Canadian Mental Health Association
British Columbia
Mental health for all

How can we enhance the effectiveness of addiction recovery programs?

CMHA BC SUBMISSION TO THE SELECT STANDING COMMITTEE ON HEALTH

July 29, 2016

The Canadian Mental Health Association, BC Division is pleased to have the opportunity to share our vision and our recommendations in response to the question: ***How can we enhance the effectiveness of addiction recovery programs?***

We know that the timing has never been more critical to generate a significant shift in our system of care to support persons recovering from addiction. We also know that the members that comprise the Select Standing Committee on Health are deeply invested in making our system right – a system that is cost-effective, efficient, accessible, and serves the whole person, including addiction recovery.

The Canadian Mental Health Association in British Columbia (CMHA) has a vision of mentally healthy people in a healthy society. We are the nation-wide leader and champion for mental health. In BC, mental health, substance use and addictive behavior are within the scope of our organization. With our centennial birthday approaching in 2018, we are arguably the oldest charitable group who have supported persons living with mental health and addiction. CMHA in BC has a network of 14 branches that deliver high quality community-based services in over 100 BC communities and helps people access the resources they need to build resilience and support recovery from mental illness and addiction.

Recommendations

We are proposing five recommendations to the Select Standing Committee on Health, in response to answering the question: ***How can we enhance the effectiveness of addiction recovery programs?***

1. Review and report on the progress made against each of the recommendations in the *Stepping Forward: Improving addiction care in British Columbia* policy paper.
    - ◊ Review the ten recommendations that were proposed in the *Stepping Forward* policy paper.
    - ◊ Evaluate progress made on each of these ten recommendations.

2. Formally and fully recognize addiction as a chronic, treatable disease under BC's health system.
    - ◊ Ensure physicians have access to guidelines and protocols to better support, diagnose and care for patients recovering from addiction;
    - ◊ Ensure addiction is fully included in the Practice Support Program;
    - ◊ Fully integrate addiction into BCs Chronic Disease Management program so that physicians receive funding to identify and treat people living with addiction;
    - ◊ Provide longitudinal care treatment for persons recovering from addiction.

3. Strengthen the provision of addictions care in the primary care setting.
    - ◊ Develop a system of care that properly addresses addiction needs;
    - ◊ Develop standards of care such as wait-time standards to see addictions specialists;
    - ◊ Ensure there is province-wide coordination;
    - ◊ Models of primary care *must* go beyond screening, co-location of mental health and addiction providers and referrals to specialists. We urge the committee to consider the Collaborative Care Model.

4. Expand coverage for addiction treatment.
    - ◊ Include addiction medication under PharmaCare's Plan G to ensure drug-based treatment is accessible to all British Columbians;
    - ◊ Include behavioural health treatments, such as treatment from counsellors and psychologists, to ensure behaviour-based therapy is accessible to all British Columbians.

5. Invest in education about addictions.
    - ◊ Ensure that non-specialist human service professionals have a better understanding of addiction.

A fuller discussion is provided within each of these recommendations. However, in order to situate the urgency and value of these recommendations, the current status of addiction and strategic policy context are first addressed.

The status of addiction

In British Columbia, substance use has recently become a high profile issue.

- From 2002-2007 the rate of hospitalizations caused by illicit drugs increased by 36.6%, and the rate of hospitalization caused by alcohol has increased by 3.4%.[1] Between 2001 and 2009, alcohol consumption in BC increased faster than in the rest of Canada.[2]
- The Minister of Health and the Provincial Health Officer declared a public health emergency after 200 fentanyl overdose deaths occurred in the first three months of 2016.[3]

- This year alone, between January and June, 371 British Columbians have already died as a result of an unintentional overdose death.[4] This is a 74.2 percent increase over the number of deaths (213 deaths) that occurred during the same amount of time in 2015.

