



Community-Based Supports for Mental Health and Substance Use Care

2015 Budget Consultation

October 17, 2014

Submission to:

The Select Standing Committee on Finance and Government Services

Submitted by:

The Canadian Mental Health Association BC Division

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Executive Summary of Recommendations

Community-Based Mental Health and Substance Use Care

- 1) Increase spending in the area of community-based mental health and substance use services. Track subsequent cost avoidance (e.g., reduced hospitalizations, police response, incarceration) to ensure that savings are re-invested in programs and services which support mental health.
- 2) Invest in other community-based supports that form part of the community resource base, including housing, income supports, education, and employment.

Housing

- 3) Build upon recent federal¹ and municipal government commitments² to support Housing First. Invest in increasing the supply of social/supported housing to address the high unmet need, and track subsequent cost avoidance (e.g., reduced hospitalizations, police response, incarceration) to ensure that savings are re-invested in programs and services which support mental health.

Income Supports

- 4) Raise the Persons with Disabilities (PWD) rate to a minimum of \$1,200 per month.
- 5) Index the PWD rate against the cost of living.
- 6) Abolish the two-year independence rule so that young people can receive the supports they need without delay.

Child and Youth Mental Health and Substance Use

- 7) Improve access to mental health and addictions services for children and youth.
- 8) Provide better supports and services for vulnerable children and youth:
 - a. **Children and youth in government care and leaving care:** young people up to age 19 who are in foster care, group homes, or are involved in the justice system.
 - b. **Transition-age youth:** young people ages 16 to 24 who are moving from child and youth mental health services to adult mental health services.
- 9) Build a system of supports including education, training, and housing which are important determinants of mental health and wellness for children and youth.
- 10) Invest in upstream approaches to mental health, health promotion, and illness prevention for children and youth.

¹ Employment and Social Development Canada. (2014, 04 30). *Terms and Conditions of the Homelessness Partnering Strategy*. Retrieved from <http://www.esdc.gc.ca/eng/communities/homelessness/funding/terms.shtml>

² Cleverly, B. (2014, 09 23). *B.C. mayors push province on mental health*. Retrieved from Times Colonist: <http://www.timescolonist.com/news/local/b-c-mayors-push-province-on-mental-health-1.1386684>

About CMHA

The Canadian Mental Health Association – BC Division is part of a national, charitable organization, and our vision of “mentally healthy people in a healthy society” provides the framework for our work in mental health and substance use. In addition to our Division office, we have 17 branches across British Columbia serving 80 communities. Each year, CMHA in B.C. provides services and supports to over 80,000 British Columbians through our provincial and local programming including community navigation, employment supports, and supported housing. CMHA promotes mental health for all and supports the resilience and recovery of people experiencing mental illness or addiction.

Introduction

In keeping with our past provincial budget submissions, we hope this submission for the BC Budget 2015 Consultation process can provide useful input to help ensure mental health and substance use receive a wise and fair allocation of provincial healthcare spending.

In this submission, we focus on the second question posed in the Budget 2015 consultation paper *Successive Balanced Budgets*: “What program and spending areas are most important to you?”³

We highlight four priority areas for improved investment in B.C.:

- 1) Community-Based Mental Health and Substance Use Care**
- 2) Housing**
- 3) Income Supports**
- 4) Child and Youth Mental Health and Substance Use**

It is our assessment that B.C. is currently underspending in these areas, and is thus paying for mental health and substance use care in the most expensive way possible. B.C. lacks robust and accessible community-based mental health services, effective housing supports, and adequate income supports. These contribute to mental health and substance use issues and increase demand for the most expensive types of treatment and support: specialized services, emergency room visits and hospitalizations, incarceration and police calls.

Without improvements in the child and youth mental health and substance use system, demand for adult services will likely continue to increase. Even a small shift has the potential to make a big impact: it has been estimated that the effects of mental illness and addiction cost the B.C. economy an estimated \$6.6 billion per year.⁴ We believe that targeted upstream investments today will generate efficiencies and savings in the short- and long-term, while better supporting British Columbians in recovery from illness, good mental health and wellbeing.

³ Government of British Columbia. (2014). *Budget 2015 Consultation: Successive balanced budgets*. Retrieved from http://www.leg.bc.ca/cmt/finance/docs/2015_Budget_Consultation_Paper.pdf

⁴ Government of British Columbia, Ministry of Health Services, & Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia*. Victoria, BC.

