Mental Health for All

Canadian Mental Health Association
British Columbia
Mental health for all

Building a Comprehensive System of Care in BC

CMHA BC Policy and Advocacy Roadmap

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We respectfully acknowledge xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), səlilwətaʔɬ (Tsleil-Waututh), Lkwungen (Songhees) and Wyomilth (Esquimalt) peoples on whose traditional, unceded lands the CMHA BC offices are located.

The Imperative

One third of people in Canada will experience a mental illness or substance use disorder in their lifetime[1] **– that is almost 1.7 million people living in British Columbia.** In BC, almost a quarter of people perceive their mental health to be fair or poor.[2] Around 10% of the provincial population experiences a mood or anxiety disorder[3] and 25% of the population will experience a substance use disorder in their lifetime.[4] BC has the highest rates of toxic drug deaths in Canada,[5] and we have lost over 14,000 people to toxic drugs since 2016.[6] While the worst of the COVID-19 may be over, the pandemic only made things worse, with 37% of Canadians saying their mental health declined during the pandemic.[7]

There are around 30,000 people who are admitted to hospital involuntarily under the *Mental Health Act* annually in BC, a number that has increased significantly over the last decade.[8] Almost 15% of mental health patients in BC will be admitted to hospital at least three times a year, which is higher than the Canadian average.[9] BC also has a higher-than-average rate of self-harm, including suicide,[10] losing at least 639 people to suicide in 2023.[11]

Almost 10% of people living in BC live below the poverty line. Housing insecurity, food insecurity and poverty are all risk factors for mental illness.

In 2023, homelessness grew 31% from previous years, with over 11,000 people identified as experiencing homelessness in BC—a number that is most certainly an underestimate.[12] Over-represented in this population are Indigenous peoples and 2SLGBTQ+ individuals who also experience disproportionate mental health and substance use problems. Twenty-one percent of people living with mental health-related disabilities live in unsuitable, inadequate or unaffordable housing and cannot afford alternative housing in their community.[13] Almost 10% live below the poverty line.[14] Housing insecurity, food insecurity and poverty are all risk factors for mental illness.

Mental illness affects us all, whether we have experienced it ourselves, or know a loved one, friend or neighbour who has. So why aren't we doing more to prevent mental illness or intervene early before things get worse? Why don't we treat mental health like physical health and give people the supports and tools they need before it becomes a crisis? Why are we addressing mental illness in the most expensive and least effective ways, plugging up already overtaxed health and justice systems? **The imperative to build an accessible, high quality and coherent system of care for mental health and substance use has never been stronger.**

Context

The Province of BC has made some incredible strides over the past decade to improve mental health and substance use care. The addition of a new Ministry in 2017—the Ministry of Mental Health and

Addictions—has resulted in a much-needed dedicated focus on mental health and substance use, moving the mental health and substance use system out from under the cover of the Ministry of Health. While this may not serve the long-term vision of equity between physical and mental health care, it presently serves a very important role in directing policy development and financial resources towards establishing a better mental health and substance use system of care. **Since the Ministry of Mental Health and Addictions was created, total new allocations for mental health and substance use equal $2.65 billion.** We have seen important investments through *A Pathway to Hope* and a number of new innovations in mental health and substance use policy.[15]

However, **the cost of the status quo continues to outpace what is being invested.** The estimated impact of mental illness and substance use-related harms in BC stands at $6.6 billion annually,[16] and yet we continue to pay for care in the most expensive ways by waiting for problems to become crises and inappropriately over-utilizing our health and justice systems. Cost modelling of investing in mental health care shows significant potential for cost savings. If policy initiatives could reduce the incidence of mental illness by 10%, we could expect an annual savings of $4 billion on direct health and social care costs for mental health problems after 10 years, with these cost savings increasing year by year.[17] While it takes time to see the impacts of investment, we cannot approach these complex issues through a shortsighted lens.

Further, new investments are not the be-all to end-all. Even with historic investments in the mental health and substance use system, one could argue that we still don't have a coherent "system of care" in BC. **While it is important to invest in new and innovative initiatives, it is also necessary to ensure that all the parts of the system are well-connected, integrated and supported.** Investing in the plumbing of the system may not be as exciting, but it is absolutely necessary for developing and sustaining an actual system of care.

With the upcoming provincial election in October 2024, we cannot take our foot off the gas with all the important gains made, and we must do more to ensure that people are able to access voluntary, timely, high-quality and dignified mental health and substance use supports **across the spectrum of prevention, early intervention, crisis, treatment and recovery services.**

Our Vision

At CMHA BC, we envision a society where everyone can realize their human right to their best possible mental health. We strive for a province where mental health and physical health are on the same footing and treated equally as seriously.

We believe the key to realizing the right to mental health and approaching it as any other health problem is to **ask once and get quality help fast.**[18] This is currently not the reality for mental health and substance use care in BC. Knowing this, **CMHA BC is concerned about the growing trend towards expanding involuntary care across Canada and in BC.** We know that people are not

getting the help they need when they ask for it, so why are we considering expanding the most intrusive, coercive and undignified way to treat mental illness or substance use before we have given people true options and choice for their own care?

We have developed a comprehensive roadmap—ahead of the 2024 Provincial Election—that creates the foundation for a voluntary system of care spanning across the spectrum of prevention, early intervention, crisis, treatment and recovery services and supports, while also addressing the interconnected social factors that are inextricably linked with well-being. This plan is predicated on the important role of the Ministry of Mental Health and Addictions and seeks to embolden its mandate to make BC a leading jurisdiction in mental health care. Building on the momentum of the last decade, **CMHA BC's mental health roadmap provides 31 tangible and actionable recommendations to future decision makers across the political spectrum** on how to create a coordinated, holistic and dignified system of care.