Fifteen years ago, the economic cost of substance use in BC was staggering and we can say with near certainty that these costs are even higher today. As illustrated in Figure 1, in 2002, the burden of substance use was $6 billion dollars, with 40 percent coming from direct health care costs ($1.32 billion) and law enforcement costs ($810 million). But what is even more staggering is that of $1.32 billion in direct health care costs, about half of this ($670 million) is attributable to hospitalization.[5] We know that hospital visits are some of the most expensive ways to pay for addictions care and they continue to increase. In fact, between the years of 1992 and 2002, the number of days spent in hospital for tobacco, alcohol and illegal drugs increased by **90.8 percent**.[6]

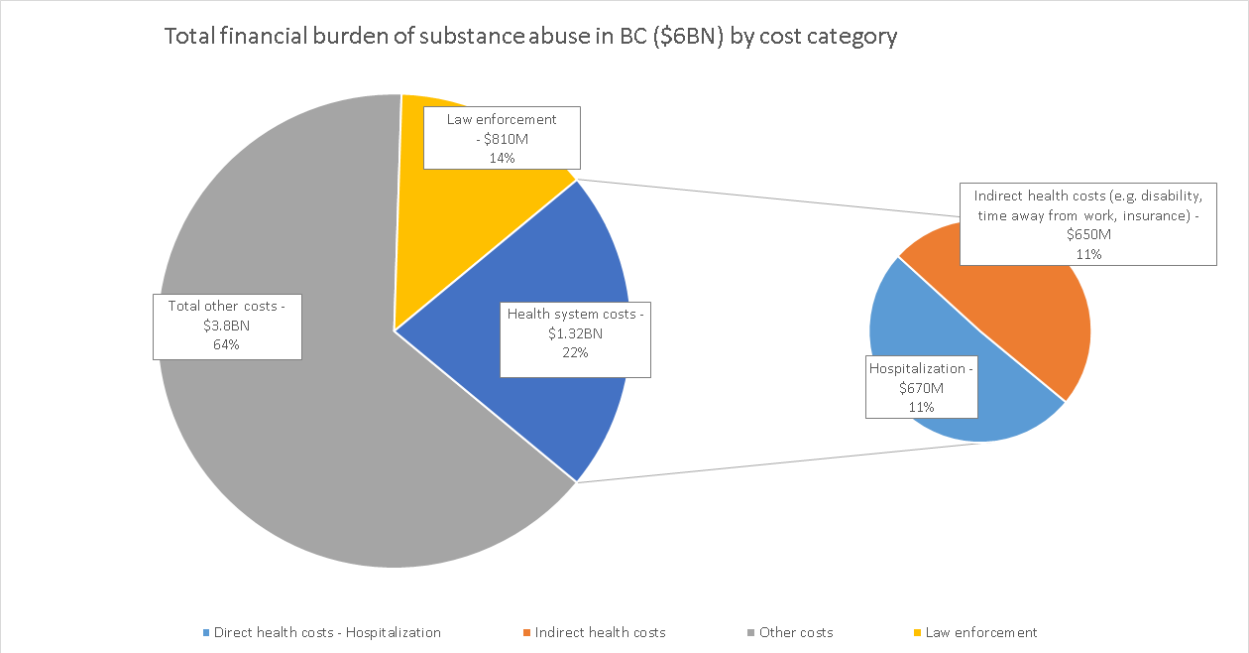

Figure 1. *Total financial burden of substance use in BC ($6 billion) by cost category (2002)*[7]

But the burden of addiction does not just sit among the adult population. A report by the Representatives of Children and Youth note that a conservative estimate of the youth (between 15 and 24 yrs.) who meet the criteria for a substance use disorder is 68,000. Yet the number of publicly funded treatment beds available to this cohort is a "miniscule" 24.[8]

There is an urgent need to build a truly integrated continuum of care for addiction in British Columbia. The current reality in British Columbia is that our system is fragmented, uncoordinated, and inaccessible. People who use the various levels of addiction care in British Columbia often describe a system that is not designed for the person seeking recovery in mind. In fact, some have argued that there is *no* system of addictions care in our province. For example, when someone arrives at a point ready for treatment, the service they could use and are *willing* to use has a waitlist, is far from their home community, or has such restrictive criteria that they are ineligible.