1) Community-Based Mental Health and Substance Use Care

What Is Community-Based Mental Health And Substance Use Care?

Community-based mental health is defined as care provided outside of the hospital setting. It includes services and supports provided across the continuum of care, including health promotion, illness prevention, treatment and recovery. It includes not only treatment and crisis response, but also outreach, case management and related services such as housing and employment supports and court diversion programs. Community-based mental health and substance use care identifies the importance of communities in supporting recovery. This philosophy is supported by the fact that individuals receiving care generally prefer to do so within their community, and that for most individuals, formal mental health services are just one piece of the puzzle.

Mental health starts where we live, work, learn, and play

The Framework for Support model guides CMHA's work and acknowledges the importance of a variety of supports for people with mental illness, including the formal mental health system, self-help and mutual aid, family and friends and broader community supports and services.⁵ The Community Resource Base, upon which the Framework is founded, also recognizes the central importance of key determinants of health including housing, income, education and work for people with mental illness and their recovery.

Community Resource Base



⁵ CMHA National. (2004). *A Framework for Support: Third Edition*. Ontario: Canadian Mental Health Association.

Current Spending Focused on Care in Hospitals (Acute Care)

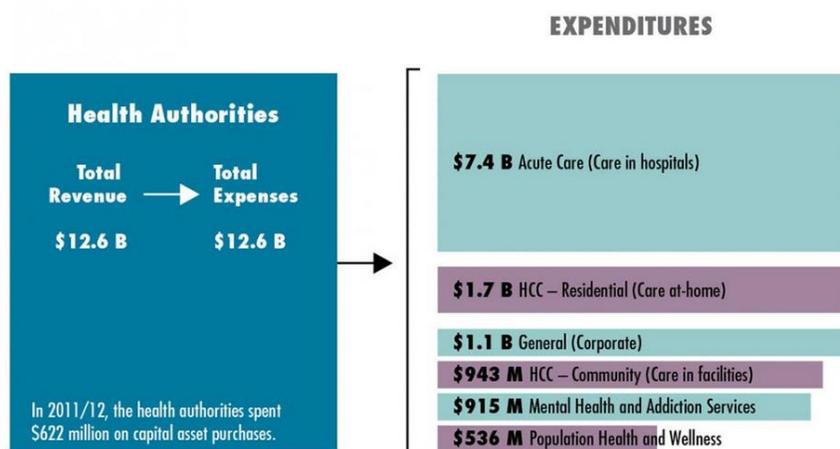
Despite evidence of the importance of community-based supports, B.C. and other jurisdictions continue to spend a significantly high proportion of the health budget on specialized treatment in hospitals and emergency treatment in the ER. The overwhelming majority of spending (\$7.4 billion) is directed at acute care, which includes acute care for mental health and substance use issues provided in hospitals.⁶

We know that treatment of mental health and substance use in hospitals is significant: nearly 20% of all general hospital separations⁷ involve a primary or secondary diagnosis of mental illness and, of that total, approximately 18% have a co-occurring substance-related disorder (a drug- or alcohol-related disorder as a secondary diagnosis).⁸ We also know that the acute care system is an expensive form of care delivery.

In total, only 7.26% of the total health authority expenditures in 2011/12 were directed toward mental health and substance use services outside of the hospital setting. Specifically, the Auditor General found that of the \$12.6B in total revenue health authorities received in 2011/12, health authorities spent only \$915M on mental health and addiction services, typically within community or at-home settings.⁹ An even smaller percentage of health spending (4.25%) was allocated to population health and wellness (a total of \$536M), which includes mental health promotion.

Figure 1: Health Authority Spending (2011/12)¹⁰

This extract from Exhibit 1 shows Mental Health and Addictions expenditures within the context of Health Authority expenditure.



⁶ Office of the Auditor General of British Columbia. (2013, 01 15). *Health Authority Expenditures*. Retrieved from <http://www.bcauditor.com/online/pubs/775/784>

⁷ A “separation” is the departure of an inpatient from hospital, either due to a discharge or death.

⁸ Canadian Institute for Health Information. (2008). *Hospital Mental Health Services in Canada, 2005-2006*. Ottawa: CIHI. Retrieved from www.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_364_E

⁹ Office of the Auditor General of British Columbia. (2013). *Health Funding Explained*. Victoria, BC.