If you are a member of the public who worries and cares about the mental well-being of people living in British Columbia, we encourage you to review and support these recommendations, which are based on three key principles: closing the gap in access to care, raising the bar in the quality of care, and responding to crisis with care.

If you are a candidate or working in government – regardless of your political stripes – we urge you to consider and commit to:

1. **Closing the gap** in access to care and the social factors that affect mental health;
2. **Raising the bar** in the quality of care and for mental health spending so it is comparable to physical health spending; and
3. **Responding with care** to mental health crisis in community and the toxic drug crisis across the province.

Beyond the election, this document will serve as CMHA BC's advocacy roadmap, allowing us to prioritize policy areas, track progress, assess our advocacy efforts and guide our best possible advice to decision makers on improving the mental health and substance use system.

Advocacy Pillars

CLOSE THE GAP
for all individuals providing affordable, accessible, and equitable mental health care to prevent and/or intervene early

RAISE THE BAR
of mental health care by improving quality, ensuring dignity, driving transparency and improving coordination

RESPOND WITH CARE
to individuals experiencing a mental health crisis and to address the toxic drug crisis

CLOSE THE GAP

We know that one third of people who experience a mental illness or substance use disorder in Canada, and as many as three quarters of children, can't get the care they need.[19] Our current system is set up to provide supports only once someone's symptoms worsen to the point of crisis and it is not good at prevention. This is especially the case for equity-deserving groups who experience more barriers to accessing care and are less likely to have private mental health care coverage through their employers. There is a crisis of access to affordable and timely care in BC, and it is leading to the worsening of well-being and an over-reliance on the most expensive forms of care (e.g., hospitalization). **We must close this gap in access to care.**

Further, no one can be well if they do not have access to basic survival needs and opportunities for social and economic participation and inclusion. As BC continues to face a housing and affordability crisis, inequity continues to grow. People who are precariously housed or unhoused and experience poverty are more likely to experience mental health or substance use problems. We cannot address mental health without also addressing the circumstances that contribute to well-being: housing, income, employment, education and more. **We must close this gap in the social factors that affect mental health.**

Studies show that for every dollar invested in covering psychological services in Canada, two dollars is saved for society over the long-term.

Access to Care

Over the last decade, there has been much greater societal recognition of the benefits of counselling and psychotherapy to promote positive mental health and address mental illness. Psychotherapy has been found to reduce disability, morbidity and mortality, improve work functioning and decrease hospitalization related to mental illness.[20] For the more than 52,800 people living in BC who have been lucky enough to access free or low-cost counselling through the provincially funded Community Counselling Fund, counselling has opened the door for better mental health and connection.[21] However, before the pandemic, of the Canadians living with a mental illness or substance use disorder, 17% reported a need for mental health care, of which 25% reported an unmet need for counselling.[22]

One of the single most impactful things that government can do for prevention and early intervention is universalize access to publicly funded and delivered mental health care, as it does physical health care. Jurisdictions like the UK and Australia have implemented universal access to counselling and are seeing the benefits; studies show that for every dollar invested in covering psychological services in Canada, two dollars is saved for society over the long-term.[23] In Canada's federated model, nothing is stopping provinces from taking this on. In fact, since 2017, the Quebec government has been slowly building a public system, investing funding in moving mental health services from the private to the public sector and launching their first public psychotherapy program.[24] Just as we work to universalize dental care and pharmacare, mental health care is the logical first step, and BC could be a leader in making this a reality.

There are three ways to realize this recommendation: through sustainable funding provided to service providers, through an insurance scheme like integration into MSP, or a combination of the two. Infrastructure for and aspects of both models already exist in BC, and community-based mental health organizations in BC would be ready to support government in planning and delivering services for such a transformational initiative.

RECOMMENDATION 1

Implement universal access to publicly funded and delivered counselling and psychotherapy through a combination of targeted and sustainable grants for those who need it most and a new insurance-based model that works with existing private insurance models.

For many, having access to counselling in a timely way may be all they need to be well. For others, acute or specialized levels of service may be required, many of which require assessment and/or diagnosis to access. Currently the main pathway to assessment and subsequent diagnosis is through primary care, which many people struggle to access as BC continues to experience a shortage in family doctors and primary care providers. Even once connected to a primary care physician, individuals can wait over six months to see a psychiatrist.[25] We must find other ways to ensure people get timely access to assessment and government should ensure transparent ways of sharing wait times with the public. Community-based mental health organizations also experience barriers to accessing psychiatric consultation, which can limit effective community-based supports for certain conditions like psychosis.

RECOMMENDATION 2

Ensure that no one waits more than 30 days to be assessed, that this measure is monitored and publicly reported, and that everyone is provided supports while waiting for services to prevent worsening symptoms.