It is clear that the social and fiscal burden of downstream care is unsustainable and we are now in a position where it is critical that we examine the current gaps in our system and address strategies to yield the highest return on our investment – both in terms of economic cost and social capital. There is a critical need to join up and resource the key ingredients for high-quality care of a chronic, and treatable health condition like addiction.

Strategic Policy Context

There are a number of reports that have been released on the state of the union in British Columbia in regards to addiction and addiction recovery.

Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction provides sound suggestions for the redesign and restructuring of services.[9] The authors in this report suggest a comprehensive continuum of services built on four domains: population health, health promotion, harm reduction and community capacity-building with clear examples of evidence-based programs and services at every level on the continuum.

In May 2016, the BC auditor general released a report on *Access to adult tertiary and substance use services*.[10] This report provided good insight into the current status of our system of care. It emphasized the challenges that people with mental health and substance use problems face in accessing care at the health authority level. A number of sound recommendations were made in this report, with an eye towards building a system of care that is community driven, sustainable, and coordinated.

A review of youth substance use services in B.C., by the Representative of Children and Youth was also released this year.[11] It illustrates a sound picture of the current state of practice, including the services available to youth and the responsiveness of these services to the needs of some of the most vulnerable and marginalized in our community. The report identifies key gaps in the system and offers firm and concrete recommendations to address these gaps.

A fourth notable report that we would like to highlight is one that was produced by the British Columbia Medical Association (now Doctors of BC). *Stepping forward:*

Improving addiction care in British Columbia is a powerful policy paper that brought to the forefront the need to address addiction as a systemic and critical issue in our province.[12] The authors of this paper provided 10 recommendations that, arguably, still hold relevance. That is why today, seven years later, we would like to once again bring this paper forward and reintroduce this report as part of our recommendations.

Recommendations

We are urging the Select Standing Committee to consider the following recommendations:

1. Review and report on the progress made against each of the recommendations in the *Stepping Forward: Improving addiction care in British Columbia* policy paper.

We have made strong reference to this policy paper. There are 10 recommendations that the Doctors of BC included in this document and we believe that these are solid recommendations that remain relevant today. Therefore, our first recommendation, to enhance the effectiveness of addiction recovery programs in BC, is for the Select Standing Committee to review and report on the progress that has been made on these 10 items.

The Select Standing Committee's review of this paper would serve as an important opportunity to take stock of the actions government has already taken in response to the physicians' recommendations and examine where progress can still be made.

2. Formally and fully recognize addiction as a chronic, treatable disease under BC's health system.

In the policy paper that was referenced in our first recommendation, *Stepping Forward: Improving addiction care in British Columbia,* their number one recommendation called upon the provincial government to:

> *Formally recognize addiction as a chronic, treatable disease under the BC Primary Care Charter and the BC Chronic Disease Management Program.*

The government of the day acted, and in April 1st, 2011, BC became the first jurisdiction in Canada to recognize alcohol addiction as a chronic medical condition. This sent a bold message to the community that a person with alcohol addiction would receive the same level of care as someone else with a chronic physical illness. It meant that physicians had access to guidelines and protocols to better support, diagnose and care for patients living with alcohol addiction and additional training through the Practice Support Program.

The Health Minister of the day, Colin Hansen, said "if somebody is diagnosed with a chronic illness, then treat it in a preventive way, rather than in a crisis intervention way."[13] The words of the former Health Minister have particular relevance as we fast forward to 2016 and examine whether our systems of care really have moved towards *prevention* or whether we wait until stage four, responding when the situation has reached a point of crisis.

When *Stepping Forward* was written in 2009, 201 British Columbians died as the result of an unintentional overdose while using "illicit" substances.[14] And, as noted above, in the first half of this year alone, 371 British Columbians have died as the result unintentional overdose.[15] Recently, the Ministry of Health released data focused on the cohort of British Columbians living with mental health and substance use problems, utilizing publicly funded systems of care. According to this data, amongst this group, there were 681,496 visits to the emergency department in 2013/14.[16] **Twenty-one percent of those visits were related to substance use.** Put another way, out of a total of 1.26 million emergency department visits in 2013/14, **one in ten related to substance use.**

This last point is particularly important given some recent research that shows that people who present to the emergency department with a substance use related acute trauma **do not** meet criteria for moderate to severe substance use disorders. Yet, a crisis resource appears to be all that is available for people who would likely benefit from less acute resources in the community, not to mention the financial burden of paying for services through the emergency department.

