

Vancouver Mental Health and Addictions Systems Barrier Report – 2016/2017

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**Canadian Mental
Health Association**
Vancouver-Fraser Branch

**Association canadienne
pour la santé mentale**
Vancouver-Fraser Branch

Vancouver Mental Health and Addictions Systems Barrier Report 2016/2017
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Designed by: Rokotype Design

ISBN: 978-0-9736593-6-8

Acknowledgement: CMHA, Vancouver-Fraser Branch gratefully acknowledge the financial support of Vancouver Coastal Health Authority whose funding enables the operation of the Peer Navigator Program. The opinions expressed herein are the opinions of CMHA, Vancouver-Fraser Branch and the authors and do not in any way reflect the opinions of Vancouver Coastal Health Authority.

An illustration of a woman with brown hair, wearing a pink shirt and green shorts, riding a skateboard on a path. The background is a stylized desert landscape with orange and yellow tones, featuring jagged rock formations and cacti. A dashed white circle highlights the woman's head and shoulders, and another dashed white circle highlights the skateboard. A line connects the text 'Meet Lynda' to the woman's head, and another line connects the text 'Follow Lynda's story...' to the skateboard.

Meet Lynda

Follow Lynda's story as she faces the barriers to recovery from mental health and addictions concerns

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The authors would like to thank
program participants and their editor, Jan Rennie.

Introduction



Welcome to the second annual systems barrier report of the Canadian Mental Health Association Vancouver-Fraser Branch (CMHA-VF). 2016/2017 was the second year of our Peer Navigator Program funded by Vancouver Coastal Health Authority, a capacity-building program for individuals living with mental health concerns and/or addictions. Peer staff who have lived experience accessing the mental health and addictions systems deliver the program. We work on an individual and group basis with program participants to help them to identify relevant resources in the community and develop self-advocacy skills. In the process, we draw from our own lived experience to empower a diverse array of people to navigate Vancouver's very complex mental health and addictions systems.

Our report covers the fiscal year April 1, 2016 to March 31, 2017. Changes in barriers within the larger mental health and addictions care systems after April 1, 2017 are not addressed in this report. Further, this report focuses on barriers to services in the mental health and addictions systems (and other related social support systems) in the municipality of Vancouver (i.e. excluding Burnaby, Surrey, etc.). This report references practices and realities experienced by our participants as they try to obtain the supports they need from various systems in order to be able to live full and contributing lives. This includes income support programs, housing, mental health care, etc. No one agency is singled out for criticism. Although our report is about barriers to care, where there have been improvements to the systems since last year's report, we highlight them here. We hope the reader will appreciate the nature of this report and its limitations.

The data collected from program participants over the last two years provides a preliminary picture of the barriers that our program participants face when they try to access services. While these preliminary numbers are

small, they suggest areas that need attention within the mental health and addictions systems in Vancouver. We have included general indicators of whether each of the barriers is getting better, staying the same, or getting worse based on participant reports and the experiences of Peer Navigator staff in attempting to assist our participants in navigating these systems.

The information and data for this report was gathered in several ways. The Barriers to Care Evaluation [BACE] (Clement et al., 2012), a 30-item standardized measure that assesses barriers to mental health care, was completed by twenty-two program participants. This exploratory study provided us with a small empirical basis for the information contained in this report, supplementing data obtained through other processes. In future years, we plan to have most, if not all, program participants complete the BACE. Information for this report was also gathered from program evaluation statistics (output and outcome data), case notes, conversations with participants, discussions amongst Peer Navigators, and relevant academic and grey literature.

The barriers identified do not occur in isolation. Each barrier interacts with other barriers, resulting in a cumulative effect on the individuals that we serve. In order to illustrate the complex interactions between the barriers, we have included an example of a fictional participant, Lynda. Throughout the report,

Lynda experiences the common barriers that our participants face. Her story provides an illustration of the volume and complexity of the challenges that individuals confront when trying to navigate Vancouver's mental health and addictions systems.