Mental illness is now the leading cause of childhood disability, with as many as 12.7% of children being affected at any given time.[26] A systematic review of studies from high income countries like Canada show that only 44% of children with mental illness receive any mental health services or supports, which is even more prominent for equity deserving groups such as Indigenous children.[27] In a recent province-wide survey of youth aged 12 to 19, young people are feeling less optimistic, less connected to school and community and less positive about their mental health.[28] Of significant concern is the highest reported incidences of suicidal ideation since 1992; 18% of respondents said they considered suicide in the past year.[29]

These concerning figures should be cause for alarm; **the kids are not doing okay**. However, there is extensive evidence to suggest that effective early intervention can prevent problems from emerging or can greatly mitigate their impact.[30] Children and youth are not getting the support they need in schools and calls for more mental health expertise in schools are being echoed by administrators, teachers, parents and students alike. As the core place for connection and learning, every young person should be able to access mental health support at school.

RECOMMENDATION 3

Put a dedicated, qualified mental health professional in every school across BC and implement minimum standards for staffing based on school population. These professionals should be incorporated into Integrated Child and Youth teams in communities where these teams already or will exist in the future.

Outside of the school system, young people who require additional mental health support access this through the Child and Youth Mental Health (CYMH) service stream of the Ministry of Children and Family Development. However, the waitlists for these services are long and there are not enough clinicians to support demand. For some families who may be struggling, accessing services through the same ministry responsible for child protection is a barrier. For youth and young adults, the transition from CYMH services to adult mental health delivered through the Health Authorities often leaves them falling through the cracks.

RECOMMENDATION 4

Double investments in Child and Youth Mental Health services and move them out of the Ministry of Children and Family Development into the health system for more integrated care.

As a community-based mental health organization, CMHA BC is acutely aware of the human resource challenges in the mental health and substance use sector. Despite significant investments, government continues to face challenges in staffing new resources. Without a strong and qualified workforce, we will fail to stand up the foundational system we need.

RECOMMENDATION 5

Ensure a strong mental health and substance use workforce by providing recruitment and retention initiatives (e.g., compensation), providing funding for training and education, reviewing compensation models and increasing post-secondary seats in important areas such as mental health and addictions, social work and psychiatry.

Social Factors that Affect Mental Health

Nineteen percent of people living in BC who rate their mental health as poor-to-fair live in unsuitable, inadequate or unaffordable housing and cannot afford alternative housing in their community.[31] Despite significant efforts to address the housing crisis, the over-emphasis on market-based solutions fails to meaningfully address the needs of people with low or very low incomes.* In order to meaningfully address housing insecurity and address homelessness, there must be significant investments in a variety of options, including supportive housing, affordable non-profit/non-market housing and affordable market housing with support from non-profits (e.g., rent supplements, scattered site housing). While funding emergency shelters is one option for getting people off the streets, they are not an appropriate solution for everyone.

RECOMMENDATION 6

Rapidly scale up housing options across the continuum for people with low and extremely low incomes, including supportive housing and rent-geared-to-income options that address a variety of needs.

CMHA branches in BC are significant housing providers, offering housing across the continuum from emergency shelters to affordable rental housing. Within this continuum, supportive housing is an often misunderstood but important housing option that, when done effectively, provides important wrap-around supports with the goal of maintaining housing and supporting health and well-being. Non-profit supportive housing providers have long operated these sites on budgets that do not

* According to BC Housing, a low-moderate household income for couples without children, living in a residential unit with less than 2 bedrooms, in 2024 is $84,780. A very low-income would be considered a "Deep Subsidy Income", which is $23,549 in 2024, for a residential unit with less than 2 bedrooms.

reflect the current needs of staff or residents. In order for supportive housing to operate safely and effectively, the provincial government must establish standards and fund them accordingly.

RECOMMENDATION 7

Develop and implement a Supportive Housing Policy Framework that outlines provincial standards, minimum staffing levels and minimum funding requirements for the safe and effective provision of housing.

Ten percent of people living in BC live below the poverty line.[32] Many of these people receive government assistance. In BC, a single person living on disability assistance receives $17,802 a year and is permitted to earn up to $16,200/year before their assistance is clawed back dollar for dollar, meaning their annual income does not exceed $34,002.[33] With the poverty line ranging from $43,069 in rural areas to $50,569 in Vancouver,[34] this is legislated poverty. Mental illness has been found to be more prevalent for people living in poverty, where they have fewer resources to get better.[35]

RECOMMENDATION 8

Increase disability assistance rates to $2000/month and index them to inflation, while also increasing disability earnings exemptions to $25,000/year to get people living with a disability over the poverty line.

People living with mental illness and/or substance use problems deserve opportunities for social and economic inclusion through employment, but often experience complex and multiple barriers. Traditional employment programs can fail to address the needs of those living with severe and persistent mental illness or substance use disorder. The Links to Employment program, founded by CMHA BC, implements the evidenced based model of Individual Placement and Support (IPS) to help these job seekers reach their goals of obtaining meaningful training, volunteer work, and/or employment. Links to Employment provides a full range of support that is incorporated into a comprehensive treatment plan currently delivered in seven communities through Primary Care Centre partnerships and integration into five bed-based treatment and recovery centres.[36]

RECOMMENDATION 9

Expand the Links to Employment program that integrates best practice in employment supports for people with mental illness and/or substance use disorder with primary care and treatment and recovery services.

Challenges with service navigation and lack of integration of the numerous siloed government programs and services are one of the primary challenges reported to CMHA BC from clients, community members, service providers and more. Community Integration Specialists within the Ministry of Social Development and Poverty Reduction help people at risk of or experiencing homelessness access government programs and get connected to services ranging from case management, social assistance, housing and health services.

RECOMMENDATION 10

Increase the number of Social Development and Poverty Reduction Community Integration Specialists by 50% for better service navigation and to help people connect to wrap-around supports.