Considering all of this, we are at an opportune time to act on the recommendation to formally adopt the full continuum of addiction, not just alcohol addiction, as a chronic and treatable disease.

There is a rich body of evidence to support that addiction is indeed a chronic and treatable disease. We know that addiction disrupts the normal functioning of reward, motivation and memory systems in the brain.[17] And, like other chronic diseases, requires longitudinal care and treatment,[18] instead of no treatment or downstream treatment (e.g., detoxification). Evidence-based interventions to support people in the recovery process exist. But the structure of our current healthcare system plays a very prominent role in this, beginning with the recognition of addiction as a chronic and treatable disease under BC's health system. Including addiction in BC's Chronic Disease Management Program would mean that physicians would receive funding to identify people living with addiction issues and would allow addiction health care providers to utilize systems that are already in place, including collaborative care teams, data collection platforms, and appropriate care plans.

3. Strengthen the provision of addictions care in the primary care setting.

Nearly a decade ago, our provincial government initiated the Conversation on Health – "the largest and most wide-ranging public discussion on health and our public health care system ever held in the history of our province".[19] The goal of this public discussion was to engage British Columbians on what they viewed to be the most pressing health care issues and to help shape the future of our health care system. A core theme that emerged in the report *Summary of Input on the Conversation on Health* was the challenges that British Columbians face when it comes to addiction care. These challenges include:

- A lack of coordination and strategic development to support persons with addictions and mental health problems;
- A lack of alignment between services and the needs of individuals;
- Significant barriers to treating addiction, including lack of treatment options, waitlists, inadequate lengths of stay, the requirement to be sober before beginning treatment; and
- A lack of longitudinal care for substance use, in spite of some addictions being "touted as a chronic illness."

In other words, we were missing a system of care that supports recovery from addiction. And, today, as echoed in findings from BC's Office of the Auditor General[20] as well as Representative for Children and Youth[21] we continue to lack a system of care that properly addresses addiction. There is an absence of standards, quality assurance processes, province-wide coordination and stewardship, and a lack of proactive planning to sustain the future needs of our province.[22]

It is imperative that we focus on investing in the role of primary care to support the effectiveness of addiction recovery programs. We recognize that no one part of the health system is fully equipped to provide high-quality and effective care for the entire cohort of people living with addiction problems. We also recognize the provincial government's strategic policy direction towards establishing primary care homes as a "cornerstone of health services across the province at the local service level."[23]

We understand that primary care homes will include a full service family practice linked to, or integrated with, a health authority or health-authority contracted inter-professional team. And, that it will offer a range of primary care services that, in the case of mental health and substance use, will include assessment, short- and long-term care, and medication monitoring. Given the advent of primary care homes, strengthening the provision of addictions care in primary care is critical for four key reasons:

1. Primary care is an optimal site to provide care for people living with a full range of addictions, when specialist support is not yet required;

2. Access to high-quality addictions care in primary care is sparse due to variability in physician training, expertise, and capacity;
3. There are excellent evidence-based interventions that can add addictions expertise to primary care settings that drive significant improvements in outcomes; and
4. Effective addictions care in primary care settings yields enormous medical cost savings and improved patient satisfaction. Conservative estimates indicate that we would see a return of between $4 and $7 for every dollar invested in addiction treatment.[24]

While the full details of primary care homes have yet to be publicly released by government, we would urge the Committee to ensure that the addictions care available in primary care homes go beyond screening, co-location of mental health providers in primary care clinics, education and training, and referrals to specialist care. We know that these approaches alone, and in combination, do not improve patient outcomes.