¹⁰ Office of the Auditor General of British Columbia. (2013). *Health Authority Expenditures*. Retrieved from <http://www.bcauditor.com/online/pubs/775/784>.

The ‘De Facto System’¹¹: Hospitals, Jails, and Homeless Shelters

In part due to the high cost of beds in psychiatric hospitals and the lack of a robust community-based mental health and substance use system to support individuals with low to moderate needs, many individuals do not receive the supports they need. Instead, individuals end up in the ‘de facto’ system – jails, homeless shelters or the street. The majority of people who come into contact with the criminal justice system in B.C. have a diagnosed mental health and/or substance use disorder.¹²

We know that individuals with mental health and substance use issues are over-represented in the following systems:

- **Jails:** Data from a large study of all individuals in contact with B.C.’s provincial corrections system revealed that **56%** of offenders had a diagnosed mental health and/or substance use disorder; specifically, **26%** had a mental disorder, **7%** had a substance use disorder, and **24%** were dually diagnosed with both a mental health and substance use disorder.¹³ These numbers are rising: rates of mental health issues rose 71% among men in the correctional system and 61% among women in the correctional system between 1997 and 2007.¹⁴
- **Police Interactions:** A 2008 study found that **30%** of all police calls involve individuals who suffer from a mental health or substance use issue.¹⁵
- **Homelessness:** Self-reported statistics in Metro Vancouver from the annual Homeless Count (2014) show half of respondents reported having an addiction (**49%**), about one third (**34%**) of respondents reported a mental illness and one fifth (**21%**) of respondents reported a concurrent disorder (i.e., both mental illness and addiction) – and these percentages continue to increase.¹⁶
- **Suicide:** Approximately 500 people in B.C. die by suicide every year.¹⁷

In addition to immense human and personal costs, ineffective spending results in immense costs to the economy. The effects of mental illness and addiction cost the B.C. economy an estimated \$6.6 billion per year.¹⁸

¹¹ Szabo, L. (2014). *A man-made disaster: A mental health system drowning from neglect*. Retrieved from USA Today: <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/>

¹² Ministry of Health Services & Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia*. Victoria, BC.

¹³ Somers, J. M., Cartar, L. & Russo, J. (2008). *Corrections health and human services: Evidence-based planning and evaluation*. Vancouver, BC: Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University.

¹⁴ CMHA: BC Division. (2012). *Mental health and the criminal justice system*. Retrieved from CMHA: <http://www.cmha.bc.ca/get-informed/public-issues/justice>

¹⁵ Ibid.

¹⁶ Greater Vancouver Regional Steering Committee on Homelessness. (2014). *Results of the 2014 Homeless Count in the Metro Vancouver Region*.

¹⁷ BC Coroners Service. (2012). *Suicide Deaths: 2002-2011*. Burnaby, BC: Ministry of Justice.

¹⁸ Government of British Columbia, Ministry of Health Services, & Ministry of Children and Family Development. (2010). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia*. Victoria, BC.

Other jurisdictions are beginning to recognize the costs incurred as a result of not investing in community support and treatment of mental health and substance use. USA Today recently released a series entitled “The Cost of Not Caring” in which researchers estimated what \$30,000 would pay for, depending on the type of service provided. Researchers estimated **19 days** in hospital, **94 days** in jail or **one full year** of intensive support and treatment in the community had the same cost (see Figure 2 below).

Figure 2: The Cost of Treating Mental Illness (US Data)¹⁹



Though the figures are American, we are confident that B.C. data would provide similar evidence. The cost of an average hospital stay in B.C. is **\$5,517**.²⁰ Mood disorders and schizophrenia rank among the 15 most expensive medical conditions for total acute care inpatient costs. Patients with these conditions have substantial average costs per stay on top of a high number of stays.²¹ Mental and behavioural disorders comprise 6.6% of estimated total acute care inpatient costs in Canada.²²

Hospitalization is an emergency intervention; without community-based care and supports including housing and income, as described in the following sections, individuals are likely to be re-

¹⁹ Szabo, L. (2014). *A man-made disaster: A mental health system drowning from neglect*. Retrieved from USA Today: <http://www.usatoday.com/longform/news/nation/2014/05/12/mental-health-system-crisis/7746535/>

²⁰ Canadian Institute for Health Information. (2014). *Your Health System*. Retrieved from Canadian Institute for Health Information: <http://yourhealthsystem.cihi.ca/>