RAISE THE BAR

While there have been record investments in the mental health and substance use system, with new programs constantly popping up across the province, the system itself was built on an outdated foundation, archaic laws and prejudicial attitudes about mental illness. Over the last two decades, there has been a dramatic over-reliance on involuntary services paired with a decrease in voluntary services.[37] Those seeking care often report not being met where they are at and subsequently not getting the care they need. There have been awful stories out of psychiatric wards across the province, including the inappropriate use of restraints and seclusion rooms, the coercive use of sedation and a lack of trauma-informed care that has led to further trauma. Despite these troublesome trends, there remains very little oversight or accountability. **We must raise the bar in the quality of mental health care people receive.**

It has never been more apparent that mental health is inextricably linked to physical health, and yet, we do not invest a comparable amount of funding into mental health care as we do physical health

care. Community-based mental health care providers provide incredible holistic supports and services that extend beyond the traditional health care system and are often forced to do so on a shoestring budget. **We must raise the bar for mental health and substance use spending to bring it in line with physical health spending.**

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Quality of Care

The *Mental Health Act*, passed in 1964, governs the provision of mental health and substance use services in BC. Having not undergone any significant changes since 1998, the legislation is extremely outdated and no longer addresses the current context. Despite this, the Mental Health Act is utilized 30,000 times a year to involuntarily detain people in BC, with limited understanding of its effectiveness in addressing individual and systemic needs. In it remains provisions that all other provinces and territories have since eliminated from their legislation to improve patient autonomy and choice, i.e., "deemed consent," which outlines that everyone with involuntary status is deemed to consent to all forms of psychiatric treatment and can be forcibly treated, regardless of their actual capacity to consent[38]—a provision which is currently being challenged in the Supreme Court of Canada.[39] We must ensure the quality and context of care maintains the dignity and respect that people deserve. A review of the *Mental Health Act* is overdue and should be done through an independent public inquiry to ensure the voices of those most affected by the Act are centered in recommendations.

RECOMMENDATION 11

Establish a comprehensive legislative review of BC's Mental Health Act through a public inquiry led by an independent commissioner to modernize the legislation to give people admitted under the Act greater choice, autonomy and support, and make sure that everyone is treated with dignity and respect throughout treatment.

There is currently no governance or oversight body assigned to monitoring the mental health and substance use system in BC. As a result, the significant gaps, failures and inefficiencies often go unchecked, to the detriment of people who need care. Several other jurisdictions have created robust ac-

countability and oversight mechanisms for mental health services. For example, the Australian province of Victoria established a Mental Health Complaints Commissioner as part of their *Mental Health Act* 2014.[40] The independent body is responsible for safeguarding rights, resolving complaints, and recommending service improvements, through meaningful engagement with people with lived expertise.

RECOMMENDATION 12

Establish an Independent Office of the Mental Health Commissioner, with statutory authority like the BC Office of the Human Rights Commissioner, that centers lived expertise to undertake individual and systemic advocacy to improve mental health and substance use systems of care.

Despite being the one place where you are guaranteed to see a medical professional if you are experiencing a mental health crisis, many patients report negative experiences in both emergency rooms and psychiatric wards. Hospitals are currently not set up in ways that are conducive to providing good mental health treatment. The use of seclusion rooms, especially when paired with sedation, leave patients feeling afraid and without the ability to self-advocate.[41] Patients report a lack of engaging activities and opportunities to improve well-being while hospitalized. Often patients come out feeling worse than when they were admitted.

RECOMMENDATION 13

Improve the experience of in-patient mental health care, in both emergency rooms and psychiatric wards, through co-developing care standards with patients, implementing safeguards for the use of seclusion rooms, monitoring and enforcing the quality of care and providing opportunities for positive patient engagement (e.g., psychosocial rehabilitation).

Peers are persons who apply their lived or living experience of mental illness and/or substance use to the performance of their job duties within the health and social service sectors. The sector employs peer workers to perform a range of jobs, from support and outreach workers to educators and researchers. There is a wealth of evidence that shows the benefits of peer support for people with mental illness and or substance use problems; the inclusion of peers leads

to a higher quality of care experience.[42] Despite the growing recognition of the role of peers workers, they report inadequate pay, social inequity, exploitation, stigma, and discrimination.[43]

RECOMMENDATION 14

Increase opportunities for peers to work in the mental health and substance use sector and improve working conditions by creating a funding stream exclusively for peer positions that is tied to employment conditions such as a living wage.

In BC, very few helping professionals (e.g., physicians, nurses, counsellors, teachers, police etc.) receive the training they need to be able to effectively support people who are experiencing thoughts of suicide. Suicide care in BC is not standardized, and it is widely known to be an area where health-care providers feel they lack confidence and competence.[44] Not only is this training largely absent from post-secondary programs, but it is also seldom provided by workplaces to new hires and/or recent graduates. Lack of knowledge and information can lead to uncertainty and fear, and to care that results in negative outcomes for those seeking support.

Most individuals who die by suicide come in contact with the health care system in the year leading up to their death.[45, 46] It is paramount that helping professionals feel well-equipped and supported to be able to confidently meet these individuals in their time of need and provide excellent, lifesaving care. Timely, responsive and person-centered suicide care can, and does, save lives.

RECOMMENDATION 15

Mandate comprehensive, evidence-based, and culturally sensitive suicide response and intervention training for all helping professionals training in or working in BC (e.g., physicians, nurses, counsellors, school-based mental health supports, teachers, police).

