become involved in problematic substance use
- Improved community awareness and partnerships with related stakeholders.

A Story of Success:

The Matrix Youth Addictions Program

The customized Matrix Pilot Project for Maple Ridge & Pitt Meadows offers withdrawal management, treatment and aftercare services to youth ages 16 to 24 years old, along with their family and others who are substance affected.

Utilizing a 'wrap around' approach to youth-centered addiction treatment, the Matrix's success rests with the team's ability to build relationships with youth where they are at in their stages of change.

This process facilitates a creative and collaborative inquiry process by introducing expressive arts, therapeutic recreation, and narrative therapy to help youth understand which form of treatment works best for them.

Another key aspect of the customized Matrix Pilot Project is easy and timely access to a continuum of services:

- Consistent Outreach
- Community Capacity Building
- Clinical Counseling
- Recreational Activities
- Home Detox
- Peer Education and Support
- Integrated Case Management
- Family Education and Support

The Pilot has established a safe house for withdrawal management and post acute withdrawal support. Supervised home detox will need to be evaluated and if effective, replicated across other Fraser Health communities. The Matrix program aims to empower youth to make healthy choices and supports ongoing self management during the recovery journey. The Matrix pilot receives on-going advice from a community-based steering committee and the highly-acclaimed Matrix Institute, affiliated with UCLA.

Tertiary Service Stream

The 1998 Provincial Mental Health Plan promoted providing care closer to home in smaller community settings as the new model for delivering specialized mental health services in British Columbia. This model is typified by the decision to redevelop Riverview Hospital and allocate beds to each of the provincial Health Authorities. In this process, 267 beds have been allocated to Fraser Health to develop capacity for a range of Specialized Residential, Tertiary Rehabilitation, and Tertiary Acute Care beds.

The key principles identified for the development of tertiary services in Fraser Health are:

- Care clients receive will be equal to or better than care received at Riverview Hospital
- Clinical programming will be directed by evidence-based best practices
- Performance indicators will be used to measure clinical and program outcome
- Service replacement will add to the existing continuum of service
- Access to service will be equitable across Fraser Health
- Existing resources will be optimized.

Fraser Health currently has 177 acute psychiatry beds for a 1.47 million population. With robust community systems and tertiary services available, a benchmark of 20 secondary acute beds per 100,000 population and 10 per 100,000 for tertiary beds is realistic and supported by the Clinical Services Planning Team (ACCI Report).

Fraser Health plans to develop a continuum of tertiary services, including specialized residential programs, adult tertiary rehabilitation care, geriatric behavioral stabilization care, and adult and geriatric tertiary acute care.¹⁷

1. **Specialized Residential Programs** for individuals requiring more intensive ongoing supports than are available in existing community mental health residential services.
2. **Adult Tertiary Rehabilitation Care** for individuals with a serious mental illness requiring intensive psychosocial rehabilitation to assist them in managing their illness and reaching their goals.
3. **Geriatric Tertiary Acute Service** for elderly individuals requiring longer-term assessment, treatment and acute stabilization of mental health issues.
4. **Adult Tertiary Acute Care** will provide assessment and treatment under both general and intensive care models. The RCH site services will provide predominately acute and secure care for adults with severe mental illness.

¹⁷ Appendix 8 details the breakdown of acute Psychiatry and Addictions beds by site

The table below quantifies the allocation of tertiary services for Fraser Health:

Table 4: Development of Tertiary Facilities within Fraser Health

| Bed Type | Beds | Location | Status |
|-------------------------------------|------|------------------|-------------|
| Tertiary Adult Acute | 30 | RCH site | 2010 |
| FHA/VCHA – Intensive Care Unit | 12 | RCH site | 2010 |
| Tertiary Geriatric Acute | 24 | RCH site | 2010 |
| Intensive Tertiary Rehab | 17 | RCH site | 2010 |
| Community Tertiary Rehab | 25 | LMH site | Early 2009 |
| Community Tertiary Rehab | 20 | RVH site | Early 2009 |
| Community Tertiary Rehab | 20 | Chilliwack | Early 2009 |
| Neuropsychiatry | 10 | VCHA | Spring 2008 |
| Geriatric Behavioural Stabilization | 47 | Delta View | Spring 2007 |
| Neuro-psych Complex Care | 5 | Delta View | Spring 2007 |
| Specialized Residential | 20 | Connolly - RVH | Oct 2006 |
| Specialized Residential | 24 | Cottonwood - RVH | Nov 2006 |
| Specialized Residential | 19 | Delta View | July 2004 |
| TOTAL | FHA | 267 | |
| TOTAL | VCHA | 6 | |
| GRAND TOTAL | | 273 | |

Enhancing
Capacity

Recommendation: Increase tertiary capacity and the continuum of care to include new acute, rehabilitation and specialized residential resources

Fraser Health is in various stages of completing the initiative to build a continuum of acute, tertiary rehabilitation and specialized residential treatment facilities. These services are being developed in communities across the region either near or on existing hospital sites, adjacent to existing facilities, or in partnership with community providers who add value to the tertiary system of care. These multiple initiatives will result in better access to tertiary services as well as increased self – sufficiency related to meeting the clinical requirements of clients with severe, complex and co-morbid psychiatric conditions.

This is also a unique opportunity for Fraser Health to build a specialized work force, initiate and participate in research activities, and lead the way in acute and intensive treatment within a recovery-orientated system care.

Improving
Info Systems

Recommendation: Plan, design, and implement an evaluation and quality framework for the Tertiary Care services established by Fraser Health

The Riverview Redevelopment Project offers opportunities for Fraser Health to evaluate, research and follow-up clients transferred from Riverview Hospital so as to sustain best practice and contribute to future research directions. Evaluation tools can be aligned with provincial evaluation initiatives, and also meet Fraser Health's need to measure outcomes and quality. An important component will be establishing quality assurance indicators to monitor performance and improve systems, especially

wait times and appropriate client matching. Assessment of client, family, staff and contracted service providers' satisfaction and the creation of a client data base will also be included.

Strengthening
Coordination

Recommendation: Develop and implement an integrated, centralized Access and Utilization strategy for Tertiary Care Services across Fraser Health

The key purpose of this recommendation is to break down traditional barriers that block access to treatment, and at the same time provide a seamless continuum of care, and create a transparent, centralized access model based on clinical need. The utilization of tertiary beds will be regularly monitored and analyzed.

Strengthening
Coordination

Recommendation: Maintain an active partnership with PHSA on the development and implementation of tertiary clinical networks

As each health authority develops Tertiary Care capacity, this creates an opportunity to share information and resources and thus provide a more comprehensive continuum of services. Developing clinical networks linked across the province is still in early planning stages but will provide an opportunity to partner on research, training, education, knowledge exchange functions and clinical pathways and protocols. Expert clinicians from all health authorities participate in clinical networks and have the opportunity to collaborate and problem solve on some of the most refractory clinical challenges within the MH&A service.

Signs of Success

These priorities for Tertiary Services will have a range of positive results when implemented and will:

- Expand closer to home tertiary care continuum of services
- Establish an evaluation and quality assurance framework
- Improve access and utilization to reduce waitlists and improve client matching to services
- Create a mutually beneficial partnership with PHSA and other health authorities.

A Story of Success:

Connolly and Cottonwood Lodges

When individuals require more intensive support to work towards recovery, Connolly Lodge (20 beds) and Cottonwood Lodge (24 beds) specialized residential facilities, located on the Riverview site, offer a program reflective of best practice in recovery orientated care. Purpose-built Cottonwood Lodge has a homelike environment, single person rooms, and space for teaching and social activities, and involves clients in routine activities such as meal preparation and care of the home. For some, this creates opportunities to move into supported employment, education or volunteer opportunities.

A variety of success stories illustrate the benefits of this type of tertiary care. For example, one resident was successful in gaining paid employment in a local grocery store and decided to buy a bike with his hard earned money! Five residents are actively involved in the Community Volunteer Support Program, and one resident participates in the Tri Cities Advisory Council.

Most unique is the fact that future residents can tour the facility and be introduced to the programming via the world wide web. Virtual tours are available at <http://www.fraserhealth.ca/healthinfo/mentalhealth/cottonwood.htm> and are an ideal way to gently introduce clients to new treatment opportunities.

Housing Service Stream

Fraser Health lacks sufficient safe, affordable and suitable housing options for individuals coping with mental health and/or addiction problems. This primary need must be met before clients can adequately engage in care and treatment services.

Using benchmarks developed by Fraser Health in March 2005, the projected need for licensed residential, supported housing, family care home, and crisis stabilization beds was identified. Future demands were factored into the benchmarking model such as Supported Independent Living (SIL) waitlists, Alternate Level of care (ALC) days on Fraser Health psychiatric Inpatient units, and the impact of the closure of beds at Riverview Hospital on Fraser Health housing resources. The total projected need for additional housing and residential resources is 915 by 2011.

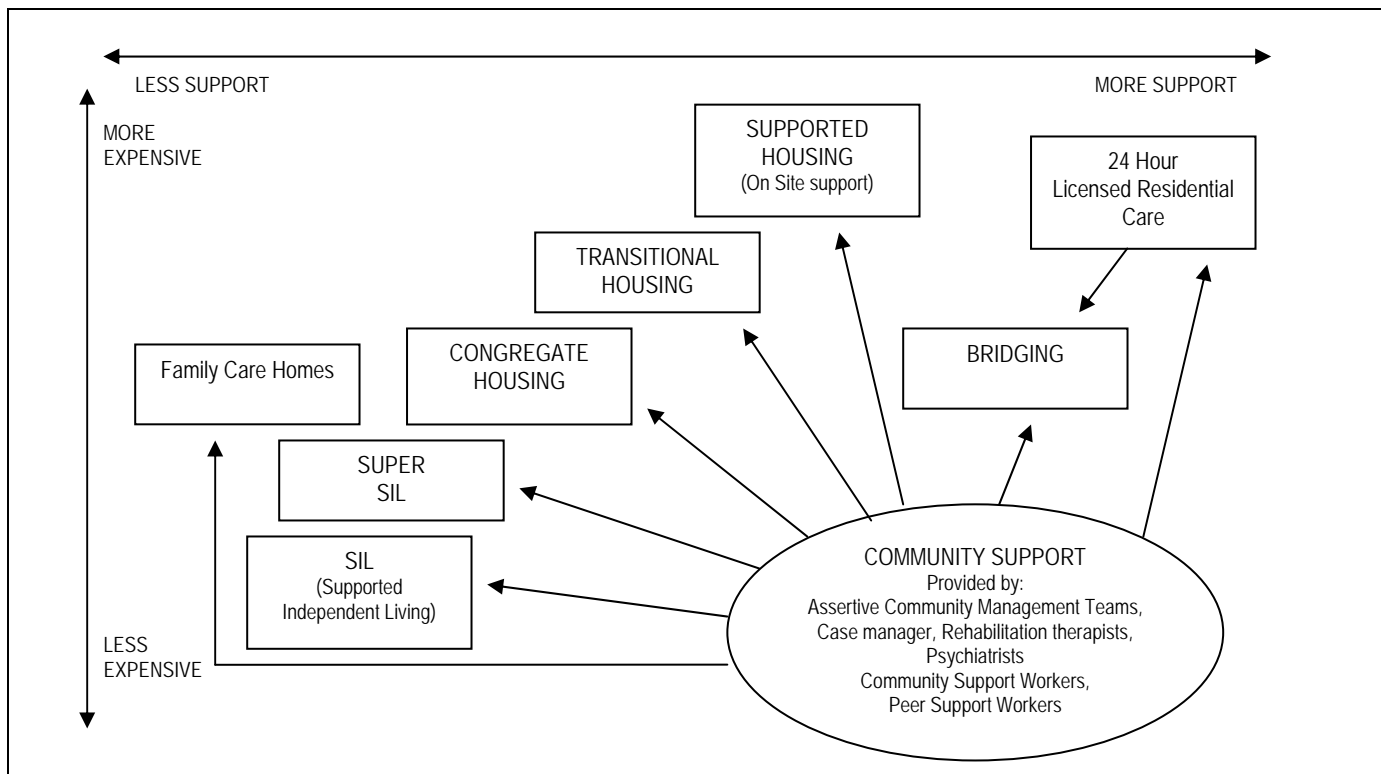
The Mental Health and Addiction Services Five-Year Housing Plan recommends a three-pronged approach to address the current and projected residential and housing bed shortages. The housing plan recommends the addition of 135 specialized residential beds, 255 supported housing units, and 525 subsidized rental units for a total new investment of 915 units. It should be noted that best practices indicate the majority of housing investment should be in the area of supported and subsidized housing, as this is the model most preferred by clients.