We have grouped the barriers faced by participants of the Peer Navigator Program into six sections. The rest of this report explores the barriers faced by our program participants in each of these areas:

INCOME

- outlines the barriers our participants face in obtaining the minimal financial resources to meet their needs.

HOUSING

- summarizes several of the barriers that our participants face in accessing safe and affordable housing in Vancouver.

ACCESS TO HEALTH SERVICES

- provides an overview of some of the barriers participants face when trying to connect with mental health and addictions resources to get the support that they need.

DIAGNOSIS

- details some of the barriers that our participants experience when going through the process of psychiatric diagnosis.

TREATMENT

- reviews a number of the various barriers that our participants face when receiving treatment for their mental health and/or addictions concerns.

SYSTEMIC

- discusses several barriers that are embedded within the patterns of behaviour, practices, policies, procedures, structures, and culture of the mental health and addictions systems.

Although individuals may experience an overwhelming number of barriers in trying to access treatment for mental illness and addictions, there is hope. The Canadian Mental Health Association in BC has recently launched a campaign calling on our society to start treating mental illness and addictions like all other health conditions, with early treatment interventions and improved education to prevent treatment delays. We encourage you to join us in this call for change by showing your support at <http://www.b4stage4.ca>.

Lynda's story



Lynda is a very talented artist, who dreams of studying painting at Emily Carr University of Art and Design. She identifies as queer and has recently turned 23. She is currently single and estranged from most of her family. Her dad and siblings haven't been in contact with her since she was a teenager, when they found out about her sexuality. Lynda has a history of childhood trauma and dropped out of high school in Grade 11 after being kicked out of her dad's house. Her mom lets her stay with her on and off, but they have a difficult relationship. When she can't stay with her mom, she couch surfs at friends' houses. Her part-time job at a restaurant pays her minimum wage and she does not receive any benefits. Lynda has struggled with anxiety and depression since she was 16, but has never received any help for her mental health. She uses drugs and alcohol on occasion to cope with her problems...

Income



Income is considered a fundamental social determinant of individual health (Mikkonen & Raphael, 2010). As incomes rise, individual wellness improves. The Living Wage for Families Campaign established that a minimum after tax income of approximately \$2,886.80 per month is required for an individual to thrive in Vancouver (Living Wage for Families Campaign, 2015). This year, we have separated income from our discussion of housing in order to highlight the impact that income-related barriers has on our participants.

1. Income Levels

The Employment and Assistance Benefits of the Ministry of Social Development and Social Innovation (MSDSI) supported most of the participants in the Peer Navigator Program in 2016-17. Our clients on Income Assistance benefits through MSDSI have a fraction of the income required to meet the living wage rate. Those unattached individuals on basic income assistance receive an amount totalling \$235.00 for food, transportation, clothing, telephone, etc. and those on Persons with Disabilities (PWD) Benefits receive \$606.42 for these same needs. The \$235.00 of Employment and Assistance Benefits barely covers the cost of food. Telephone bills and transportation costs remain out of reach in any realistic budget based on EA Benefits. Personal hygiene can

suffer when toiletries are beyond one's budget. Adequate nutrition is also an early casualty in life at the poverty line. Dental care is an aspect of personal health that is seen by welfare recipients as a low priority amid a struggle for the basics of daily life. The amount provided for rent for Employment and Assistance Benefits as well as for Persons with Disabilities Benefits is only \$375.00 per month and is addressed in the Housing section below. The seniors' cohort of participants in our program were supported by Old Age Security, Canada Pension Plan and the Guaranteed Income Supplement as well as rent subsidy programs such as Shelter Aid for Elderly Renters (SAFER), which are not adequate to meet participant needs.

RECOMMENDATION

We recommend that the provincial government either raise income assistance rates to ensure recipients have an income equal to a living wage, or implement a guaranteed minimum income program that provides a minimum of a living wage income to all British Columbians.

TRENDS



MSDSI increased assistance rates by \$77 in September, 2016, \$52 of which can be allocated to a monthly bus pass.