The Province of BC has been working to address wait times for health interventions like surgeries and other medical interventions. Unlike the structure of surgical wait time goals that are addressed by specific interventions, targets for mental illness tend to refer to wait times until contact with the care system.[47] There are no standards for accessing specific mental health interventions; and for individuals trying to access these interventions, it often feels like 'choose your own adventure.' No matter where someone goes for help, they should have a sense of what supports are out there, how to access them and how long they will likely have to wait.

For serious mental health conditions where there is strong evidence to support early intervention for better outcomes, someone should expect to access care quickly to prevent the worsening of symptoms. For example, the National Health Service in the UK have mandated a maximum two week wait time from referral to the start of treatment for early psychosis intervention.[48]

RECOMMENDATION 16

Implement a streamlined waitlist management system and mandate aggressive minimum wait-time standards for programs like early psychosis intervention and eating disorders intervention to prevent worsening of symptoms.

Accountability and oversight are only possible when there is data available to monitor. While there have been recent efforts to more adequately and publicly report on government-funded MHSU programs and services through the release of regular data snapshots from the Ministry of Mental Health and Addictions, there remains a dearth of publicly available and interconnected data on MHSU trends, program and service usage, race-based data and more. Ensuring this data is publicly available is the first step towards greater oversight and accountability.

RECOMMENDATION 17

Improve oversight and transparency through publicly available data collection and ongoing monitoring.

Mental Health and Substance Use Funding

Demand for service continues to outpace the funding received for services and organizations are forced to piece together time-limited contracts and limited administrative funding.

Community-based mental health is a fundamental part of mental health and substance use care in BC. Community mental health organizations, like local CMHA branches, provide more cost-effective mental health support than the health system does and often do so in a more holistic way, addressing not only mental health, but important related factors such as housing, employment, social connection, food security and more. They work across the continuum of mental health care, focusing not only on treatment, but also prevention, early inter-

vention, crisis response and recovery. When medical care is required, these organizations support an individual's well-being before, during and after medical care.

Since the COVID-19 pandemic, the community mental health sector has never experienced more demand for its services. Compared to other provinces, the community mental health sector in BC is relatively well-supported. However, demand for service continues to outpace the funding received for services, and organizations are forced to piece together time-limited contracts. The limited provision of administrative funding (sometimes as little as 5% from funding for a contracted service) to support backbone infrastructure like human resources and IT continues to create operational challenges for organizations, ultimately impacting the people they serve. Recruitment and retention of qualified staff remains a challenge, especially in rural and remote communities. Organizations lose good staff to Health Authorities because their better and more stable funding means they can pay better and provide more stability. A dedicated funding stream to support the resiliency and capacity of the community mental health sector would go a long way in addressing these issues.

RECOMMENDATION 18

Establish a $50 million Community Mental Health Resiliency and Capacity Funding stream within the Ministry of Mental Health and Addictions for community-based mental health organizations.

While community mental health care plays a significant role in the system of care, so does the health system, where people access important outpatient and inpatient services and also have their physical health needs addressed. However we don't fund mental health care like we do physical health care. In 2012, the Mental Health Commission of Canada set a spending target of 7-9% of all health care funding be directed to mental health to address need.[49] Twelve years later, the need has only grown.

In BC, Health Authorities spend as little as 5% in Northern Health and as much as 9.6% in Vancouver Coastal Health on mental health and substance use. As a high-income country and province, we must increase our mental health and substance use spending.

RECOMMENDATION 19

Legislate that the Health Authorities spend no less than 10% on mental health and substance use care annually.

RESPOND WITH CARE

In the context of growing income inequality, an untenable housing market, global unrest, visible impacts of climate change and other social and societal challenges, people in communities across BC are struggling, both on the streets and behind closed doors. For some, their struggles might come to a crisis point where they are no longer able to cope on their own and need urgent intervention and support. This is a mental health crisis, something that thousands of people living in BC experience each year. The current status quo crisis response often results in meeting people with police and a trip to the Emergency Department, sometimes against their own wishes. With recent investments in mobile crisis response teams in BC, this is starting to shift, but there is more to do. **We must respond to people experiencing a mental health crisis with care.**

Another crisis that has plagued BC over the last decade is a result of an unpredictable supply of illicit substances cut with a myriad of unknown and dangerous additives. Since 2016, BC has lost over 14,000 loved ones and community members to this toxic drug supply. While there has been a slight decrease in deaths in 2024 so far, we have still lost over 1200 people since January,[50] despite record investments in substance use care. When we see substance use as a moral failing, as opposed to the symptom of much deeper challenges such as underlying mental health conditions, unaddressed trauma, the housing crisis and poverty, our tendency is to respond with hostility and fear. Every human lost to the toxic drug supply was a son or daughter, brother or sister, mother or father, who had people in their lives who loved and valued them. **We must respond to those affected by the toxic drug crisis with care. In this context, care means providing a spectrum of preventative, harm reduction and treatment and recovery supports.**

The impact of an incomplete crisis care system has significant consequences for the individual in crisis and our provincial system of care. The result is an unnecessary interaction with the criminal justice system, the overuse of burdened emergency departments, and an inefficient, costly, and sometimes fatal crisis care system.

Mental Health Crises in Community

Over 2 million calls for help are made to 911 each year in BC.[51] While police, fire fighters and paramedics bring their expertise to help people who call 911, there isn't an equivalent with mental health expertise or a process to ensure a mental health crisis is met with the right response, at the right time and embedded in 911.