These projected bed investments do not include the housing needs of the homeless population of which a significant portion (20%-50%) have mental health and/or addiction problems. Based on homeless counts done in the eastern Fraser Valley in 2004 and the Greater Vancouver Regional District in 2005, over 1050 persons within the Fraser Health region were identified as being homeless. To address the issues of homelessness, there will also need to be a significant allocation of resources to be utilized for partnerships with other agencies and Ministries to develop “minimal barrier” supported & subsidized housing units.

These investments in housing and residential resources will greatly improve access, care, and treatment for one of Fraser Health’s most vulnerable populations, those persons with serious mental illness.

Figure 5 illustrates the types of housing and care necessary to supply a full continuum of services.

Figure 5: Continuum of Mental Health Residential Care & Housing Programs



Recommendation: Establish a Mental Health Housing & Residential Services Steering Committee

To improve clinical standards, and increase coordination and communication, a Steering Committee is required to lead implementation of the redesign of residential services according to the 2006 Fraser Health Housing Plan.



Recommendation: Implement a Supported Independent Living (SIL) Program review

No significant program review of the SIL program has taken place since its inception in the early 1990s except for an update of the draft program guidelines provided by the Ministry of Health in 1999.

To ensure program standardization across Fraser Health, taking into consideration local issues and needs, a SIL program guidelines review is timely and necessary. This review would also look at portability of SIL benefits as well as client admission to and discharge from the SIL program.



Recommendation: Develop a quality improvement and policy framework for licensed residential facilities and supported housing

Fraser Health currently has no comprehensive quality improvement program in place for the Mental Health community residential program, so no measures exist of the care quality provided by contracted service providers. A Quality Improvement program can ensure the care is evidence-based through the development of indicators and outcome measures.

Responsibility for quality rests with local staff, and quality issues usually come to light when residents or their families complain. Licensing maintains regular inspections of licensed facilities, but does not have the same focus on clinical issues as Mental Health.

The necessary quality improvement / risk management program will be effective if it has a dedicated staff position, responsible for developing and monitoring clinical standards, ensuring contractual obligations are met, and developing and maintaining a risk management program for the residential and housing program.



Recommendation: Increase mental health supported housing capacity

Fraser Health currently has very few supported housing resources, so additional supported apartment-style housing units must be developed as funding permits.

In the past few years, Fraser Health has successfully partnered with BC Housing to develop new housing resources. BC Housing provides the development expertise and capital financing, and manages the construction phase. Fraser Health ensures the building meets program needs, is responsible for the mortgage, retains control of the facility, and manages the contracted service provider. This model has been successfully implemented in a number of Fraser Health Mental Health projects and serves as an ideal model for future developments.

New supported housing units will have an accompanying need for funding for additional staff. It is estimated that 63 health care worker/community support worker FTEs will be required to provide on site or outreach support to the proposed new units.



Recommendation: Replace, upgrade and purpose-build licensed residential care facilities as opportunities present

Mental Health and Addictions Services needs to partner with residential care facility owners to upgrade the physical plant and safety of their buildings. All facilities must meet minimum safety standards for fire protection (e.g., fire sprinkler, smoke alarm systems). Fraser Health needs to move toward increasing the number of single occupancy rooms and improving access for persons with disabilities. As a result, some licensed residential care beds may need to be replaced.

Recommendation: Redevelop licensed residential care continuum

A number of identified populations will need specialized housing and residential resources developed to meet their specific needs. An evaluation of existing housing stock will identify where reallocation will better respond to these needs. These populations include clients needing minimal barrier housing¹⁸, youth and younger adults, persons living with mental illness and addiction, second stage housing for persons with addictions¹⁹, and clients needing aging-in-place resources²⁰.

Signs of Success:

Fraser Health's plans for future housing needs will, when implemented, result in:

- Improved clinical standards in housing and residential programs
- Clients having ready access to safe and appropriate housing
- Better monitoring of housing and residential contracts
- Increased client independence and satisfaction
- Reduced hospitalization
- Improved facility and living conditions.

A Story of Success:

Safe, affordable housing

Independent living and significant mental health needs are not going to coexist easily, unless a creative solution can be found. That creative solution is demonstrated at the Len Sheppard apartments, allowing 25 clients to live safely and independently in the privacy of individual apartments within the local community.

The creative solution to make this happen comes from a Fraser Health and BC Housing partnership. Clients have access to meal service, as well as recreation and recovery-oriented programs. On-site support from mental health workers is offered 7 days per week, while individual case management and rehabilitation programs are also available.

¹⁸ See Homeless section of this plan.

¹⁹ See Addictions section of this plan.

²⁰ See Geriatric section of this plan.

Supportive Service Streams

Partnerships

Mental Health and Addiction service providers' commitment to improving the well being of residents in the health authority cannot be achieved alone. It requires collaboration, partnership and involvement of consumers and their families, other health and social services, local government, academic institutions, support and advocacy organizations, and the wider community. There are many challenges to creating a seamless and well-integrated system of mental health and addiction services.

Mental health and addiction service consumers typically have multiple needs requiring access to multiple services. MH&A must continually work on many levels, both internally and externally, ensure that consumers and their families receive the right services at the right time and in the right way.

Partnerships within Fraser Health

All Mental Health and Addiction services will be more effective when built through integration and coordination between all inpatient, outpatient and community health services/programs; and between Mental Health and Addiction services.

Within Mental Health Services, there is a need to bridge levels of care and make flow through more effective. Services need to be flexible enough to tailor the level of care provided to the clients changing needs. Recent initiatives such as Psychiatric Nurse Clinicians in Emergency Departments and Concurrent Disorder therapists illustrate the benefits of collaboration and the need to expand all such efforts. This requirement leads to the recommendation:



Recommendation: Enhance integration, coordination and partnerships among all Mental Health services, Mental Health and Addiction Services, and other Fraser Health Portfolios

Establishing networks between MH&A and other portfolios will promote service collaboration and integration. Partnerships with home care, health promotion, primary care and chronic disease management are examples of how this effort will ultimately benefit patients and their families. Key strategic examples of these types of partnerships include the Perinatal Depression Implementation Strategy, Smoking Cessation Strategy, Fraser Health Dementia Framework and Aboriginal Health Adaptation Plan.

Partnerships with External Organizations

Health Authorities

Opportunities for provincial alignment among Health Authorities occur within both the planning and clinical realms. An example of this is Fraser Health's participation in the Provincial MH&A Planning Council where many key strategic initiatives are planned, endorsed, and disseminated. In a similar but different venue, clinical issues are developed, discussed and put into action in Clinical Tertiary Care Networks that are led by Provincial Health Services Authority. Tertiary Care Networks will help to build an effective and sustained response to the needs of the most critically ill clients and ensure Fraser Health Authority's efforts are coordinated with those of their health authority partners. This drives one recommendation:



Recommendation: Where appropriate align Fraser Health Mental Health and Addiction initiatives with provincial initiatives

Government Agencies

Individuals with mental illness and/or problematic substance use often present with multiple complex needs which challenge health, social service, and criminal justice agencies. Such individuals may end up un-served, underserved, or not appropriately served by government agencies. Fraser Health needs to continue to partner and work collaboratively with other government agencies to remove systemic barriers and improve service delivery for mental health and addiction clients. One recommendation comes from this requirement:



Recommendation: Enhance inter-agency service collaboration for Mental Health and Addiction clients

Contracted Health Service Providers

A significant proportion of Fraser Health's mental health and addiction services are provided by contracted health service provider agencies (HSPs). These providers are uniquely placed within local communities to deliver responsive and appropriate support to individuals living with mental illness and/or addiction. Fraser Health would be unable to deliver the range and breadth of services to its population without the important work provided by these partner agencies. The goal for Fraser Health is to continue to strengthen these working relationships based on the principles of integrity, professionalism, mutual respect, and a commitment to delivering recovery-oriented services and supports based on best practices.



Recommendation: Maintain and enhance Fraser Health's working relationship with Health Service Providers and external support and advocacy organizations

One mechanism for maintaining and enhancing Fraser Health's relationships with HSPs is the Tri Regional Addictions Committee (TriRAC) made up of direct service and contracted addictions service providers. The primary purpose of the TriRAC is to provide a forum for discussion, planning, coordinating, communicating and resolving issues. Fraser Health intends to establish a Fraser Health-wide council in 2007 for its mental health HSPs, modeled on TriRAC.

Support and advocacy organizations can make valuable contributions to enhancing mental health and addiction services throughout Fraser Health, making the need to establish practical partnerships with them another ongoing priority. It is particularly valuable to link up with the Health Promotion and Prevention activities by groups such as BC Alliance that focus on initiatives that are “person centred, health promoting and community based”.³⁵

Academic Institutions & Research Organizations

Fraser Health’s ability to act on strategic initiatives requires partnerships with academic and research organizations that will:

- Facilitate understanding the changing needs of the Mental Health and Addiction population group
- Support transformative models of service delivery
- Enhance capacity development
- Support coordination and integration
- Improve information systems and monitoring.



Recommendation: Continue to develop partnerships with local, provincial and national academic groups and institutions to support Fraser Health’s strategic initiatives

MH&A has been successful in developing relationships with a number of academic groups, researchers and research projects. The Centre for Applied Research in Mental Health and Addiction (CARMHA) based at Simon Fraser University Faculty of Health Sciences has a role in the development of key research initiatives of which Fraser Health Authority is a partner.

In addition, Fraser Health is one of four founding partners in the Centre for Health and Human Potential, created to translate research findings into policy and practice, outcome evaluation and knowledge translation. While this organization is in the capacity building stage, all partners believe that it will play a critical role supporting initiatives related to Mental Health and Addiction.



Recommendation: Initiate activities with the Centre for Health and Human Potential

The Centre for Health and Human Potential is a partnership of Fraser Health Authority, SFU Faculty of Arts and Social Sciences, the British Columbia Institute against Family Violence (BCIFV), and MCFD, Fraser Region, launched in April 2006. This partnership brings together the expertise of educators, researchers, health care providers, policy makers and administrators from the four founding organizations with the goal of improving the health and well-being of citizens through research, the dissemination of research findings, and the synthesis and translation of research findings into policy and practice.

The Centre is now ready to move forward with undertaking research and knowledge translation activities.

Partnerships with Primary Care

Primary Care

Research indicates that about a third of people who consult their family physician have mental health and/or addiction problems, with up to 25% having a diagnosable disorder.³⁶ Research suggests that the primary care sector is the most efficient and effective place to meet the management needs of the majority of individuals experiencing mild-moderate mental health and addiction problems.³⁷

People living with chronic mental illness and/or addiction frequently have high and complex chronic physical health needs. However, studies highlight that medical problems for mental health and addiction service consumers are typically ignored or poorly treated. A large number of individuals with mental health and addiction problems who cannot obtain a regular family physician, access care through walk-in medical clinics and hospital emergency departments. This situation results in poor continuity of care for people who are at heightened risk of developing complicated health conditions. In turn, individuals with chronic health conditions are at increased risk of developing mental illness and/or addiction.