²¹ Canadian Institute for Health Information. (2014). *Your Health System*. Retrieved from Canadian Institute for Health Information: <http://yourhealthsystem.cihi.ca/>

²² Canadian Institute for Health Information. (2008). *The cost of acute care hospital stays by medical condition in Canada, 2004-2005*. Retrieved from: https://secure.cihi.ca/free_products/nhex_acutecare07_e.pdf

hospitalized. It is also worth noting that the rate for repeat hospital stays for mental illness in B.C. is 13.3%, while the national average of 11.1%.²³ The average cost of a standard custody day in B.C. is **\$202** per person, per day, or almost \$74,000 per person, per year.²⁴

In comparison to hospital and custody costs, the cost of providing supported housing, income supports, and community-based care and treatment are small and have the added potential to support lasting change and recovery. The option of 'living at home' is both the most cost effective and has – by far – the most likely chance to promote recovery and reintegration.

Recommendations

- 1) Increase spending in the area of community-based mental health and substance use services. Track subsequent cost avoidance (e.g., reduced hospitalizations, police response, incarceration) to ensure that savings are re-invested in programs and services which support mental health.**
- 2) Invest in other community-based supports that form part of the community resource base, including housing, income supports, education, and employment.**

2) Housing

We know that housing is a key determinant of health, meaning it has significant impacts on health and mental health. Safe, accessible, appropriate and affordable housing can support cost-savings in the long-run, resulting in a reduction in hospital stays, demand for healthcare services, police calls, demand for social services and supports and incarceration.

While there are no exact figures available on the current number of homeless individuals in B.C., it was estimated that there were up to 15,500 homeless individuals in B.C. in 2008.²⁵

The Cost of Homelessness

The costs of not addressing the issues of homelessness are greater than the costs of taking action. A 2001 B.C. study found that homeless people, compared to similarly-housed people, cost the system 33% more on average when crisis services, hospital costs, police, ambulance, jail and court costs are factored in. The combined service and shelter costs of homeless people ranged from

²³Canadian Institute for Health Information. (2014). *Your Health System*. Retrieved from Canadian Institute for Health Information: <http://yourhealthsystem.cihi.ca/>

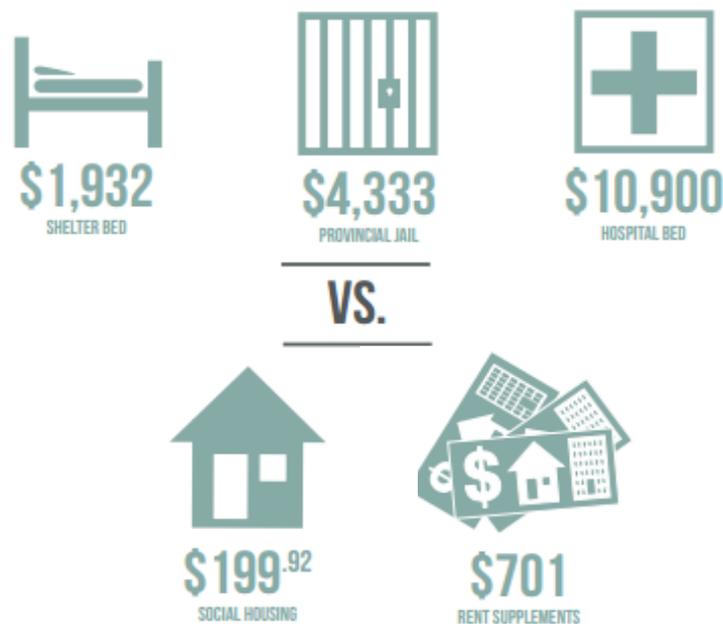
²⁴ Corrections Branch, Ministry of Justice. (2013). *A profile of B.C. Corrections: Protect communities, reduce reoffending*. Victoria: Government of British Columbia. Available from <http://www.pssg.gov.bc.ca/corrections/docs/BCCorrectionsProfile>

²⁵ Patterson, M., Somers, J., McIntosh, K., & Shiell, A. &. (2008). *Housing and support for adults with severe addictions and/or mental illness in British Columbia*. Vancouver: Centre for Applied Research in Mental Health and Addiction.