The impact of an incomplete crisis care system has significant consequences for the individual in crisis and our provincial system of care. Mental health calls have been on the rise for years and with only police, fire, or ambulance available to callers, each year, thousands of people experiencing a mental health crisis are primarily responded to by police. The result is an unnecessary interaction with the criminal justice system, the overuse of burdened emergency departments, and an inefficient, costly, and sometimes fatal crisis care system.

RECOMMENDATION 20

In alignment with recommendations from the Special Committee on Reforming the Police Act, integrate mental health as a 4th option in 911 to provide the right response at the right time for people experiencing mental health crisis.

When people call a crisis line, no matter where they are in BC, they're connected with a specially trained crisis responders who are available 24/7. Through their application of mental health expertise 99.5% of calls, including calls where suicide was a primary factor, can be safely de-escalated over the phone, without the need for additional intervention.[52] In 2020, without intentional diversion tactics, crisis lines saved BC taxpayers $10.4 million in hospital and urgent mental health responses and over $47 million in police attendance.[53]

911 call takers in BC already assess calls to determine if a police, fire, or ambulance response is required and either dispatches police calls or connects callers to the respective local dispatch. After initial assessment the most direct and available option to ensure people in crisis receive the right response at the right time is through diversion of mental health calls received by 911 to crisis lines. In BC, crisis lines are trained in suicide intervention, crisis de-escalation and already connect callers with mobile mental health responses and emergency services should it be required. Diversion importantly frees up 911 responders to take other calls. Crisis lines have time to provide a mental health response, connecting with callers and often resolving a crisis on the phone, saving the cost of an in-person response.

RECOMMENDATION 21

Double the funding for crisis lines to enhance their capacity to respond to diverted 911 calls.

In many jurisdictions 911 emergency call taking is a provincial or national responsibility but in BC the protocols for call handling and diversion rest with municipalities and police agencies. Setting a provincial standard of crisis care, that integrates mental health as a fourth option to ensure people across BC can receive the right response when they call for help, will require a collaboration across many actors. Achieving diversion of some 911 calls to more appropriate resources will require provincial leadership.

RECOMMENDATION 22

Establish provincial leadership and build consistent protocols between 911, emergency responders and mobile crisis teams.

In order to ensure a true fourth option for mental health emergencies, we also need to ensure that a mobile mental health response is available. In four (soon to be six) communities, this is already a reality. Peer Assisted Care Teams (PACT) are community-led mobile crisis response teams that provide in-person support to individuals experiencing a mental health and/or substance use crisis. The team consists of trained crisis responders with a combination of lived and professional expertise in mental health who help to de-escalate crisis, create safety and connect people to services. Since officially launching in January 2023, PACT have received thousands of calls for service and have only required police intervention around 1% of the time. These teams are saving lives and reducing reliance on more expensive ways of responding such as policing.

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PACT are currently operating in North West Vancouver, Victoria and New Westminster where they are available 18 hours a day, 7 days a week. A new team in Prince George is in its soft launch phase and another two teams in Kamloops and the Comox Valley will be launching in the fall of 2024. The

Province of BC has publicly committed to 10 PACT and two Indigenous-led teams in their Safer Communities Action Plan.[54] CMHA BC envisions a British Columbia where these community-led crisis response teams are in every community.

RECOMMENDATION 23

Double the commitment to funding Peer Assisted Care Teams to 14 new communities for a total of 20 communities across BC, alongside investments for Indigenous-led crisis response teams.

Hospital emergency departments and police have become the default response to mental health crises, but these systems are overburdened and can often do more harm than good. Diversion is widely supported; however successful diversion requires that there is somewhere to divert people to. Community-based crisis stabilization beds exist in jurisdictions across North America, including Ontario, and have been proven to be successful in diverting people away from busy and expensive emergency rooms. They provide temporary residential accommodation and support for individuals experiencing crises related to mental health and/or substance use, including onsite and follow-up counselling, referrals and individualized care plans. Implementing crisis stabilization beds in communities where there are community-led mobile crisis response teams would allow for the effective implementation and monitoring of a full spectrum of crisis services.

RECOMMENDATION 24

Establish community-based crisis stabilization pilots in communities where there are Peer Assisted Care Teams to divert people experiencing acute crisis away from hospital emergency departments.

Toxic Drug Crisis

Addressing the impacts of the toxic drug crisis should start far before anyone is exposed to the toxic drug supply. Schools can and should play an important role in both harm reduction education and upstream prevention. Abstinence-based education (e.g., "just say no" campaigns) have been evaluated extensively and show limited effectiveness in reducing the harms of substance use,[55] which is why there has been a significant movement towards initiatives that focus on reducing the health and social harms of substance use.

Beyond harm reduction education, there is significant opportunity for upstream prevention by focusing on enhancing protective factors (e.g., social connection, belonging, positive adult relationships etc.) and minimizing risk factors (e.g., isolation, low self-worth, lack of safety etc.). Simon Fraser University's Child Health Policy Centre recently undertook a systematic review of a number of studies on health promotion and disorder prevention programs and opioid-related outcomes for young people and found strong evidence to suggest these programs can prevent opioid misuse starting in childhood.[56] Programs studied focused on skills training for young people, parents and teachers in the areas of empathy, effective communication, addressing peer pressure, decision-making, coping and more, with strong evidence to support a related risk reduction for prescription opioid use even 14 years after the program.