Strengthening
Coordination

Recommendation: Identify strategies to build closer working relationships and capacity within Primary Care

It is essential that Mental Health and Addiction Services begin to build effective relationships with primary health care providers, and to assist the primary care community respond more appropriately to the mental health and addiction concerns of their patients. An additional need is to target the development of primary care services for those with chronic and serious mental illness and/or addiction.

One potential response is the establishment of Primary Care clinics within Mental Health and Addiction service sites. The demonstration model in Surrey has proven to be extremely successful, indicating the value of expanding this model throughout Fraser Health. The recruitment of nurse practitioners is another option which Mental Health and Addiction services should consider.

Shared Care Programs

The Shared Mental Health Care Program involves mental health professionals (psychiatrists and clinicians) working closely with family physicians in their practices to enhance the delivery of mental health services in the primary care setting. A key focus of the Shared Care Program is on the early identification and early intervention/treatment of mental illness.

Shared Care began in late 2001 as a pilot project and now has 12 teams serving 17 practices distributed across Fraser Health. Overall, the Shared Care programs have led to more timely access to specialized mental health services and on more efficient use of specialized psychiatric services.

Enhancing
Capacity

Recommendation: Develop a strategy for sustaining and expanding Shared Care

As the program is at an early stage of implementation and has only recently expanded across the health authority, the program must receive central support and coordination, to provide assistance

and direction to current teams, and to ensure consistency in the delivery of services by developing program guidelines/standards.

Looking ahead, Shared Care needs a strategy to enhance capacity. Such a strategy should articulate when and how existing teams can serve additional family practices in their community; and also when, where and how additional teams should be added for Shared Care across Fraser Health.

Improving
Info Systems

Recommendation: Continue to evaluate the Shared Care programs

Evaluation efforts to date have shown very positive results, in terms of the benefits of Shared Care to patients, family physicians and family practices. These efforts must continue to examine the effects of Shared Care, particularly with respect to the impacts of this program on the health care system. To support the evaluation of this multi-site program, a web-based data entry system has been developed for Shared Care that will allow practitioners to enter evaluation data via the internet into a central database. This database will allow for efficient, routine reporting on the Shared Care program.

Enhancing
Capacity

Recommendation: Support the transfer of knowledge to primary practitioners

Knowledge transfer/translation activities undertaken in this area include:

- Presentations on Shared Care at national and provincial conferences
- Regular workshops for family physicians
- Toolkits and other educational resources which have been developed for physicians and other involved mental health professionals.

There is a need to continue with knowledge transfer/translation activities – particularly those aimed at building the knowledge and skills of physicians in primary care.

Consumer and Family Involvement

Consumer Involvement

The value and importance of consumer and family involvement in all aspects of mental health cannot be overestimated. Research consistently reports consumer participation, self-help and consumer-led initiatives as being associated with:

- reductions in hospitalization
- reduced use of other services
- increased knowledge, information and coping skills
- increased self-esteem, confidence, sense of well being and of being in control
- stronger social networks and supports.

The Best Practices for BC's Mental Health Reform notes that effective consumer involvement requires:

- meaningful involvement, not just "tokenism"
- democratic decision-making processes that value and actively include the input and opinions of a variety of consumers
- training, education and support for consumers
- advocacy and outreach to give a voice to those without a voice and to involve more of them meaningfully.

Consumer involvement can include mutual support, advocacy, cultural activities, knowledge development and skills training, public education, education of professionals, or involvement on boards and committees. In addition, services can involve consumers' expert knowledge in planning, monitoring and evaluating their programs.

Consumers must be encouraged and supported to be active participants in all aspects of their care planning, including decisions around medication, admission, housing, and rehabilitation supports. Health professionals must view consumers and their families as valuable experts in considering the best road to recovery for consumers, and develop effective communication with them to enhance the outcomes of treatment plans.

While in the early stages of harnessing the broad power of consumer involvement, Fraser Health MH&A has successfully enlisted consumer involvement by:

- Hiring consumers to work in Peer Support positions
- Encouraging consumer representation on boards and committees
- Establishing a working group to address issues of consumer and family involvement system wide (2005).



Recommendation: Enhance consumer and family involvement in service planning, implementation and evaluation

Involving consumers and family members as active participants to reform and improve the mental health care system is a core value affirmed in British Columbia's 1998 Mental Health Plan. This involvement needs to be a key feature of regional and community systems for mental health. By acknowledging and using the wisdom and experience of consumers, the delivery of mental health services will be improved.



Recommendation: Strengthen the Community Advisory Committee network

Mental Health Advisory Committees have been established in a number of communities throughout Fraser Health to advise MH&A about attaining and maintaining quality services. These provide a forum for consumers and families to discuss systemic issues effecting consumers and families. Strengthening the advisories will result when:

- Greater clarity and consistency has been achieved regarding the role and membership of advisory committees
- General guidelines are in place about who is represented and how to communicate with constituents
- The roles and scope are set for both local advisories and regional advisories.



Recommendation: Develop a charter of client rights and responsibilities for Mental Health and Addiction

A Charter of Client Rights and Responsibilities offers known benefits. It:

- Helps individuals understand expectations both for themselves and staff as they work collaboratively to achieve treatment goals
- Protects rights and enhances the well being of consumers by informing them of key aspects of clinical care
- Applies to both community and inpatient settings.

Fraser Health can use the Charter developed by clients, families and staff at Riverview as a guide for a Fraser Health Charter.



Recommendation: Educate service providers on the meaningful roles of consumers and families in the planning, implementation and evaluation of Mental Health and Addiction services

Not all health professionals unreservedly support the role of consumers and families in service planning, implementation, delivery, or evaluation. There are substantial benefits to the active involvement of consumers and families and, therefore, all service providers must work to eliminate attitudinal barriers to participation. Individuals in leadership roles have a significant role in advocating for, promoting and supporting meaningful consumer and family participation.



Recommendation: Improve consumer and family access to information about services available within Mental Health and Addiction

Lack of access to information about available services is a major barrier for consumers when they attempt to address their own wellness needs or provide input into the overall system. A wide array of services is offered in local communities, and awareness of these will increase with a coordinated approach to promoting mental health and addiction services.

Family Involvement

The Standing Senate Committee³⁸ reported that many family members are frustrated with the complex mental health and addiction system, the physical and emotional effects of caring for their loved one, and the effort of ensuring they have what they need to provide the best possible care. In particular, there are issues with lack of information, lack of recognition and support for caregivers, lack of respite options, absence of respect and being treated with dignity.

The Fraser Health ACSS and ACM program review (2005) indicated that the level of family involvement with community mental health services is low across all programs. Family education and involvement in psychosocial interventions, such as relapse prevention, is essential for the best outcomes. Efforts need to be made to increase involvement of families in treatment as well as to improve education and supports to families, given the importance of family engagement to both client outcome and family well-being.

Families face a wide range of issues when dealing with mental illness. These can include:

- Difficult decisions about treatment, hospitalization, housing, and contact with the family member experiencing the mental illness
- Anxiety of an uncertain future and the stress of what can be a severe and limiting disability
- Physical and emotional demands of care leading to burnout
- Fear that they caused the mental illness
- The cost of medication, time off work, and extra support, resulting in a severe financial burden
- Both the care requirements and the stigma attached to mental illness often result in isolation of family members from the community and their social support network.

Training in coping skills, communication, information and support reduces the level of crisis in families, as well as reducing the relapse rate of the patient.

Enhancing
Capacity

Recommendation: Provide more counseling and support for family members

Family members of mentally ill individuals can benefit, in a number of ways, from receiving counseling and support from professionals. Counseling helps families to cope with the effects that living with mental illness has had on their own mental and physical well being. Family members can at times feel overwhelmed; however, support is often limited and there may be costs associated with these services. Mental health staff needs to provide family members with information, support and coping skills. However, heavy caseloads, time constraints and conflicting priorities are barriers to providing these supports to family members.

Transforming
Services

Recommendation: Improve family member involvement in treatment planning

A strong social support system is an important part of any wellness program for consumers. Research has demonstrated that involving families in the treatment planning process leads to better care and improved outcomes. Confidentiality is often cited as a reason to exclude family members from treatment planning. In many cases, however, the family member may be the primary caregiver and it is essential that they are informed and aware of the treatment plan. It has also been recognized that discharge planning should not only focus on the individual's needs but also the family's capacity to support and care for the individual.

Enhancing
Capacity

Recommendation: Increase availability of respite care

Family members who provide direct support for their loved one face a heavy physical, emotional and financial burden. Access to respite services to alleviate some of the burden has been limited because of available funding. Caregivers need to be able to access a flexible respite care program that will provide on going support through outreach, home care and activities for the family member that is ill.

Enhancing
Capacity

Recommendation: Increase support for self-help training

Self help models have been proven to have great potential if skilled facilitators and resources are in place. Studies show that family support groups are a cost-effective way to provide support to families who in turn can provide needed support and care to their mentally ill family member. Effective self help models provide family members with the tools to:

- Improve self esteem
- Improve knowledge
- Recognize the collective wisdom and practical experiences of families.

Expansion of this type of education program would benefit families across Fraser Health as they explore self help resources.

Workforce Development

The delivery of efficient, effective, and acceptable mental health and addiction services is contingent, to a large extent, upon developing and maintaining a strong, vibrant workforce. A number of factors contribute a strong workforce, including:

- Recruiting skilled professionals that address the current and future needs of the organization, and that reflect the communities in which they work
- Retaining staff through employing strategies targeted at specific groups of professionals
- Providing training and development opportunities for staff to build their skills and to grow professionally
- Fostering a healthy workplace environment where staff feel supported, valued, and rewarded.

Enhancing Capacity

Recommendation: Increase human resources in psychiatry for Mental Health and Addictions

Fraser Health has experienced a chronic shortage of psychiatrists, a significant barrier to developing and delivering mental health services. Currently, Fraser Health has the lowest psychiatrist-to-population ratio in the province: 73 per 100,000, versus more than 200 in VCHA, and more than 100 in VIHA and IHA. The shortages are particularly acute in relation to geriatric and child/youth psychiatrists.

The Royal College of Physicians and Surgeons of Canada, the Canadian Medical Association, and the Canadian Psychiatric Association collaboratively determined an appropriate psychiatrist-to-population ratio of one psychiatrist for every 8,400 Canadians. Applying the formula to Fraser Health illustrates the critical shortfall of mental health specialists relative to population:

- The current ratio is 1 specialist for every 14,893 people (with significant local variations) - almost double that which was deemed to be appropriate
- By 2020, assuming the current number of specialists remains constant, it is projected this ratio will rise to approximately 1:18,926.

Enhancing Capacity

Recommendation: Increase the number of selected mental health professionals

In addition to psychiatry, significant human resource shortages exist in relation to a number of other key mental health professionals. Addressing these shortages is essential to support the recovery-focused service model, and to meet the current and future needs of MH&A clients.

Enhancing Capacity

Recommendation: Increase number of selected addictions professionals

In addition to the staff needs noted already, Mental Health and Addiction Services will require a larger complement of physicians, concurrent disorders specialists and addiction counselors to meet anticipated future demands.



Recommendation: Initiate workforce development strategies for mental health and addiction service providers

Staff development strategies for Mental Health and Addictions are similar to those required throughout the Fraser Health organization and include efforts such as:

- Planning education and leadership development initiatives
- Identifying core competencies for employees
- Providing ongoing training in substance misuse and concurrent disorder issues.



Recommendation: Implement strategies to promote a Healthy Workplace within Mental Health and Addiction Services

A key factor in recruiting and retaining a strong workforce is the promotion of a healthy workplace environment for MH&A staff. Strategies that support a healthy workplace culture include:

- The promotion of physical and mental wellness through healthy lifestyles (exercise, nutrition, self-help, healthy balance between work and home)
- The promotion of a respectful and supportive work environment
- Injury prevention through safe workplace practices
- Proactive approach to illness and injury through strategies that support early detection, early intervention and return to work of the injured worker.