TRENDS



Improved



Deteriorated



Stayed the same

Lynda's story



Lynda's housing with her mom is becoming unstable. She has been fighting with her mom daily and feels like she needs to move out ASAP. She is able to stay with a few friends on and off. When getting off the bus one day, her ID falls out of her bag and she is unable to find it. Her mom lost her SIN and birth certificate when she was a kid, so she has no ID. Without consistent sleep, her anxiety and depression are getting worse...

2. Benefits Application Process

Another income-related barrier to accessing service is having access to the technology required to complete the application for Person with Disabilities benefits. In the spring of 2017, MSDSI implemented an online application for income assistance and Persons with Disabilities (PWD) Benefits and now require all applicants to use the online application system. The application process, which requires an email account and BCeID, has been decried by more than 60 organizations across the province (BC Public Interest Advocacy Centre, 2017). To qualify for income assistance, an applicant must use a smartphone or scanner to upload photos and other documents to the application system. In addition to the online application form, a medical doctor must complete a lengthy paper form. Doctors usually insist on knowing a patient/applicant for at least six months in order to assess them with confidence before completing the form. Our program participants often do not have their own Family Physician, and as was documented in last year's Barrier Report and later in this report, it is very difficult to find a doctor accepting new patients.

RECOMMENDATION

If an income assistance system is redesigned, we recommend that MSDSI ensure the application process does not require access to technology or computer skills that are barriers for people needing to access the system.

HOW WE HELP

Peer Navigators regularly assist program participants with applications for Income Assistance and Persons with Disabilities benefits. Our PNs have received orientations from the Ministry regarding completion of the online application, and we assist individuals in adjusting to the recent changes. PNs also assist with accessing emergency funds for unexpected circumstances through Ministry supplements, Consumer Initiative Fund grants and Vancouver Rent Bank assistance. However, these resources do not meet the extreme needs of participants and provide minimal financial supports.

TRENDS

MSDSI implemented a new online application system, which introduces new barriers for individuals applying for Ministry benefits.



Housing

Housing is an essential element of individual well-being and one of the major social determinants of health. It provides people with a place of safety and privacy where they can organize their affairs, plan, and execute choices for accessing the resources they need in the community. Without a safe, affordable home, people are unable to realize their goals and their dreams. Our program participants encounter two major barriers to accessing housing, affordability and availability of subsidized, affordable housing.

1. Affordability

The majority of our program participants receive all or most of their income through the Income Assistance programs of Employment and Assistance Benefits and Persons with Disabilities Benefits (PWD). The average rent for a bachelor apartment in Vancouver is \$1013.00 per month (Canada Mortgage and Housing Corporation, 2016), an increase of \$83.00 from last year, which is substantial for program participants. The shelter portion of monthly income assistance cheques in both programs for single individuals is \$375.00. Because of the discrepancy between rental costs and the shelter allowance provided by Income Assistance, many individuals continue to use up both their shelter allowance and support allowance (or almost all of their income) on rent, leaving them without the means to get adequate nutrition, a telephone, transportation, and other necessities of life in Vancouver.

Being unable to communicate and travel makes accessing services and maintaining social, and support connections nearly impossible. These program participants cannot leave a phone number for callbacks from health services, and sometimes they cannot travel the long distances required to reach appointments or centralized service centres. If an individual on either Employment and Assistance or PWD benefits cannot secure subsidized housing, the alternatives are to either spend their entire benefit cheque on rent, or find housing in unsafe, unsanitary Single Room Occupancy (SRO) hotels in the city. Both options leave them isolated, at risk, and still without a phone or bus transit fare. Lack of adequate income supports for individuals who cannot work constitutes a significant barrier to service within the mental health system.

RECOMMENDATION

We recommend that the shelter portion of MSDSI benefits be increased to the average cost of a rental unit in Vancouver (\$1013.00 per month for a bachelor suite) or that a guaranteed minimum income program be implemented in B.C.