For some people, entering a safe consumption or overdose prevention site can be the first step in being connected to higher levels of care.

RECOMMENDATION 25

Ensure substance use education is grounded in evidence-based harm reduction and implement mental health promotion and prevention programs designed to prevent problematic substance use in school districts across BC.

While not a panacea to a complex crisis that affects diverse people along a spectrum of first-time, recreational and regular drug users, we know that safe consumption and overdose prevention sites save lives. Over 50,000 lives have been saved by these important services across Canada.[57] For some people, entering a safe consumption or overdose prevention site can be the first step in being connected to higher levels of care. Despite the overwhelming evidence, there are many communities in BC that do not have these services, or do not have enough relative to the population of people who need them. In particular, there is a dearth of these services in more rural and remote communities across the province.

RECOMMENDATION 26

Add 50% more safe consumption and overdose prevention sites across BC, including for safe inhalation, with a particular focus on rural communities and those who do not currently have these services. Implementation of this expansion should integrate all five recommendations from the recent Auditor General of BC's report on the implementation of harm reduction programs in BC.[54]

Medication-assisted supports like opioid agonist therapy and prescribed alternatives to the toxic drug supply are important harm reduction measures that help people stay alive and serve as a pathway for treatment. Without them, more people would die before they ever get to treatment. Medication-assisted supports have been proven to help people improve their day-to-day functioning, find stability, manage withdrawal symptoms and work towards recovery.[58] They reduce the risk of fatal overdose, the transmission of diseases such as Hep C and HIV and help people better engage in their own care.[59,60] They are an important part of the continuum of care for people with substance use disorder.

RECOMMENDATION 27

Ensure access to medication-assisted supports to those who need them (e.g., opioid agonist therapy, prescribed alternatives).

For people who are ready to pursue treatment for substance use disorder, the first step is withdrawal management (also known as detox), which is a requirement for most residential treatment programs. For individuals who are ready to make a change, access to immediate support is an important factor in successful recovery. However, when seeking this immediate withdrawal management, people who use drugs, family members and social service workers across the province are faced with limited services and long waitlists. Some communities do not have any withdrawal management services, forcing people to leave their communities to access supports. Other better resourced communities see waitlists of 100 days or more.[61]

RECOMMENDATION 28

Ensure immediate access to low-barrier withdrawal management services in communities across BC.

The Government of BC has invested heavily in bed-based treatment, with a particular focus on publicly-funded beds, including 205 beds overseen and managed by CMHA BC. In addition, the Road to Recovery initiative at St. Paul's Hospital, a significant investment by government, looks to transform the way addictions care is provided, through a comprehensive, full range of services in one place including withdrawal management, stabilization, transitional care and long-term recovery services. It is encouraging to see a $150 million investment in expanding this model to all Health Authorities across BC.[62]

However, bed-based treatment is not the only way of providing substance use treatment. This form of treatment often requires individuals to leave their community, which for some may be a significant barrier in accessing services. For some people, there are important aspects of their lives that prevent them from seeking residential treatment – caregiving responsibilities, pets, maintaining housing, maintaining employment and more. This is why we cannot forget about other evidence-based treatment modalities like community-based outpatient treatment that allows individuals to stay in their community.[63] We know that there is no one-size-fits-all approach to addressing mental illness or substance use disorder.

RECOMMENDATION 29

Match investments in bed-based care with a spectrum of community-based outpatient substance use treatment services.

In recent years, there have been a number of concerning stories with allegations of abuse, sexual assault and death of clients coming from the private treatment and recovery sector. While private entities, these organizations receive funding from the Government of BC. While the Province of BC has been working with Health Authorities over the last few years to provide greater oversight, including hiring more inspectors, drug users and their advocates continue to raise concerns about staff training, non-evidence-based treatment modalities and a lack of data and evaluation.

RECOMMENDATION 30

Provide greater oversight over private treatment and recovery centres by developing specific regulations for treatment and recovery services that address quality of services, ensure evidence-based practices, set standards for staffing and establish strong data collection and evaluation measures.

Finally, for most people who engage in treatment and recovery services, recovery is an ongoing and lifelong journey, not a final destination. For those individuals who have gone to or are currently in live-in treatment and recovery programs, integration back into community can be a significant and ongoing challenge that requires adequate psychological and clinical support, especially for the many individuals who engage in treatment and recovery outside their home communities.

According to internal CMHA BC data, between January and March of 2024, 38% of clients who discharged from treatment and recovery centres and facilities relapsed as a direct result of a lack of adequate supportive aftercare.

According to internal CMHA BC data, between January and March of 2024, 38% of clients who discharged from treatment and recovery centres and facilities relapsed as a direct result of a lack of adequate supportive aftercare. Twenty-seven percent of discharging clients did not have adequate housing or a supportive environment they could return to. For clients who enter treatment and recovery programs that are fully publicly funded, as with the CMHA BC Bed-Based Treatment & Recovery grant funding,[64] the experience of programming can be life saving. However, if appropriate aftercare that includes longer term supportive recovery, alumni programming and financial and employment planning is unavailable, the ability for an individual to realize long-term recovery is greatly diminished. We must support people to be well, not only in the short term, but also in their journey to integrate back into their home community or into their community of choice post-treatment.

RECOMMENDATION 31

Invest in post-treatment aftercare, including psychosocial rehabilitation services, such as access to counselling, access to evidenced-based interventions to address trauma, mental illness and substance use disorder, supported employment, peer support, relapse prevention and cultural and community recovery services.