Information Systems and Performance Monitoring

Despite the proven value of quality information systems and performance monitoring, Mental Health and Addiction Services are challenged by the current information management systems and the lack of available reliable data and reporting. This in turn hinders clinical and administrative planning and decision making.

Effective and efficient information management systems are essential in order to support service planning and provision. Ideally, information systems:

- Provide ready access to information to support an efficient client waitlist and registration system
- Sustain outcome measurement at all levels of service through appropriate data capture and reporting capabilities
- Capture and share, in electronic form, clinical client information to ensure continuity of care and client satisfaction
- Ensure client confidentiality through appropriate levels of system security, whilst enabling collection and submission of all data reporting requirements internally and externally
- Enable sharing of clinical resource materials between care providers thus developing a well informed and competent workforce.

The vision for Mental Health and Addiction information needs is to move towards an integrated system that will house the entire MH&A client record including the Acute Care and Residential components and will capture and submit all reporting requirements and management needs.



Recommendation: Achieve Provincial Reporting Requirements

The Ministry of Health is developing a new Minimum Reporting Requirement (MRR) dataset for Health Authorities, which is due to be implemented in 2007/08. Mental Health contracted services, hospital outpatient services and some contracted Addictions Services are currently not part of any reporting systems. The Addictions MRR is new and is not currently being captured but it is mandated by MOH for implementation in September 2007 with no option for a paper based system.

The first phase of the implementation of an integrated information management system would ensure all MOH reporting requirements are captured and would accommodate referral management and patient scheduling. A system for submitting the data to MOH on a regular basis must also be developed in order to meet MH&A's performance agreement with MOH.



Recommendation: Improve integration and standardization of data collection

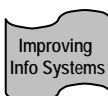
Mental Health and Addictions needs to have the ability to readily assess the level of care required and then match service to the identified needs, using standardized assessment and evidence-based care plans. To achieve this, MH&A needs to improve its information sharing and analysis, eliminating stand alone databases and developing an integrated information system.



Recommendation: Develop a Fraser Health-wide Electronic Health Record for Mental Health and Addiction clients

The continuum of care for Mental Health and Addiction Services within Fraser Health provides a multitude of services between prevention and chronic disease management. MH&A clients will likely be accessing these services over their entire lifetime, some continuously, some periodically, and some only once. The continuum of care for these clients should be reflected in one longitudinal mental health and addiction electronic client record, ideally housed within a total electronic health record, encompassing all areas of health. The information management plan for MH&A builds on this process by presenting a plan for a longitudinal MH&A electronic health record.

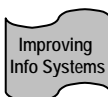
Acute and community services must be able to access and update clinical information from all sites across Fraser Health. The development of the Electronic Health Record (EHR) will help achieve this. A system is needed which provides clinical decision support to assist in creating care plans and evaluating outcomes.



Recommendation: Establish systems and processes which support collection of outcome measurement information

In recent years, outcome measurement mechanisms have been built into the evaluations of key initiatives and pilot projects within MH&A. However, it has yet to implement outcome measurement processes and tools for many of its core programs, both in hospital and in the community.

Routine outcome measurement processes will require a standardized reporting system, dependent on improvements to the current database systems and the introduction of Electronic Health Records.



Recommendation: Establish performance indicators for all services and programs

Continuous performance improvement is an essential component of the clinical and business imperative of Mental Health and Addictions. Clear, meaningful performance indicators are a priority and will capture data relating to the following quality dimensions: access, acceptability, efficiency, effectiveness and safety.

Current performance indicators for MH&A include a variety of case flow and service utilization statistics, including:

- Readmission rates
- The percentage of clients accessing care within 30 days of discharge
- Residential placement capacity; waitlists and wait-times
- Workforce benchmarks.

However, these indicators do not capture much of the service that is provided by Mental Health and Addictions, nor, the outcomes of those services. There is a need to develop a Balanced Score Card which includes core performance indicators, such as client satisfaction, fiscal performance, clinical outcomes, utilization outcomes, and professional staff growth and development.

Conclusion and Next Steps

The recommendations presented in this Strategic Plan form the basis for strengthening Fraser Health's continuum of care with the goal to improving health status and overall quality of life for individuals with mental illness and addictions. They represent priority responsibilities for this portfolio, given its vision of a recovery-oriented system and its goals of providing more accessible, seamless and responsive care for all clients.

This plan highlights the need to develop services along the continuum and in particular upstream health promotion and prevention initiatives to compliment the care and treatment work already solidly underway.

This plan aligns with Fraser Health's Strategic plan, and is designed to contribute to the goals of developing an integrated health system and creating new opportunities through partnerships. At the same time, success will contribute a more skilled and satisfied workforce, and will also further goals related to the ability to measure performance and the benefits that creates.

The next step will be the development of a three-year service plan with clear deliverables, outcome measures, action plans and proposed budget for implementation of priorities.

Implicit in this report, but not stated until now, is the assumption of the need for leadership. Administrative, clinical, and physician leaders in Mental Health and Addiction Services are committed to supporting these recommendations, and ask for a comparable demonstration of support from leaders throughout Fraser Health. Services such as Mental Health and Addictions no longer plan, work or succeed in isolation: a committed team effort moves each service towards its goals and ultimate fulfils its vision, along with that of Fraser Health as a whole.

Appendices

Appendix 1: Summary of Recommendations

| <i>Service Stream</i> | <i>Recommendations</i> |
|--|--|
| <i>Client-Centred Service Streams</i> | |
| Youth and Young Adult | <ul style="list-style-type: none"> • Improve coordination, integration and networking between mental health and addiction services for youth and young adults • Expand early intervention capacity • Increase acute care capacity • Develop rehabilitation services for young adults • Develop specialized residential facilities |
| Adult | <ul style="list-style-type: none"> • Ensure that CMHCs are providing the best model(s) of care and are operating with appropriate resources • Incorporate rehabilitation and recovery core values and practices throughout MH&A • Improve service engagement with individuals who are hard to reach • Expand implementation of early intervention strategies • Increase acute care capacity • Improve crisis/emergency services • Expand health promotion and prevention activities |
| Older Adult | <ul style="list-style-type: none"> • Determine the best model of care for community older adult mental health services • Improve coordination and collaboration with health care providers serving the older adult population • Ensure alignment with the Provincial Dementia Strategy • Build the continuum of older adult acute care services • Increase housing options for geriatric mental health and addiction consumers |
| <i>Specialized Services</i> | |
| Eating Disorders Services | <ul style="list-style-type: none"> • Develop inpatient capacity for treatment of eating disorders • Enhance community outpatient treatment capacity • Provide support to clients waiting for treatment |

| <i>Service Stream</i> | <i>Recommendations</i> |
|---------------------------------------|--|
| | <ul style="list-style-type: none"> • Increase community and service provider awareness/understanding of eating disorders and available programs |
| Concurrent Developmental Disabilities | <ul style="list-style-type: none"> • Improve access to tertiary acute care for individuals with concurrent developmental disabilities • Build collaborative working relationship in order to better serve/support individuals with concurrent developmental disabilities • Enhance capacity and continuum of community-based services • Provide increased training and education about concurrent developmental disabilities |
| Reproductive Mental Health | <ul style="list-style-type: none"> • Develop a Fraser Health Reproductive Mental Health Program |
| Mentally Disordered Offenders | <ul style="list-style-type: none"> • Strengthen partnerships aimed at promoting a coordinated approach to the delivery of services to mentally disordered offenders |
| <i>Specific Populations</i> | |
| Aboriginal communities | <ul style="list-style-type: none"> • Strengthen relationships, linkages and partnerships with Aboriginal service constituents • Develop an Aboriginal mental health and addictions action plan • Enhance the continuum of mental health and addiction services • Improve access to mental health and addictions services by the Aboriginal population |
| Diverse communities | <ul style="list-style-type: none"> • Form a Cultural Diversity Advisory Committee • Develop a sustainable cultural competency training program (in partnership with MCFD) • Improve accessibility of Mental Health and Addictions services for multicultural and LGBT consumers • Develop culturally specific direct services in partnership with community agencies who work with visible minorities and LGBT population |
| Homeless | <ul style="list-style-type: none"> • Finalize the homelessness strategy for Mental Health and Addictions • Develop “minimal barriers” housing projects for the homeless • Partner with community agencies/ministries in the development of “transitional housing” resources • Develop “supported housing” resources in priority communities for individual with complex mental health and substance use needs • Utilize assertive outreach strategies to engage the homeless population |

| <i>Service Stream</i> | <i>Recommendations</i> |
|--|---|
| Addictions | <ul style="list-style-type: none"> • Expand withdrawal management services • Build the continuum of youth and young adult addiction services • Expand pilot of the Early Discharge follow-up program • Develop second stage housing for addictions clients • Expand the range of older adult addictions services • Initiate development of low threshold/harm reduction interventions • Improve services for clients with concurrent disorders • Improve crisis care and response services to individuals living with an addiction • Improve the responsiveness of Addictions services to special populations • Expand addiction prevention and health promotion activities • Expand addiction outpatient activities |
| Tertiary | <ul style="list-style-type: none"> • Increase tertiary capacity and the continuum of care to include new acute, rehabilitation and specialized residential resources • Plan, design and implement an evaluation and quality framework for the Tertiary Care services established by Fraser Health • Develop and implement an integrated, centralized Access and Utilization strategy for Tertiary Care services across Fraser Health • Maintain an active partnership with PHSA on the development and implementation of tertiary clinical networks |
| Housing | <ul style="list-style-type: none"> • Establish a Mental Health Housing & Residential Services Steering Committee • Implement a Supported Independent Living (SIL) Program review • Develop a quality improvement and policy framework for licensed residential facilities and supported housing • Increase mental health supported housing capacity • Replace, upgrade and purpose-build licensed residential care facilities as opportunities present • Redevelop licensed residential care continuum |
| <i>Supportive Service Streams</i> | |
| Partnerships | <ul style="list-style-type: none"> • Enhance integration and coordination between all Mental Health services, and between Mental Health and Addiction services • Continue to build partnerships between Mental Health and Addictions and other Fraser Health portfolios • Align Fraser Health Mental Health and Addictions initiatives with provincial initiatives, where appropriate • Enhance inter-agency service collaboration for Mental Health and Addictions clients • Maintain and enhance Fraser Health's working relationship with Health Service Providers and external support and advocacy organizations |

| Service Stream | Recommendations |
|--|--|
| | <ul style="list-style-type: none"> • Continue to develop partnerships with local, provincial and national academic groups and institutions to support Fraser Health's strategic initiatives • Identify strategies to build closer working relationships and capacity within Primary Care • Develop a strategy for sustaining and expanding Shared Care • Continue to evaluate the Shared Care programs • Support the transfer of knowledge to primary practitioners |
| Consumer and Family Involvement | <ul style="list-style-type: none"> • Enhance consumer and family involvement in service planning, implementation and evaluation • Strengthen the Community Advisory Committee network • Develop a charter of client rights and responsibilities for Mental Health and Addictions • Educate service providers on the meaningful roles of consumers and families in the planning, implementation and evaluation of Mental Health and Addiction Services • Improve consumer and family access to information about services within Mental Health and Addictions • Provide more counseling and support for family members • Improve family member involvement in treatment planning • Increase availability of respite care • Increase support for self-help training |
| Workforce Development | <ul style="list-style-type: none"> • Increase human resources in psychiatry for Mental Health and Addictions • Increase the number of selected mental health professionals • Increase number of selected addictions professionals • Initiate workforce development strategies for mental health and addiction service providers • Implement strategies to promote a Healthy Workplace within Mental Health and Addiction Services |
| Information Systems and Performance Monitoring | <ul style="list-style-type: none"> • Achieve Provincial Reporting Requirements • Improve integration and standardization of data collection • Develop a Fraser Health-wide Electronic Health Record for Mental Health and Addictions clients • Establish systems and processes which support collection of outcome measurement information • Establish performance indicators for all services and programs |