\$30,000 to \$40,000 per person per year on average. In contrast, the combined costs of service and housing for housed individuals ranged from **\$22,000 to \$28,000** per person per year.²⁶

A 2008 report commissioned by the B.C. Ministry of Health commissioned SFU's Centre for Applied Research in Mental Health and Addiction which focused on adults with severe addictions and/or mental illness concluded that the average street adult with severe addictions and/or mental illness in B.C. costs the public system over **\$55,000 per year**. Provision of adequate housing and supports is estimated to reduce this cost to **\$37,000 per year**, an overall cost avoidance of about **\$211 million per year**.²⁷ This cost represents both the provision of safe affordable housing and support services. See Figure 3 (below) for details of the average monthly costs of housing people while they are homeless according to a recent Canadian report.²⁸

Figure 3: Average Monthly Housing Costs (Canadian Data)²⁹



Housing First

²⁶Ministry of Social Development and Economic Security. (2001). *Homelessness: Causes & effects. Volume 3. The Costs*. Victoria: Government of British Columbia.

²⁷ Patterson, M., Somers, J., McIntosh, K., & Shiell, A. &. (2008). *Housing and support for adults with severe addictions and/or mental illness in British Columbia*. Vancouver: Centre for Applied Research in Mental Health and Addiction.

²⁸ Canadian Alliance to End Homelessness. (2013). "The State of Homelessness in Canada 2013. Accessed from: http://lookoutsociety.ca/images/State_of_Homeless2013.pdf

²⁹ Gaetz, S., Donaldson, J., & Richter, T. &. (2013). *The state of homelessness in Canada 2013*. Toronto: Canadian Homelessness Research Network Press.

Housing first is an evidence-based intervention model that focuses on providing access to permanent housing for individuals who are homeless and living with serious mental illness. Housing First is based on evidence that housing is a key determinant of health, as well as a major mediating factor in recidivism, criminal behavior and overall well-being.

Housing First features assertive engagement; it provides housing for individuals first, followed by multidisciplinary on-site support. No pre-conditions, such as having substance abuse under control or being stabilized on medications, are imposed.

Housing First approaches have been shown to have significant impacts on health – specifically in mental health and substance use – and on preventing more expensive care, including hospitalizations/emergency department visits, police calls/police officers' response time and even custody/jail time.

The At Home/Chez Soi project was a Housing First pilot program that ran from 2009 to 2013 in cities across Canada. Evaluation results for At Home/Chez Soi show that over the two-year period following entrance to the study, every \$10 invested in Housing First services resulted in an average savings of \$9.60 for high-needs participants and \$3.42 for moderate needs participants.³⁰ Overall, every \$10 invested in Housing First services resulted in an average savings of \$21.72 in health care, policing, judicial, social services and other societal costs.³¹

A 2004 report found that clients randomly allocated to Housing First had a rate of approximately 80% retention in housing over a two-year period.³² This success rate directly challenges the idea that mentally ill or drug-using individuals are not capable of maintaining their own tenancy.

Programs that require individuals to be a patient first and receive supported housing when they are well are not serving this group of individuals. We consider it a missing level of care that would not be tolerated in any other medical illness.

Recommendation

- 1) Build upon recent federal³³ and municipal government commitments³⁴ to support Housing First. Invest in increasing the supply of social/supported housing to address the high unmet need, and track subsequent cost avoidance (e.g., reduced hospitalizations, police response, incarceration) to ensure that savings are re-invested in programs and services which support mental health.**

³⁰ Mental Health Commission of Canada. (2014). *Vancouver final report: At Home/Chez Soi Project*. Calgary, AB: Vancouver At Home Research Team & Mental Health Commission of Canada.

³¹ British Columbia News. (2014, 04 08). *Canada adopts housing first strategy to address homelessness*. Retrieved from British Columbia News: <http://www.britishcolumbia.name/news/canada-adopts-housing-first-strategy-to-address-homelessness/>

³² Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis, *American Journal of Public Health*, 94(4), 651-656.