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Summary of Policy Recommendations

Close the Gap

in access to care

1. Implement **universal access to publicly funded and delivered counselling and psychotherapy** through a combination of targeted and sustainable grants for those who need it most and a new insurance-based model that works with existing private insurance models.
2. Ensure that **no one waits more than 30 days to be assessed**, that this measure is monitored and publicly reported, and that everyone is provided supports while waiting for services to prevent worsening symptoms.
3. Put a **dedicated, qualified mental health professional in every school across BC** and implement minimum standards for staffing based on school population. These professionals should be incorporated into Integrated Child and Youth teams in communities where these teams already or will exist in the future.
4. **Double investments in Child and Youth Mental Health services** and move them out of the Ministry of Children and Family Development into the health system for more integrated care.
5. Ensure a strong mental health and substance use workforce by providing **recruitment and retention initiatives**, providing **funding for training and education, reviewing compensation models**, and **increasing post-secondary seats** in important areas such as mental health and addictions, social work and psychiatry.

in the social factors that affect mental health

6. Rapidly scale up housing options across the continuum for people with low and extremely low incomes, including **supportive housing and rent-geared-to-income** options.
7. Develop and implement a **Supportive Housing Policy Framework** that outlines provincial standards, minimum staffing levels and minimum funding requirements for the safe and effective provision of housing that address a variety of needs.
8. **Increase disability assistance rates to $2000/month** and index them to inflation, while also **increasing disability earnings exemptions to $25,000/year** to get people living with a disability over the poverty line.
9. **Expand the Links to Employment program** that integrates best practice in employment

supports for people with mental illness and/or substance use disorder with primary care and treatment and recovery services.

10. **Increase the number of Social Development and Poverty Reduction Community Integration Specialists** by 50% for better service navigation and to help people connect to wrap-around supports.

Raise the Bar

in the quality of care

11. Establish a **comprehensive legislative review of BC's *Mental Health Act*** through a public inquiry led by an independent commissioner to modernize the legislation to give patients greater choice, autonomy and support, and make sure that everyone is treated with dignity and respect throughout treatment.

12. Establish an **Independent Office of the Mental Health Commissioner,** with statutory authority similar to the BC Office of the Human Rights Commissioner, that centers lived expertise to undertake individual and systemic advocacy to improve mental health and substance use systems of care.

13. **Improve the experience of in-patient mental health care, in both emergency rooms and psychiatric wards**, through co-developing care standards with patients implementing the safeguards for the use of seclusion rooms, monitoring and enforcing the quality of care and providing opportunities for positive patient engagement (e.g., psychosocial rehabilitation).

14. **Increase opportunities for peers to work in the mental health and substance use sector** and improve working conditions by creating a funding stream exclusively for peer positions that is tied to employment conditions such as a living wage.

15. **Mandate comprehensive, evidence-based, and culturally sensitive suicide response and intervention training for all helping professionals** training in or working in BC (e.g., physicians, nurses, counsellors, school-based mental health supports, police).

16. Implement a **streamlined waitlist management system** and mandate **aggressive minimum wait-time standards** for early psychosis intervention and eating disorders intervention to prevent worsening of symptoms.

17. Improve oversight and transparency through **publicly available data collection** and ongoing monitoring.

for mental health and substance use spending

18. Establish a **$50 million Community Mental Health Resiliency and Capacity Funding**

stream within the Ministry of Mental Health and Addictions for community-based mental health organizations.

19. Legislate that the **Health Authorities spend no less than 10% on mental health and substance use care** annually.

Respond with Care

to mental health crises in community

20. In alignment with recommendations from the Special Committee on Reforming the Police Act, integrate **mental health as a 4th option in 911 to provide the right response at the right time** for people experiencing mental health crisis.

21. **Double the funding for crisis lines** to enhance their capacity to respond to diverted 911 calls.

22. Establish provincial leadership and **build consistent protocols** between 911, emergency responders and mobile crisis teams.

23. **Expand Peer Assisted Care Teams** to 14 new communities for a **total of 20 communities across BC**, alongside investments for Indigenous-led crisis response teams.

24. Establish **community-based crisis stabilization pilots** in communities where there are Peer Assisted Care Teams to divert people experiencing acute crisis away from hospital emergency departments.

to the toxic drug crisis

25. **Ensure substance use education is grounded in evidence-based harm reduction** and implement mental health promotion and prevention programs designed to prevent problematic substance use in school districts across BC.

26. Add **50% more safe consumption and overdose prevention sites across BC**, including for safe inhalation, with a particular focus on rural communities and those that do not currently have these services. Implementation of this expansion should integrate all five recommendations from the recent Auditor General of BC's report on the implementation of harm reduction programs in BC.

27. Ensure access to **medication-assisted supports** to those who need them (e.g., opioid agonist therapy, prescribed alternatives).

28. Ensure **immediate access to low-barrier withdrawal management services** in communities across BC.

29. Match investments in bed-based care with a **spectrum of community-based outpatient substance use treatment** services.

30. Provide greater oversight over private treatment and recovery centres by **developing specific regulations for treatment and recovery services** that address quality of services, ensure evidence-based practices, set standards for staffing and establish strong data collection and evaluation measures.

31. Invest in **post-treatment aftercare**, including psychosocial rehabilitation services, such as access to counselling, access to evidenced-based interventions to address trauma, mental illness and substance use disorder, supported employment, peer support, relapse prevention and cultural and community recovery services.

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