Appendix 2: Acronyms Used in Mental Health and in this document

| Acronym | Stands for | Acronym | Stands for |
|---------|--|---------|--|
| ACCI | Acute Care Capacity Initiative | FHA | Fraser Health Authority |
| ACM | Assertive Case Management | FTE | Full-time equivalent staff position |
| ACRP | Adolescent Crisis Response Program | GLBT | Gay, lesbian, bisexual and transgendered |
| ACSS | Adult Community Support Services | HAD | Hospital Diversion Program |
| ACT | Assertive Community Treatment | HSDA | Health Service Delivery Area |
| ADTP | Adolescent Day Treatment Program | HSP | Health service provider |
| AHT | Acute Home-Based Treatment | IHA | Interior Health Authority |
| ALOS | Average length of stay | IPT | Interpersonal Psychotherapy |
| APU | Adolescent Psychiatric Unit | IPU | Inpatient Psychiatric Unit |
| ARHCC | Abbotsford Regional Hospital & Cancer Centre | MCFD | Ministry of Children and Family Development |
| ASTAT | Adult Short-Term Assessment and Treatment | MEIA | Ministry of Employment and Income Assistance |
| BCIFV | BC Institute of Family Violence | MHST | Mental Health Support Team |
| CBT | Cognitive Behavioural Therapy | MOH | British Columbia Ministry of Health |
| CCHSA | Canadian Council of Health Services Accreditation | MRR | Minimum reporting requirement |
| CHC | Community Health Centre | NGO | Non-Governmental Organization |
| CLS | Community Living Services | NOS | Not Otherwise Specified |
| CMHC | Community Mental Health Centre | PAU | Psychiatric Assessment Unit |
| CRESST | Community Residential Emergency Short Stay Treatment | PHSA | Provincial Health Services Authority |
| CRP | Community Residential Program | PSR | Psycho-social rehabilitation |
| DART | Drug and Alcohol Resource Team | PSW | Peer Support Worker |
| DEWY | Day, evening and weekend treatment for youth | RVH | Riverview Hospital |
| DEWY | Day, Evening, Weekend Youth Treatment Program | SIL | Supported Independent Living |
| ECT | Electro Convulsive Therapy | STLR | Stabilization and Transitional Living Residences |
| EDNOS | Eating disorder not otherwise specified | VCHA | Vancouver Coastal Health Authority |
| EHR | Electronic health record | VIHA | Vancouver Island Health Authority |
| EMHS | Emergency Mental Health Service | WHO | World Health Organisation |
| EPI | Early Psychosis Intervention | WMU | Withdrawal Management Unit |
| FH | Fraser Health | YRCP | Youth Crisis Response Program |

Appendix 3: Glossary of Services²¹

HEALTH PROMOTION: Initiatives that support individuals to engage in safer and healthier lifestyles, and which create supportive environments, strengthen community action, and develop personal health and coping skills. These initiatives create conditions that make the healthy choice the easy choice.

MENTAL HEALTH PROMOTION: Initiatives that support individuals, families, and communities to take control over their lives and improve their mental health, recognizing that mental health is inextricably linked to their relationships with others, environmental and lifestyle factors, and the degree of power they can exert over their lives. These initiatives include mental health literacy, and vehicles for information sharing to address levels of literacy, communication barriers (including language and sensory barriers), and geographic and technological barriers to access to information

PREVENTION SERVICES:

Primary Prevention: Initiatives that provide information on mental health, and harms associated with substance abuse, including education and support through awareness of community resources that facilitate resiliency, positive choices and effective coping skills to enhance problem solving.

Universal Prevention: Initiatives targeted to the whole population to strengthen protective factors to build resiliency, reduce risks among populations and mitigate potential threats to health, and support healthy lifestyle choices.

Selective Prevention: Initiatives targeted to individuals or subgroups of population with increased risk of developing a mental or substance use disorder in order to prevent or delay development of disorder by altering the susceptibility or reducing the exposure for susceptible individuals.

Secondary Prevention: Initiatives targeted to early detection and treatment of disorders, targeting to individuals exhibiting early signs or symptoms of a mental disorder or problematic substance use, or experiencing a first episode of an illness. Treatment interventions are intended to reduce severity and shorten course of the illness, limit disability and promote optimal functioning and reduce harms associated with substance use. Secondary prevention includes supports for relapse prevention, or lapses experienced when taking a harm reduction approach.

Indicated Prevention: Initiatives targeted to high-risk individuals showing minimal signs and symptoms of a mental and/or substance use disorder, or whose biological, social, and/or environmental markers indicate predisposition.

Tertiary Prevention: Initiatives targeted to alleviate or limit disability resulting from illness, reduction of co-morbidity and rehabilitation/restoration of effective function.

HARM REDUCTION SERVICES: Harm reduction is secondary and tertiary prevention that seeks to lessen the harms associated with high-risk behaviours, impulse control, and substance use (without requiring abstinence). These services and supports reduce the negative impacts of behaviours, alcohol and other drug use, including injury prevention, preventing sexual abuse or exploitation, and reducing the spread of infectious disease. Initiatives include needle-exchange programs and supervised injection sites to reduce the spread of communicable diseases such as HIV, Hep B and C, and drug overdoses. Other services provide practical solutions such as education on impulse control, as well as substance use and helping individuals who use substances to address important health concerns such as nutrition, hygiene, or immediate physical health problems such as wound abscesses, and safe housing options.

OUTREACH AND EARLY INTERVENTION SERVICES

Outreach Services: Services designed to contact, engage and link children, youth and adults who are at risk of developing mental disorders, or known to have or be at risk of having substance use problems, to treatment and support systems. Services include street-outreach, school-based outreach programs, and a combination of telephone and face-to-face outreach services.

Early Intervention Services: Early intervention services include the following: identification and referral early in the course of illness; rapid response to the referral; development of long lasting therapeutic alliance; prompt initiation of suitable treatment; and provision of relapse prevention services that lead to better short and longer term outcomes. Early intervention services are linked to a full range of biopsychosocial treatment and recovery services.

²¹ Source: Ministry of Health Minimum Reporting Requirements

CRISIS RESPONSE AND STABILIZATION SERVICES: Community crisis response and emergency services include services for individuals and families that are available 24 hours a day, seven days a week, and offer short-term interventions including assessment, stabilization, and referral for follow-up services. These services provide a safe, supportive environment to assist individuals in managing their immediate crisis and continue ongoing treatment. Crisis stabilization services are relevant to clients involved in outreach, case management, withdrawal management and treatment. Crisis response services include the following services:

Crisis/Warm Line: A telephone service provided by a trained volunteer or consumer which delivers immediate support to individuals in need by means of active listening or referral to health and social services.

Mobile Crisis Response Services: A service in which first line responders provide outreach to individuals in the community experiencing an acute mental health crisis.

Walk-in Crisis Stabilization Services: A service where individuals can walk-in and receive assessment, stabilization support and access to follow-up services.

Emergency Shelter/Transition Housing: Short-term residential support for basic needs (food and shelter) in a safe and secure setting for individuals and families during periods of crisis.

Community Crisis Residential Stabilization Services: Services include crisis response and stabilization in a short-term residential setting.

TREATMENT AND SELF-MANAGEMENT WITH SUPPORTS:

Primary Care Services: Health care services provided by physicians, nurse practitioners and other health service providers within a primary care setting for children, youth and adults experiencing mental health problems, problematic substance use, including symptoms of mental and/or substance use disorder, and other co-occurring medical conditions. Families are included in the treatment plan.

Shared Care Services: Services include mental health and addictions service providers and primary care providers sharing responsibility for mental health and addictions care of individuals and families. There are a variety of ways in which care is shared, including integrating mental health and addictions services in primary care settings, holding joint clinic and educational rounds, educational programs for primary care providers in managing mental and substance use disorders, as well as models of collaborative care where mental health and addictions specialists can support rural and remote primary care settings.

Tele-Mental Health and Addictions Services: Services include assessment, education and consultation for the diagnosis and treatment of mental and substance use disorders through the use of tele-video conferencing.

Withdrawal Management Services: Withdrawal management services support individuals through acute stages of withdrawal from alcohol or other drugs. These services may be inpatient/residential detox services or outpatient services such as daytox or home detox with professional supports.

Case Management Services: Mental health and addictions case management services include a wide variety of functions, including client finding, screening, assessment, treatment, psycho-social education, referral services, coordination of client's care, self management support, relapse prevention, crisis management, and ongoing support. Not all case management approaches encompass all these functions. The following are three common approaches to case management:

Brokerage Case Management Service: The primary focus of this service is on screening, assessments, referring clients to appropriate services, coordination of services and ongoing support.

Clinical Case Management Services: Services include client finding, screening, assessment, treatment, psycho-social education, referral services, coordination of client's care, self-management support, relapse prevention, crisis management and ongoing support.

Assertive Community Treatment (ACT): A service delivery model that provides flexible, comprehensive services to individuals with mental illness and/or addiction and who have multiple complex needs. ACT is distinct from the above case management approaches in its key components, which include a low client-to-staff ratio, operating after hours and weekends, multidisciplinary team approach, client-directed delivery of care, assertive outreach and continuous services.

Acute Mental Health Home Community Treatment Services: Services that are alternative to acute care hospitalization for acute psychiatric illness and include the following services in "Home" and community residential settings:

Acute Mental Health Home Treatment Services: Services include crisis intervention and management of acute symptoms, establishing a medication regime requiring close monitoring and/or education in managing acute illness and medications, developing a treatment plan and ensuring follow-up linkages are in place. "Home" includes the individuals or family home, family care homes and Supported Independent Living Program (SILP) units.

Acute Mental Health Community Residential Treatment Services: Licensed facilities under the *Community Care and Assisted Living Act*, designated to provide short-term assessment, treatment and intervention services and access to follow-up services

Specialized Psycho-Geriatric Assessment and Treatment Services: Specialized geriatric outreach services for the elderly with dementia, and other mental or substance use disorder, provided by a multidisciplinary team and includes specialized comprehensive assessments, competency assessments, pharmacological and psychosocial treatment, including recommendations for home care and environmental adaptations, referral services and service coordination. Psycho-social education and consultation is also provided to care providers.

Specialized Mental Health and Addictions Services for People with Developmental Disabilities: Specialized mental health and addictions services for individuals with developmental disability and mental disorder, provided by a multidisciplinary team and includes specialized comprehensive assessments, pharmacological and psychosocial treatment, and consultation with community care providers and families regarding functional impairments, symptoms, relapse prevention, challenging behaviours and other complex needs.

Outpatient Services: Services can be office-based or provided in the home and consultation, assessment, referral, education sessions, as well as individual, group and family counseling/therapy and case management can be short-term or longer-term. Services include outreach, medical

Day Programs/Intensive Day Treatment Services: Structured individual, group and family mental health and addictions treatment services for individuals with a mental and/or substance use disorder. These programs support individuals who have complex needs to receive treatment and support.

Gender-specific Mental Health and Addictions Services: Services include assessment, referral, education, as well as individual, couple and family counseling/therapy for women or men with a mental and/or substance use disorder, as well as co-occurring health problems.

Lesbian, Gay, Bisexual and Transgender Services: Services include assessment, referral, education, as well as individual, couple and family counseling/therapy for lesbians, gay men, bisexual and transgender persons, and their partners and families. The team of staff include "out" gay and lesbian therapists.

Methadone-Maintenance Treatment Program: Services that prescribe and dispense methadone as an opioid replacement therapy. Methadone is prescribed by community physicians who have received special training and authorization to prescribe, and is dispensed by community pharmacists who are authorized to dispense narcotics.