³³ Employment and Social Development Canada. (2014, 04 30). *Terms and Conditions of the Homelessness Partnering Strategy*. Retrieved from <http://www.esdc.gc.ca/eng/communities/homelessness/funding/terms.shtml>

³⁴ Cleverly, B. (2014, 09 23). *B.C. mayors push province on mental health*. Retrieved from Times Colonist: <http://www.timescolonist.com/news/local/b-c-mayors-push-province-on-mental-health-1.1386684>

3) Income Supports

Poverty and Mental Health

Income is among the most powerful determinants of health. There is significant correlation between low income and high rates of mental health issues.³⁵ In addition to being linked with poor health, poverty is also correlated with higher crime rates.³⁶ Estimates of the poverty-related costs of crime in B.C. (based on the statistical relationship between literacy, income and crime) are as high as \$745 million for 2008.³⁷

Recent data show that B.C. has highest child poverty rate in Canada (tied with Manitoba), which rose from 10.5% in 2010 to 11.3% in 2011;³⁸ however, B.C. lacks a comprehensive poverty reduction strategy for children and families.³⁹ Poverty reduction initiatives and income supports have the potential for significant impact: estimates show that if the poorest 20% of B.C. residents were raised to the income levels of those in the 2nd quintile, B.C.'s public healthcare system would save \$1.2 billion per year.⁴⁰

Mental Illness and PWD benefits

Many people who have a mental illness rely on income assistance to help meet their basic needs. We echo findings from Disability Without Poverty Network report entitled "Overdue: The Case for Increasing the Persons with Disabilities (PWD) Benefit in B.C."⁴¹ The following excerpt captures the findings of this report:

"A significant percentage of those receiving PWD benefits have been diagnosed with a mental illness. The level of assistance provided to persons with disabilities in B.C. lags behind other provinces and disability benefit rates have not kept pace with the increasing cost of living in B.C. Additionally, there is a deeper gap between disability income levels and the low income cut-off in B.C."⁴²

Since 2001, the PWD rate has only increased by \$120 per month, while the cost of basic essentials (i.e., food, clothing, personal care) has increased by 17.2%. Current PWD benefits total \$375 per month for housing and \$531 per month for basic living expenses including food, clothing, housing and personal care – a total of \$300 per month less than the amount a low-income senior would receive under the Federal OAS/GIS programs. An increase to the PWD rate to a minimum of \$1,200

³⁵ Poetz, A., Eyles, J.D., Elliot, S. et al. (2007). Path analysis of income, coping and health at the local level in a Canadian context. *Health and Social Care in the Community*, 15(6), 542-552.

³⁶ Ivanova, I. (2011). *The cost of poverty in BC*. Vancouver: Canadian Centre for Policy Alternatives.

³⁷ Ivanova, I. (2011). *The cost of poverty in BC*. Vancouver: Canadian Centre for Policy Alternatives.

³⁸ Statistics Canada. (2011, 09). *Labour Force Survey*. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/111104/dq111104a-eng.htm>

³⁹ Family Service Toronto. (2011). *Revisiting family security in insecure times: 2011 report card on child and family poverty in Canada*. Toronto, ON: Family Service Toronto.

⁴⁰ Ivanova, I. (2011). *The cost of poverty in BC*. Vancouver: Canadian Centre for Policy Alternatives.

⁴¹ Network, Disability Without Poverty. (2012). *Overdue: The case for increasing the Person with Disabilities Benefit in BC*. Vancouver: Disability Without Poverty Network.

⁴² Wilson, S. (2011). Where do we stand on income? *Visions Journal*: 7(2), 7-9. Retrieved from <http://www.heretohelp.bc.ca/visions/income-vol7/where-do-we-stand-on-income>

per month, indexed against the cost of living, has been proposed by the Disability Without Poverty Network.⁴³ This rate would better reflect the cost of living in B.C.

Two-year Independence Rule

The Ministry of Social Development and Social Innovation should abolish the two year independence rule⁴⁴, which prevents them from accessing income supports for two full years after leaving government care. This rule places young people at risk, especially if they are experiencing mental health problems.

This initiative would build on previous successful amendments to income assistance such as the Annualized Earning Exemption (AEE), which “allows individuals on disability assistance to use their earnings exemption on an annual, instead of monthly, basis and without a monthly maximum”.⁴⁵

Recommendations

- 1) Raise the Persons with Disabilities (PWD) rate to a minimum of \$1,200 per month.**
- 2) Index the PWD rate against the cost of living.**
- 3) Abolish the two-year independence rule so that young people can receive the supports they need without delay.**

Reinvest in Child and Youth Mental Health

Children and Youth Should Be a Priority

Children and youth should be a key priority for support and investment. Mental health issues often first present before the age of 19 and 50% to 70% of adults with a mental illness are diagnosed as children or youth.⁴⁶ We also know that twenty percent of Canadians will personally experience a mental illness in their lifetime⁴⁷; yet, only 31% of children and youth receive the treatments or supports they need.⁴⁸

⁴³ The Disability Without Poverty Network is a network of organizations including Inclusion BC, the BC Coalition of People with Disabilities (BCCPD), Canadian Mental Health Association, BC Division, Community Legal Assistance Society (CLAS), the Social Planning and Research Council of BC (SPARC BC) and the BC Aboriginal Network on Disability Society (BCANDS).