Considering all of this, we encourage the application of the Collaborative Care Model, a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence-based treatments for primary care patients. The Collaborative Care Model "considers patient-centered care to be the cornerstone of good medical practice."[25]

In typical primary care settings, the treatment team has two members: the primary care provider (PCP) and the patient. The Collaborative Care Model adds at least two additional and vital roles in addictions care: a mental health and substance use professional functioning as the "care manager" (embedded into the primary care home) and a consulting psychiatrist or addiction specialist (typically participating via tele-health) (Figure 2).

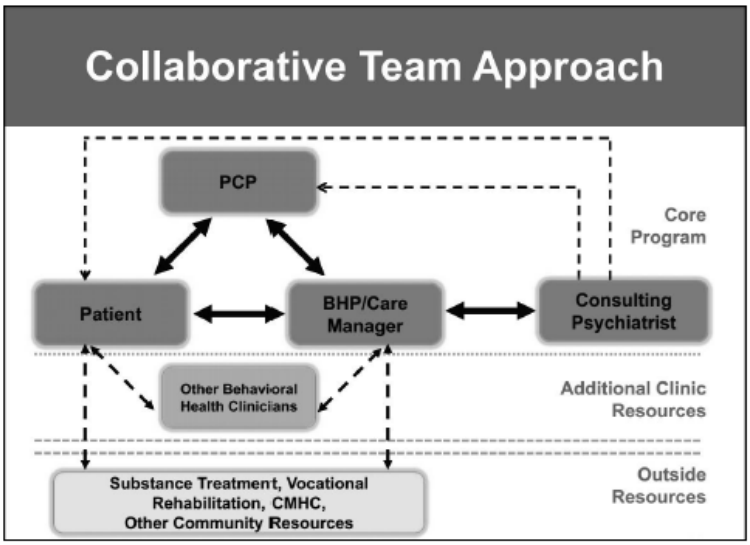

Figure 2. *Team Diagram of Collaborative Care Model* (aims.uw.edu).[26]

Robust addictions care in a setting like the primary care home should also incorporate:

- The Screening, Brief Intervention, and Referral to Treatment (SBIRT),
- Engagement with patients who are not ready for specialty treatment,
- Early detection,
- Effective referral processes, and
- Ongoing care coordination.

In Nova Scotia the Collaborative Care Model was implemented across 14 'showcase' units in hospitals throughout the province's health authorities. An evaluation released in 2010 reinforces just how promising this model is.[27] The findings include:

- Greater role clarification,
- Positive team atmospheres,
- Fewer medical errors,
- Improved job satisfaction,
- Fewer Occupational Health and Safety occurrences for providers,
- Improved health status of discharged patients, and
- Shorter lengths of stay and reduced repeat admissions.

The opportunity to develop a thoughtful and coordinated primary care approach, such as the Collaborative Care Model would serve to enhance addiction recovery in BC.

4. Expand coverage for addiction treatment, including pharmacotherapy and behavior therapy.

Our system is structured in a way where we are leaving people behind and allowing them to get to stage four before we respond to their needs. We are waiting until someone's health has deteriorated to a crisis point, where the outcomes involve family breakup, exclusion from the community, loss of employment, hospitalization, incarceration, and sometimes death. In our health care system, we have made every effort to address chronic diseases, such as cancer, far earlier than stage four. There is a clear need to act before stage four in addiction care too.

The first step towards this is in making treatment accessible to *all* British Columbians. That means expanding coverage for addiction treatment. Recently, the Ministry of Social Development and Social Innovation made a significant decision to stop deducting $18.34 from the social assistance checks of those receiving treatment from private methadone-dispensing clinics.[28] This is a significant step in the right direction. However, we know more can be done to mandate a position of equivalence.

Although healthcare in the United States remains largely owned and operated by the private sector, a fundamental principle that guides coverage is the Paul Wellstone and Pete Domenici Mental Health Parity and Equity Act of 2008.[29] The objective of this act is to ensure equivalence between mental health and substance use disorders and medical and surgical benefits with group plans of at least 50 employees. We encourage government to take a stance in providing equal coverage between

treatment for physical health problems and mental illness and addiction treatment - for all residents of British Columbia.