Short-term Addictions Residential Treatment: Addictions treatment provided in a safe, structured, and substance-free living environment for individuals up to 90 days. Treatment includes assessment, education, structured individual, group and family counseling/therapy.

Specialized Tertiary Services: Services include specialized assessment and treatment for individuals with a mental disorder that requires multidisciplinary expertise and consultation to meet the complex needs related to the mental disorder. Examples include, specialized eating disorders services, neuropsychiatry services, or specialized concurrent disorders services, which may be provided on outpatient or residential basis.

Family Support Services: A wide variety of services and supports including, self management support, counseling, psycho-social education, supporting partnerships among families, consumers and health care professionals in treatment plans, training opportunities, resources to support self-help and peer-to-peer support. Family support gives relief or support to a family caregiver who has the responsibility for the ongoing care of a family member. Respite can be includes respite care, which is temporary, short-term care, designed to provided inside or outside the home.

Psychosocial Rehabilitation Services: Psychosocial rehabilitation services include the following services:

Personal Life Skills Services: Services include specialized functional assessments, illness education (psycho-social education), personal care (e.g. grooming assistance), home management (e.g. meal preparation), home and community safety, community living support (e.g. shopping, transportation, financial management), medication monitoring, communication and interpersonal relationships support, guidance regarding sexuality and avoidance of high-risk behaviours, health programs (walking, exercising, smoking cessation and weight loss) and referral services bridging to local community resources.

Employment Support Services: Services include specialized assessments, career planning, pre-vocational skills training, transitional employment services, supported employment services, work experience, self-employment support and consumer-run businesses or co-operatives.

Supported Volunteer Services: Services include a range of support services to assist individuals to prepare for, obtain and maintain community volunteer placement positions

Therapeutic Volunteer Program (TVP): This program provides clients who are unable to enter vocational or supported education programs with financial incentives and supports to cover the costs associated with placement in a community volunteer position.

Peer Support Services: Services provided by trained clients to provide social and recreational companionship and personal life skills services including peer-to-peer education to other clients. Peer support services are coordinated within a formal structure linked to the treatment team.

Leisure Support Services: Services include specialized assessments and supports to identify interests, skills and abilities and encourage individuals to access and participate in active and passive leisure activities. Services include both individual and group leisure activities

Club House: A Club-House is a membership driven drop-in and vocational program. Individuals and staff work side-by-side to manage all aspects of the operation of the Clubhouse, including clerical services, food services, program activities and outreach services. Some Clubhouses provide on-site supported employment and work experiences.

Drop-In Centre: A Drop-In Centre is a place where individuals can drop in, usually 5-7 days a week, including after hours. Services include screening, assessment, referral services to local community resources, such as mental health and addictions services, housing and support services, vocational and employment and income support services. Some programs provide onsite meals, outreach services and social activities.

Education Support Services: Supported education includes specialized assessments, assistance, special adaptations and support for individuals to access, pursue and maintain educational opportunities.

System Advocacy Services: Services include assistance to individuals to deal with barriers to access income support, housing and support services, education, employment support, mental health and addictions services and other health and community support services.

INTENSIVE, LONG-TERM REHABILITATION AND SUPPORT:

Long-term Addictions Residential Treatment: Addictions treatment provided in a safe, structured, and substance-free living environment for individuals 90+ days. Treatment includes assessment, education, structured individual, group and family counseling/therapy, case management, community reintegration and linkages to after-care follow-up.

Concurrent Disorder Addictions Residential Treatment: Treatment for individuals with concurrent mental and environment up to six months. Treatment includes assessment, education, structured individual, group and family counseling/therapy, substance use disorders, within a safe, structured, and substance-free living psychosocial rehabilitation, case management, community reintegration and linkages to after-care follow-up.

STLRs (Support Recovery Homes): A temporary residential setting providing low to moderate addictions treatment and safe housing appropriate for longer-term recovery from addiction. Individuals may access outpatient and other community treatment services and supports.

Adult Forensic Psychiatric Services: Services for adults in conflict with the law that include specialized assessment, mental health and addictions treatment, including court liaison services through the forensic psychiatric hospital and regional forensic clinics.

Youth Forensic and Justice Programs: Services for youth in conflict with the law that include specialized assessment and mental health and addictions treatment services established specifically for young offenders. The Youth Substance Abuse Management Program is a cognitive skill-based education and treatment readiness program for youth in custody centres and in community-based locations. Youth addictions counsellors are available at youth custody centres. Youth serving a community sentence receive addictions treatment through community-based residential programs for youth.

Criminal Justice Diversion Services: A variety of diversion services such as mental health and addictions court liaison services, forensic liaison services, correctional facility liaison services and police diversion services. These services prevent clients who are at a high risk from entering the criminal justice system.

Tertiary Psychiatric Services: Services include tertiary acute care offered in the community, tertiary rehabilitation and tertiary residential care. Services include specialized assessment and treatment for individuals with a mental disorder that requires multidisciplinary expertise and consultation to meet the complex needs related to the mental disorder.

RESIDENTIAL/HOUSING SUPPORT SERVICES: Mental health and addictions residential and supported housing services include the following:

Community Mental Health Residential Care: Services provided through community mental health residential care facilities that are licensed or registered under the Community Care and Assisted Living Act, and include various levels of supports for

individuals unable to live independently. Facilities provide twenty-four hour on-site support for three or more residents, including accommodation, meals, personal life skills support, and medication administration and bridging with external mental health, addictions and local community services.

Family Care Homes: Privately owned homes, operated by a family or an individual, and approved by the regional Health Authority according to regional standards. These homes accommodate a maximum of two individuals and provide twenty-four hour on-site care and support for persons unable to live independently and requiring support services within a family setting. Services provide twenty-four hour on-site care include room and board, assistance with personal life skills and bridging with community mental health, addictions and local community services.

Supported Housing: A variety of licensed or registered facilities under the *Community Care and Assisted Living Act*, as well as, unlicensed facilities subjected to the Residential Tenancy Act and standards enforced by the regional Health Authority. Services include provision of safe, secure and affordable accommodation and support services, which vary in the level of intensity, such as assistance with personal life skills and crisis management. Supported Housing includes a variety of housing and support models:

Satellite Apartments/Mobile Homes: Clients live in self-contained subsidized private market apartments/mobile homes, usually one bedroom units, governed by the Residential Tenancy Act. Clients pay reduced rent based on income (maximum 35 percent of income). Either the health authority or BC Housing provides a rent subsidy. Off site home support and mental health and addictions services are coordinated through a mental health case manager.

Block Apartments: Clients live in subsidized self-contained one bedroom apartments whereby all units are occupied by persons with a mental disorder. The apartments are governed by the Residential Tenancy Act. BC Housing administers capital funding/maintenance of the facility; clients pay reduced rent based on income (maximum 35 percent of income). On site or off-site home support provided by the health authority or non-profit agency. Home support and mental health and addictions services are coordinated through mental health case managers.

Congregate Housing: Clients live in bachelor suites; all units in the building are occupied by persons with a mental disorder. The facility is governed by the Residential Tenancy Act. Communal food services provided on site. BC Housing administers capital funding/maintenance of the facility; clients pay reduced rent based on income (maximum 35 percent of income). On-site home support services provided by the health authority or non-profit agency. Home support and mental health and addictions services are coordinated through mental health case managers.

Group Homes: Clients share a communal home and participate in shared living arrangements. Off-site home support provided by non-profit agency. In some instances, BC Housing administers capital funding/maintenance of the facility; in other instances non-profit agencies purchase the building and provide low market rents. Clients pay reduced rent based on income. Group homes are not licensed under the Community Care and Assisted Living Act, but have to meet standards for health and safety developed by the health authority. Home support and mental health and addictions services are coordinated through mental health case-managers.

BC Housing Health Services Program: This program is a partnership between BC Housing and health authorities to provide individuals with severe and persistent mental disorders increased access to subsidized housing directly managed through the housing portfolio of BC Housing. Health Services Coordinators, such as registered psychiatric nurses, co-located in regional BC Housing District Offices throughout BC, assist clients by providing direct access to subsidized housing, link tenants to community mental health and addictions treatment and support services, and facilitate education sessions for housing providers. Off-site home support and mental health and addictions services are coordinated through mental health case managers.

Wet Housing: Housing for individuals with chronic alcoholism who are continually at risk of being homeless, or who are homeless as a result of their chronic alcoholism and require a safe place to live. Individuals are provided an opportunity to become connected with health, social and other community services.

Appendix 4: Consultation List – MH&A Staff and Physicians

Mental Health and Addiction Staff

| Strategic Plan Section | Key Contacts for Review & Input |
|---------------------------------------|--|
| Strategic Plan (all sections) | Lois Dixon, Sue Melnychuk, MH&A CSPD Team, MH&A Leadership & Management Teams, Addictions Services Planning & Steering Committee, Chiefs of Psychiatry |
| Youth & Young Adult | Karen Tee, Andy Libbiter |
| Adult | Walid Chahine, Judith Macrae, Karen Bunner |
| Older Adult | Chrystal Mihelic, Christine Dobbeltyn |
| Addictions | Akbar Bayanzadeh, Sherry Mumford |
| Tertiary | Sue Melnychuk, Lynda Price |
| Housing | Meryl MacDowell, Dan Kipper |
| Eating Disorders | Hanif Mohamed, Walid Chahine |
| Concurrent Developmental Disabilities | Tina Donnelly, Dr. Robin Friedlander |
| Reproductive | Drs. Terry Isomura, Tricia Bowering |
| Mentally Disordered Offenders | Denyse Houde |
| Aboriginal | Sue Melnychuk, Frank Fung, Derek Wilson, Margaret Wilson |
| Diverse Communities | Meryl McDowell, Chrystal Mihelic, Karen Tee |
| Homeless | Meryl McDowell, Dan Kipper |
| Partnerships | Sue Melnychuk, Lois Dixon, Terry Isomura |
| Consumer & Family | Anthony Neptune, Andrew Kellet, Fraser Health Consumer and Family Planning Group |
| Workforce Development | Sue Melnychuk, Frank Fung |
| Measuring Performance | Bev Saumer, Denyse Houde |

Mental Health and Addiction Consultation with Physicians

| Strategic Plan Section | Key Contacts for Review & Input |
|---------------------------------------|---|
| Strategic Plan (all sections) | Medical Director and Chiefs of Psychiatry |
| Youth and Young Adult | Drs. Ann Turner, Betty Tang, Andrea Chapman, David Attwood, Emad Zaghloul |
| Adult | Drs. Ralph Jones, Brit Bright, Nancy Miki, and Ganga Nair |
| Older Adult | Drs. Glenn Faris, Sandi Culo, Jeremy Sable, Nirmal Kang |
| Addictions | Drs. Paul Sobey, Bob Hosein, Roy Morton |
| Tertiary | Drs. Hemlata Joshi, Ganga Nair, Glenn Faris |
| Eating Disorders | Drs. Samantha Kelleher, Joan Stogryn, Joan Fujiwara |
| Concurrent Developmental Disabilities | Dr. Robin Friedlander |
| Reproductive | Drs. Tricia Bowering, Terry Isomura |
| Mentally Disordered Offenders | Dr. Terry Isomura |
| Aboriginal | Dr. Ralph Jones |
| Diverse Communities | Drs. P Lim, Agnes To, Anson Koo, Narang Manjinath |
| Homeless | Drs. Ralph Jones, Nancy Miki, Paul Waraich |
| Partnerships | Dr. Terry Isomura |
| Workforce Development | Dr. Terry Isomura |
| Measuring Performance | Dr. Paul Waraich |