⁴⁴ Two-Year Independence Test. (2014). Ministry of Social Development and Social Innovation. Retrieved from http://www.eia.gov.bc.ca/factsheets/2004/2year_independ.htm

⁴⁵ Annualized Earning Exemption 2014. (2014). Ministry of Social Development and Social Innovation. Retrieved from <http://www.eia.gov.bc.ca/pwd/aee/index.html>

⁴⁶ Waddell C., Shepherd C.A., Schwartz C., and Barican, J. (2014). *Child and youth mental disorders: Prevalence and evidence-based interventions*. Vancouver, BC: Children’s Health Policy Centre, Simon Fraser University.

⁴⁷ Canadian Mental Health Association. (2014). *Fast Facts about Mental Illness*. Retrieved from: www.cmha.ca/

⁴⁸ Waddell C., Shepherd C.A., Schwartz C. & Barican, J. (2014). *Child and youth mental disorders: Prevalence and evidence-based interventions*. Vancouver, BC: Children’s Health Policy Centre, Simon Fraser University.

In our September 19, 2014 submission⁴⁹ to the Select Standing Committee on Children and Youth, we advocated for a number of systems-level improvements to the Child and Youth Mental Health and substance use system. Some of those recommendations are represented below.

The Child and Youth Mental Health and Substance Use System

While progress has been made, we know that the mental health system in B.C. can still be described as a patchwork of services with gaps in the continuum of care.⁵⁰ The system is centered on a narrow range of highly specialized (acute and tertiary) services that lacks focus and investment in community supports, making it difficult for youth and families to navigate. Waitlists for access to service are too long, resulting in young people feeling abandoned by the system or simply giving up and losing out on the benefits of continuity of care.⁵¹ There is strong evidence of the importance of providing supports in the communities in which people live, work, learn and play.

Some populations are particularly vulnerable to the gaps in our current system:

- 1) **Children and youth in government care and leaving care:** Young people (up to age 19) who are in foster care, group homes or involved in the justice system.
- 2) **Transition-age youth:** Young people (ages 16 to 24) who are moving from child and youth mental health services to adult mental health services.

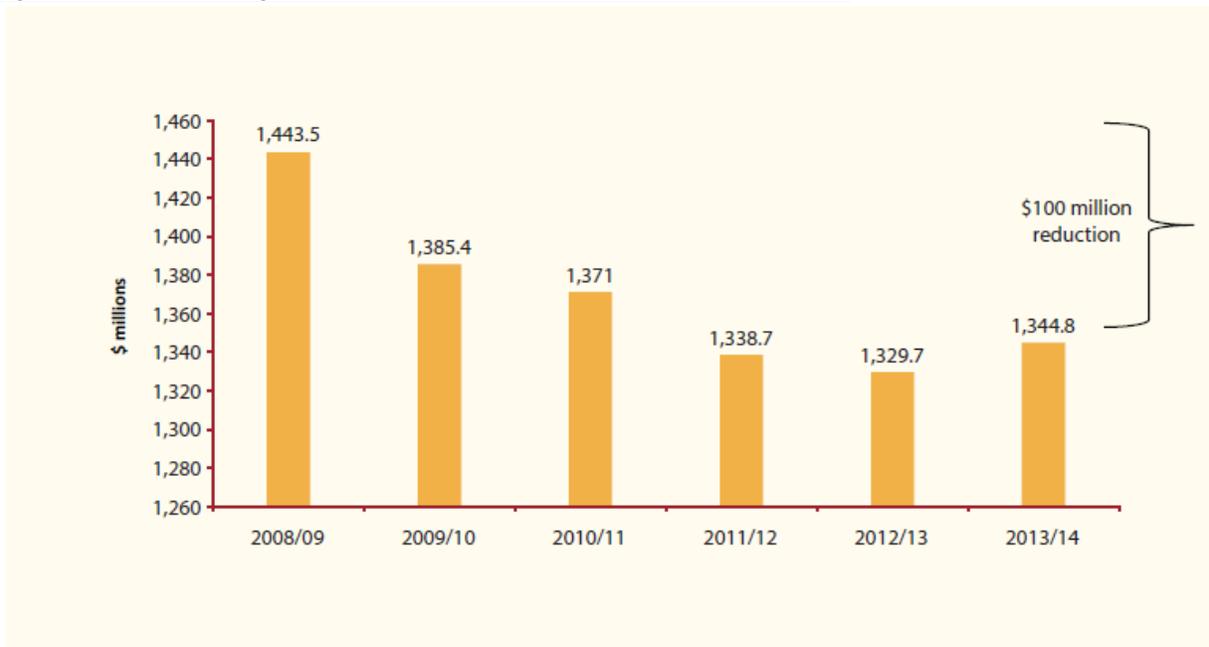
Without targeted investments and supports, some of these vulnerable children and youth may fall through the gaps. However, we note that the Representative for Children and Youth has recently found that the budget of the Ministry of Children and Family Development (MCFD) has been reduced considerably since 2008 (see Figure 4 below).