Put another way, addiction medication should be covered similar to what is done for psychiatric medications under PharmaCare's Plan G. In addition to this being *the right thing to do*, there is strong evidence that there are huge returns to be gained. In a study that assessed providing alcohol and drug treatment to 150,000 users, as much as a 12 to 1 ratio of return on investment was observed. That is, treatment to this sample cost $209 million, and a return of $1.5 billion was observed in the first year alone – largely owing to a decrease in crime.[30]

We know, however, that addiction recovery is not just about providing appropriate drug replacement therapy. Individuals also deserve access to psychosocial support; yet all too often we disregard the value that these therapies hold in the recovery process. We know, and heard from many who presented before the Select Standing Committee, that recovery is not simply about finding the right pharmacotherapy treatment, but includes other factors, such as peer support, access to good community-based programs, and the right therapy for the individual. In fact, a recent study indicates that there is strong evidence for the effectiveness of treating pain through behavior-based approaches instead of opioids, thereby minimizing the risk of developing an addiction to painkillers.[31] In spite of the evidence that *both* pharmacotherapy and behavior-based therapies work, the average person has limited access to these supports. Those who are ready and willing to engage in the recovery process are forced to pay out of pocket (assuming they have the funds to begin with). We know that the interaction between biology, psychology and the supports of our social network play a vital role in the healing process. Appropriate access and coverage to behavior-based therapy should be accessible to anyone who needs it.

A recent study indicated that only about half of British Columbians diagnosed with depression are receiving adequate treatment.[32] But a closer look at this data paints an even starker picture. Among the 108,000 individuals diagnosed with major depressive disorder, only 13 percent (14,047) received minimal*ly* adequate *counseling or psychotherapy* sessions. Also, among those between ages 19 to 25, even *less* than half (40.2 percent) received minimally adequate treatment. We would argue that the current policies, practice and fee structures that are inherently responsible for the challenges in accessing mental illness treatment apply to the challenges people with addiction face on a daily basis.

We recognize that substance use can increase the chances of an individual developing a mental illness and having a mental illness can increase risk of using substances. In fact, people with any mental illness are 2.3 times as likely to develop nicotine dependence, 3 times more likely to develop alcohol dependence, and 30 times more likely to develop dependence on other substances.[33]

On a separate note, CMHA BC applauds the College of Physicians and Surgeons of British Columbia decision to adopt a new professional standard on safe prescribing to

address the public health emergency related to opioid overdoses. We encourage monitoring of the implementation of this standard alongside intended and unintended consequences as it takes effect.

The evidence is clear. It has been well-documented. Addiction is a chronic and treatable disease. We do not charge per diems for cancer care, or pumps and syringes for insulin. Treatment for addiction recovery should be no different. In the long term, we would argue that the return on changing the way addiction treatment is funded would be an incredibly valuable investment.

5. Invest in education about addictions.

Arguably, one of the main barriers to enhancing addictions recovery in BC is the persistence of stigma and discrimination. The Canadian Mental Health Association, with funding from the Community Action Initiative, has recently launched a cost-effective online and self-paced course called "Understanding Addiction." Designed to assist non-specialist human service professionals better understand addiction, this course has the potential to help service providers engage with the complexities of living with an addiction.

Similar in format to the widely used indigenous cultural competency course offered by the Provincial Health Services Authority, we believe this course could help our broader systems of care become more responsive, inclusive, and safer for people living with addiction. We know that mental health begins where we live, work, learn, and play. The mental wellness of our community is our collective responsibility and that is why we believe that everyone - from teachers to superintendents to bus drivers - should have a basic literacy about addiction. Therefore, we are recommending that the Committee invest in educating our community.

Summary of Recommendations

We have proposed five sound and actionable recommendations that we urge the Select Standing Committee to consider in the approach to developing addiction recovery programs:

1. Review and report on the progress made against each of the recommendations in the Stepping Forward: Improving addiction care in British Columbia policy paper;
2. Formally and fully recognize addiction as a chronic, treatable disease under BC's health system.
3. Strengthen the provision of addictions care in the primary care setting;
4. Expand coverage for addiction treatment, including pharmacotherapy and behaviour therapy; and
5. Invest in education about addictions.

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