Appendix 5: Consultation List –Internal and External Stakeholders

| Service Stream | Focus | Organization | Contact Info |
|-------------------------------|--------------------------------|--|---|
| Strategic Plan (all sections) | | Fraser Health Authority | Acute Care Executive Directors and/or Delegates Community Executive Directors and/or Delegates |
| Addictions | Residential | Kinghaven Peardonville House Society | Milt Walker |
| | Residential | Last Door | Louise Cooksey |
| | Residential | Daughters and Sisters | Meaghan Dougherty |
| | Outpatient | DiverseCity | Mitra Mansoor |
| | Outpatient | Odyssey (Boys and Girls Club) | Kathy Snowden |
| | Outpatient | Abbotsford Addiction Services | Lesley Braithwaite |
| | Outpatient | Fraserside | Jill Bloom |
| | Outpatient | Share Family & Community Services Society | Joanne Granek Lynda Edmonds |
| | Outpatient | Fraser House Society | Harry O'Connor Steven Sharpe |
| | Outpatient | Peace Arch Community Services | Kevin Letourneau |
| | Day Treatment | Jackson Murray | Vince Hahn |
| | Day Treatment | Pacific Community Resources | Tom Hetherington |
| HSPs Non-Residential | Supported Housing | Mennonite Central Committee Supportive Care Services | Peter Andres Steve Thiessen |
| | Vocational Rehab | Surrey Community Services Society | Greg Terpenning |
| | Clubhouses | Fraserside Community Services Society | Caroline Bonesky |
| HSPs Residential/CRP | Community Residential Facility | Chelsey House | Debbie Howie |
| | Pioneer | Pioneer Community Living Association | Colleen Dewar |
| Aboriginal | | Sto:lo – Mission | Brian Muth |
| Mental Health and Advocacy | Mental Health | Canadian Mental Health Association BC Division | Bev Gutray |
| | BCSS | BC Schizophrenia Society | Gary Glacken |
| | Mood Disorders | Mood Disorder Association of British Columbia | Rennie Hoffman |
| | Alzheimer's Society of BC | Alzheimer's Society of BC | Rosemary Rawnsley |
| Children and Youth | Child & Youth Services | Ministry of Children & Family Development | Dr. Martha Baldwin Tigerson Young Gurpal Bamara Yuan Li |

Appendix 6: Consultation List – Consumers & Families

To obtain feedback from consumers and families on the draft Strategic Consultation Plan, focus groups were conducted at three locations across Fraser Health.

| Focus Group Location | Number of Participants |
|---|------------------------|
| New View Clubhouse 2050 Mary Hill Road, Port Coquitlam | 22 |
| Abbotsford Mental Health Centre, 32700 George Ferguson Way, Abbotsford | 22 |
| Hyland House 6595 King George Hwy., Surrey | 8 |

Feedback on the Consumer and Family Involvement Section of the Plan

Consumer Involvement

Recommendation #1: Enhance consumer and family involvement in service planning, implementation and evaluation

- Consumers and families need to have specific access to resources.
- Professionals, like doctors, for instance, should come out and sit in family support group meetings and see what it is really like for family members.

Recommendation #2: Strengthen the Community Advisory Committee Network

- There is a need for new members and new thinking on Community Advisory Committees.
- Advisory Committee meetings need to be at times and locations where people can get to and where they would feel safe.
- A regional advisory committee is needed.
- A community advisory committee needs to be established in Maple Ridge.
- Intensive outreach to business community is needed to get their input and start partnerships.

Recommendation #3: Develop a charter of client rights and responsibilities

- The charter of rights and responsibilities should be for clients and families.
- Need to research and review all “charters” and not just use the Riverview Hospital charter.
- A charter of rights is good, but there is a need to make sure that it gets out to the public.
- Service providers need to have copies of the charter.
- Staff, clients and families need education about the BC Mental Health Act.
- Education is needed regarding confidentiality laws and how they should be interpreted.
- A complaints department is needed. Clients and families need to know where they can go if they have a concern or complaint.

Recommendation #4: Educate service providers on the meaningful roles of consumers in the planning, implementation and evaluation of Mental Health & Addiction Services

- There is a need to develop a collaborative approach, and to see increased measurable participation of consumers and families.
- “This is a good recommendation.”

- Clients and families also need education on how they can become involved.
- All health professionals need to come together in partnership and help each other when working with clients.
- Information being delivered by staff to clients seems too negative.

Recommendation # 5: Improve consumer access to information about services available within Mental Health & Addictions

- People don't know about services that are available, such as the types of housing (e.g., SIL).
- There should be a Website or Newsletter for consumers and families to access information.
- There is a need to build on existing tools, such as survival kits.
- Information on Best Practices can be accessed on-line.

Family Involvement

Recommendation # 1: Provide more counseling and support for family members

- Counseling for family members of consumers is very important. This should include not only parents/caregivers, but children of consumers as well.
- Family members could be used as mentors, educators, & coaches and have family peer support.
- There is a need to evaluate current resources as well as look at alternative ways to be more effective in achieving objectives. Reference made to area having a family coordinator and the fact that there is inconsistency throughout Fraser Health.
- The importance of the family coordinator positions at BCSS and the need for one in this (Abbotsford) area.

Recommendation # 2: Improve family member involvement in treatment planning

- Family members need to be educated in the treatment planning and recovery process.
- There is a need to consult with family members regarding discharge planning.
- There should be a full range of supports (including financial) for caregivers.

Recommendation # 3: Increase availability of respite care

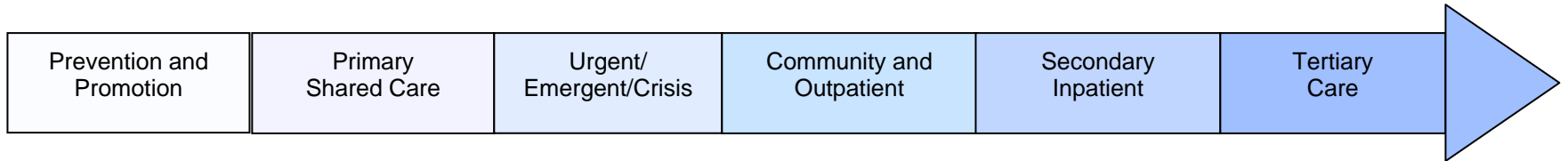
- All were in favour of this recommendation.
- Increased support services, such as respite and counseling, are needed for families.

Recommendation # 4: Increased support for self-help training

- Recommendation needs to read: Increased support for families in self-help training
- Critical need for self-help in communities in Fraser East (Hope).

Appendix 7: Comparison of Current Services to Benchmarks

PROFILE FOR ADULT MENTAL HEALTH SERVICE STREAM



Service Benchmarks 2006-07

| | | | | | |
|---------|---------|---------|----------|----------|----------|
| 57 FTEs | 25 FTEs | 95 FTEs | 518 FTEs | 298 beds | 146 beds |
|---------|---------|---------|----------|----------|----------|

Current Services 2006-07

| | | | | | |
|--------|----------|---------|----------|----------|---------|
| 0 FTEs | 6.5 FTEs | 67 FTEs | 385 FTEs | 177 beds | 63 beds |
|--------|----------|---------|----------|----------|---------|

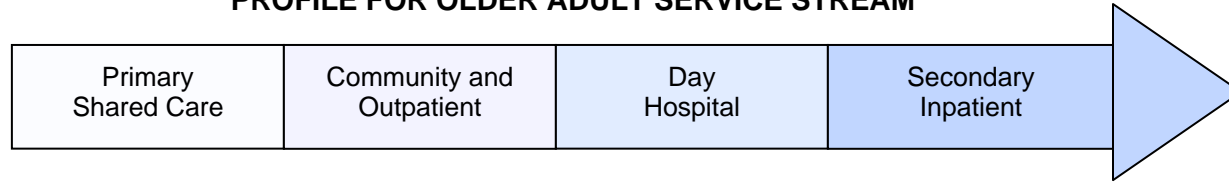
Gap from Benchmarks 2006-07

| | | | | | |
|---------|-----------|---------|----------|----------|---------|
| 57 FTEs | 18.5 FTEs | 28 FTEs | 134 FTEs | 121 beds | 83 beds |
|---------|-----------|---------|----------|----------|---------|

Projected Gap from Benchmarks based on 2010 population projections

| | | | | | |
|--------------|-----------|---------|----------|----------|---------|
| Not captured | 20.5 FTEs | 35 FTEs | 176 FTEs | 213 beds | 95 beds |
|--------------|-----------|---------|----------|----------|---------|

PROFILE FOR OLDER ADULT SERVICE STREAM



Service Benchmarks 2006-07

| | | | |
|--------------|---------|-----------|---------|
| Not captured | 93 FTEs | 58 places | 24 beds |
|--------------|---------|-----------|---------|

Current Services 2006-07

| | | | |
|---------|---------|----------|--------|
| 2 teams | 35 FTEs | 0 places | 0 beds |
|---------|---------|----------|--------|

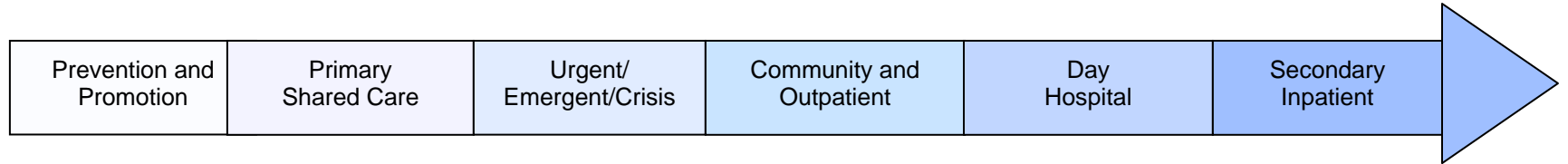
Gap from Benchmarks 2006-07

| | | | |
|--------------|---------|-----------|---------|
| Not captured | 58 FTEs | 58 places | 24 beds |
|--------------|---------|-----------|---------|

Projected Gap from Benchmarks based on 2010 population projections

| | | | |
|--------------|---------|-----------|---------|
| Not captured | 75 FTEs | 63 places | 24 beds |
|--------------|---------|-----------|---------|

PROFILE FOR CHILD, YOUTH AND YOUNG ADULT SERVICE



Service Benchmarks 2006-07

| | | | | | |
|---------------------|--------------|--------------|---------------------|-----------|---------|
| Provided by MCFD | Not captured | Not captured | Provided by MCFD | 58 places | 22 beds |
|---------------------|--------------|--------------|---------------------|-----------|---------|

Current Services 2006-07

| | | | | | |
|---------------------|---------|---------|---------------------|-----------|---------|
| Provided by MCFD | 4 teams | 17 FTEs | Provided by MCFD | 28 places | 10 beds |
|---------------------|---------|---------|---------------------|-----------|---------|

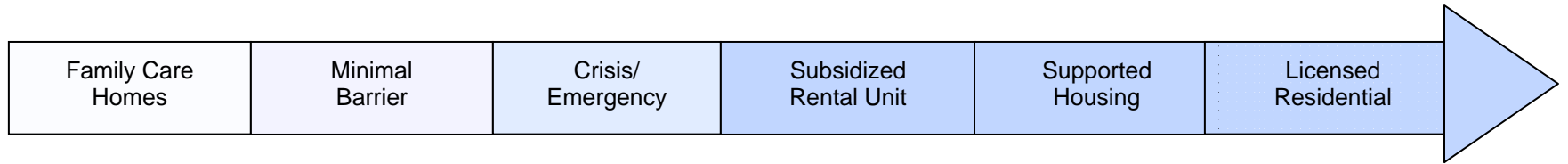
Gap from Benchmarks 2006-07

| | | | | | |
|---------------------|--------------|--------------|---------------------|-----------|---------|
| Provided by MCFD | Not captured | Not captured | Provided by MCFD | 30 places | 12 beds |
|---------------------|--------------|--------------|---------------------|-----------|---------|