⁴⁹ Canadian Mental Health Association: BC Division. (2014). Child and Youth Mental Health in BC: A submission for the Select Standing Committee on Children and Youth. Retrieved from:
<http://www.cmha.bc.ca/files/CMHABC-Child-and-Youth-Mental-Health-Submission.pdf>

⁵⁰ Turpel-Lafond, M.E. (2013). *Still Waiting: First-hand experiences with youth mental health services in BC*. Victoria, BC: The Representative for Children and Youth.

⁵¹ Cox, K.; Smith, A.; Poon, C.; Peled, M. & McCreary Centre Society. (2013). *Take me by the hand: Youth's experiences with mental health services in BC*. Vancouver, BC: McCreary Centre Society.

Figure 4: MCFD Budget Adjusted for Inflation (2008/09 to 2013/14)⁵²



Note:

1. Figures are based on MCFD Service Plans, Restated Estimates (BC Budget 2009-2013)
2. Adjusted budget are based on BC Stats, Consumer Price Index (CPI) for BC (2008/09 to 2013/14)
3. Figures are adjusted based on 2013/14 base dollars

Promotion and Prevention

We currently invest very little in mental health promotion and prevention – not only for children and youth, but also for adults. In 2011-12, of the \$12.6 billion spent by health authorities, only \$536 million was allocated to Population Health and Wellness and a small portion of that spending was allocated to mental health promotion.⁵³ Many studies have shown that investing in upstream approaches to mental health can have huge returns on investment.⁵⁴

Recommendations

- 1) **Improve access to mental health and addictions services for children and youth.**
- 2) **Provide better supports and services for vulnerable children and youth:**

⁵² Turpel-Lafond, M. E. (2014). *Not Fully Invested: A follow-up report on the representative's past recommendations to help vulnerable children in BC*. Victoria: Representative for Children and Youth.

⁵³ Office of the Auditor General of British Columbia. (2013, 01 15). *Health Authority Expenditures*. Retrieved from <http://www.bcauditor.com/online/pubs/775/784>

⁵⁴ Roberts, G. & Grimes, K. (2011). *Return on investment: Mental health promotion and mental illness prevention*. Ottawa, ON: Canadian Institute for Health Information.

- a. **Children and youth in government care and leaving care:** young people up to age 19 who are in foster care, group homes, or are involved in the justice system.
 - b. **Transition-age youth:** young people ages 16 to 24 who are moving from child and youth mental health services to adult mental health services.
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 - 4) **Invest in upstream approaches to mental health, health promotion, and illness prevention for children and youth.**

Conclusion

There continues to be widespread marginalization of people with mental illness and substance use issues, which results in an over-reliance on expensive services and supports. Marginalization is devastating for people in their daily lives and significantly impairs their opportunity for recovery. Marginalization also has profound economic impacts as it requires increased investments in policing, the criminal justice system, emergency departments, acute care hospitals, homeless shelters and related supports.

Mental illness has a significant impact on individuals, our communities, our workplaces, our health care system and, ultimately, our economy. Timely access to evidence-based treatments and supports and improved access to key determinants of health, including adequate income and housing, can reduce associated disability and related costs of mental illness and help people to lead productive and fulfilling lives.

We believe that investments in community based mental health and substance use services, housing and income supports; treatment and support for children and youth; and health promotion and illness prevention can have excellence returns on investment and make significant and lasting improvements in the lives of British Columbians.