Projected Gap from Benchmarks based on 2010 population projections

| | | | | | |
|---------------------|--------------|--------------|---------------------|-----------|---------|
| Provided by MCFD | Not captured | Not captured | Provided by MCFD | 30 places | 30 beds |
|---------------------|--------------|--------------|---------------------|-----------|---------|

PROFILE FOR HOUSING SERVICE STREAM



Service Benchmarks 2006-07

| | | | | |
|-----------|---------------------------------|---------|----------|----------|
| 22 places | 1059 places * Homeless Count | 68 beds | 900 beds | 799 beds |
|-----------|---------------------------------|---------|----------|----------|

Current Services 2006-07

| | | | | |
|-----------|-----------|---------|----------|----------|
| 13 places | 11 places | 52 beds | 900 beds | 647 beds |
|-----------|-----------|---------|----------|----------|

Gap from Benchmarks 2006-07

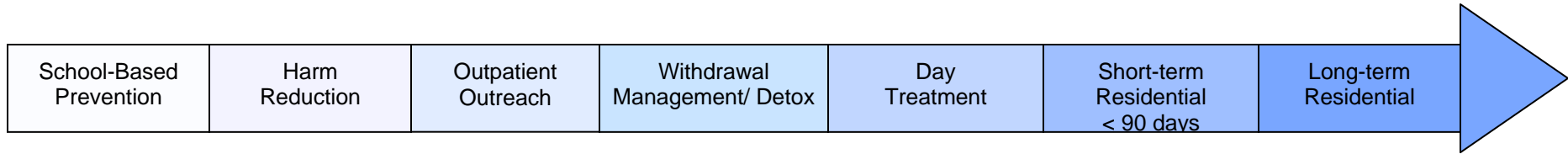
| | | | | |
|----------|----|---------|-------|----------|
| 9 places | ++ | 16 beds | --- * | 152 beds |
|----------|----|---------|-------|----------|

Projected Gap from Benchmarks based on 2010 population projections

| | | | | |
|----------|-----|---------|----------|----------|
| 0 places | +++ | 24 beds | 102 beds | 243 beds |
|----------|-----|---------|----------|----------|

* Homeless require subsidized rental/supportive housing

PROFILE FOR ADDICTIONS SERVICE STREAM



Service Benchmarks 2006-07

| | | | | | | |
|--------------|--------------|----------------|---------------|------------|----------|----------|
| Not captured | Not captured | 26,184 clients | 9,634 clients | 141 cycles | 234 beds | 265 beds |
|--------------|--------------|----------------|---------------|------------|----------|----------|

Current Services 2006-07

| | | | | | | |
|--------------|-------------|---------------|---------------|-----------|----------|----------|
| Not captured | No Services | 8,273 clients | 2,017 clients | 25 cycles | 126 beds | 147 beds |
|--------------|-------------|---------------|---------------|-----------|----------|----------|

Gap from Benchmarks 2006-07

| | | | | | | |
|---------|--------------|----------------|---------------|------------|----------|----------|
| 12 FTEs | Not captured | 17,911 clients | 7,617 clients | 116 cycles | 108 beds | 118 beds |
|---------|--------------|----------------|---------------|------------|----------|----------|

Projected Gap from Benchmarks based on 2010 population projections

| | | | | | | |
|--------------|--------------|----------------|---------------|------------|----------|---------|
| Not captured | Not captured | 19,978 clients | 8,538 clients | 128 cycles | 130 beds | 95 beds |
|--------------|--------------|----------------|---------------|------------|----------|---------|

Appendix 8: Acute Psychiatry and Addictions Beds by Site

| Hospital | Adult Psychiatry Beds | Adolescent Psychiatry Unit (APU) |
|-----------------------------------|-----------------------|----------------------------------|
| Surrey Memorial | 35 | 10 |
| Psychiatric Assessment Unit (PAU) | 10 | |
| Peace Arch | 11 | |
| Delta | 0 | |
| Langley Memorial | 18 | |
| Burnaby | 25 | |
| Eagle Ridge | 0 | |
| Ridge Meadows | 14 | |
| Royal Columbian* | 30 | |
| Chilliwack General | 14 | |
| Fraser Canyon | 0 | |
| Mission Memorial | 0 | |
| MSA General ** | 20 | |
| Total Beds | 177 | 10 |

* Excludes 4 crisis stabilization beds

** Additional 10 adult psychiatric beds approved for the new ARHCC site

| CRESST (Community Residential Emergency Short Stay Treatment) | |
|--|-----------|
| Abbotsford | 10 |
| New Westminster | 10 |
| Surrey | 12 |
| Total | 32 |

| Addictions Facility | Adult Beds | Adolescent Beds |
|--|------------|-----------------|
| Maple Ridge Treatment Centre | 60 | |
| Chilliwack General Hospital – Withdrawal Management Unit | 10 | |
| Creekside Withdrawal Management Centre | 24 | 6 |
| Total | 94 | 6 |

Appendix 9: Breakdown of Mental Health Housing Resources

(Licensed Residential Beds, Supported Housing Units, Crisis Stabilization Beds)

* Population Estimates and Projections (P.E.O.P.L.E. 30)

| | Population Projection 2006 Age 19-90 * | 2006-11-20 Current Bed/Units In Fraser Health | | | | Population Projection 2011 Age 19-90 * | 2011 Projected Bed/Units Required Based on Benchmarks ^ | | | |
|------------------|--|---|---|------------------|--|--|---|---|------------------|--|
| | | Mental Health Licensed Residential Beds | Supported Housing (SIL, Bridging, Congregate Housing, Transitional Housing) | Family Care Home | Crisis Stabilization/ Short Term Emergency Housing | | Mental Health Licensed Residential Beds | Supported Housing (SIL, Bridging, Congregate Housing, Transitional Housing) | Family Care Home | Crisis Stabilization/ Short Term Emergency Housing |
| North | | | | | Regional resource | | | | | Regional resource |
| New West | 49,023 | 67 | 134 | 0 | 20 | 52,509 | 37 | 41 | 0 | - |
| Burnaby | 166,830 | 33(+10 ``) | 117 | 1 | 0 | 176,648 | 124 | 140 | 0 | - |
| Maple Ridge | 68,071 | 36 | 67 | 0 | 0 | 77,467 | 54 | 61 | 0 | - |
| Tri-Cities | 164,524 | 46 | 136 | 4 | 0 | 184,154 | 129 | 145 | 0 | - |
| Sub-total | 448,448 | 182 | 454 | 5 | 20 | 490,778 | 344 | 387 | 0 | 29 |
| South | | | | | | | | | | |
| Langley | 95,279 | 82 | 55 | 1 | 0 | 105,408 | 74 | 83 | 0 | - |
| Surrey | 249,560 | 101 | 124 | 3 | 12 | 286,824 | 202 | 227 | 0 | - |
| White Rock | 66,898 | 79 | 91 | 0 | 0 | 73,949 | 52 | 58 | 0 | - |
| Delta | 79,243 | 36 | 53 | 1 | 10 | 83,888 | 59 | 66 | 0 | - |
| Sub-total | 490,980 | 298 | 323 | 5 | 22 | 550,069 | 387 | 434 | 0 | 33 |
| East | | | | | | | | | | |
| Abbotsford | 98,819 | 76 | 43 | 2 | 10 | 113,392 | 79 | 90 | 0 | - |
| Mission | 29,795 | 79 | 29 | 1 | 0 | 34,064 | 24 | 27 | 0 | - |
| Chilliwack | 59,468 | 12(+12 ``) | 32 | 0 | 0 | 65,695 | 46 | 52 | 0 | - |
| Hope | 6,935 | 0 | 15 | 0 | 0 | 7,206 | 5 | 6 | 0 | - |
| Agassiz | 6,874 | 0 | 4 | 0 | 0 | 7,509 | 5 | 6 | 0 | - |
| Sub-total | 201,891 | 167 | 123 | 3 | 10 | 227,866 | 159 | 181 | 0 | 14 |
| TOTAL | 1,141,319 | 647 | 900 | 13 | 52 | 1,268,713 | 890 | 1,002 | 0 | 76 |

^ A Family Care Home Program will not be a model developed as part of the continuum of housing resources

^ Fraser Health – Benchmarks March 2005. Beds/Units recommended per 10,000 population

| | | | |
|------------------------|-----|----------------------|-----|
| Licensed Residential | 7.0 | Family Care Homes | 0.2 |
| Supported Housing | 6.5 | Crisis Stabilization | 0.6 |
| Transitional /Bridging | 1.4 | | |

(Taken from *The Mental Health Housing Plan – Fraser Health (May 2006)*)

Appendix 10: ABORIGINAL HEALTH SERVICES ADAPTATION PLAN

Our adaptation framework highlights three key components to the success and ongoing sustainability of Aboriginal health adaptation within Fraser Health, all of which are supported by defined processes of communication, evaluation and sponsorship from Fraser Health and Aboriginal leaders.

1. Engagement

Engagement of Aboriginal communities and Fraser Health employees is foundational to all of the work. Each component of the plan will be designed to build new relationships and support existing partnerships. A key strategy will include the establishment of a Fraser Aboriginal Health Advisory Council.

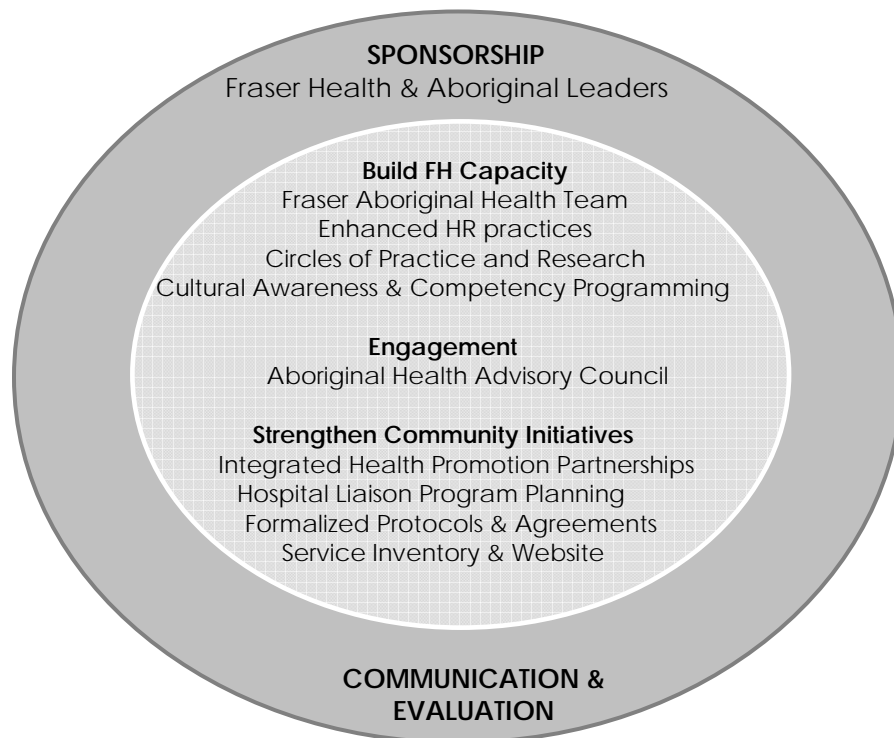
2. Fraser Health Capacity Building

Adaptation planning will focus on further development of the Fraser Aboriginal Health Team, enhancement of Human Resources (HR) practices, cultural awareness and competency programming, and creation of circles of practice and research.

3. Community Initiatives

These activities include:

- enhancement of the hospital liaison program;
- preparation of an inventory of services;
- development of website and resource materials;
- service protocol development between Aboriginal populations and Fraser Health; and
- establishment of integrated health promotion teams that will focus on healthy lifestyle choices, chronic disease, HIV/AIDS, injury prevention, mental health and addictions.



Appendix 11: References

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