HOW WE HELP

Housing affordability is a far bigger issue than the Peer Navigator Program can solve. We work with individuals to apply for subsidized housing (BC Housing, non-profit providers, co-ops, etc.), SAFER, and subsidies from partner agencies. This involves supporting participants in reading and understanding forms, as well as supporting participants in the use of the internet to identify resources. We also assist with housing searches. For those that have housing, we help with budgeting what little is left after rent payments. Even with these supports, it is impossible for many of our participants to afford housing.

TRENDS

↓ The average cost of rental units in Vancouver has increased since last year's barrier report.



Lynda's story



With her worsening anxiety and depression, Lynda starts missing shifts at the restaurant. She explains that her health has not been good and her manager asks for a sick note. As she has been unable to find a regular GP, she is forced to go to a walk-in clinic for a sick note. The doctor at the walk-in clinic is quite dismissive, but agrees to write her a sick note for 2 weeks off work. While at the clinic, Lynda spots a brochure for the Peer Navigator program. The brochure says that they help with income and housing, so Lynda schedules an appointment.

2. Availability of Subsidized, Affordable Housing

Peer Navigators have assisted numerous individuals with housing issues over the course of the year. Of these, 39 reported having applications on file with BC Housing's Housing Registry or were helped with submitting new applications. Only one of these people received a housing offer from a proprietor on the Registry. There are multiple subsidized housing application waitlists in Vancouver, which increases the complexity for individuals seeking housing to maintain their eligibility on those lists.

RECOMMENDATION

- We recommend that all levels of government invest more robustly in the construction of new social housing to reduce the wait times to gain access to affordable housing.
- We recommend that all levels of government act immediately to ensure the current affordable rental housing stock is maintained as subsidized, affordable housing.
- We recommend that all subsidized affordable housing waitlists in Vancouver be centralized, with one application process.

HOW WE HELP

Many program participants are homeless due to the lack of affordable housing. We refer individuals to shelters, transitional housing, and homeless outreach workers with our agency partners. We also explore other housing options, such as staying with family or friends temporarily. When appropriate, we provide participants with copies of the BC Housing Supplemental Form to fast track their application for subsidized housing. We also make use of the Supportive Housing Registry. We recommend that individuals waiting for subsidized housing through BC Housing call in once every six months to make sure their file is kept open.

TRENDS

Peer Navigators observed fewer program participants moving into BC Housing than in the previous year.



Access to Health Services

1. Access to Primary Care

Even though it is crucial that individuals with mental health issues receive timely treatment, many of the participants of the Peer Navigator Program do not have access to a consistent primary care provider (i.e., a nurse practitioner or a family physician). Many participants attend walk-in clinics to refill medications and express concerns about side effects and lack of follow-up care. In addition to the barriers the general population face in finding a primary care physician, participants in our program continue to report that even the few doctors that are accepting new patients often refuse to take them on due to their complex mental health needs. This is not unique to Vancouver; researchers have repeatedly documented this unwillingness for Primary Care Providers to accept patients with mental illness and addictions issues (Steele, Durbin, Sibley, &

Glazier, 2013; Durbin, Durbin, Hensel, & Deber, 2013).

Often our participants are referred to the list of doctors accepting new patients on the College of Physicians and Surgeons website. This list relies on doctors calling in to update their information and many physicians do not keep their info up-to-date. In addition, the list does not indicate which clinics are funded privately, causing confusion for individuals seeking care that cannot afford to pay.

Provincial funding for “A GP for Me” ended in 2016, and although the initiative continues to improve access to primary care in some communities, it is not currently available in Vancouver.

RECOMMENDATION

- We recommend that the Vancouver Division of Family Practice reinstate the services of “A GP for Me.”
- We also recommend that the Vancouver Division of Family Practice provide a continually updated list of primary care providers willing to accept new patients with mental health issues.
- We recommend that health authorities develop additional specialized primary care clinics for patients with mental health needs, such as the REACH Community Health Centre in East Vancouver. REACH had a significant waitlist varying from two weeks to three months for our participants during the 2016/2017 fiscal year.

HOW WE HELP

The Peer Navigator Program can walk individuals through the BC College of Physicians and Surgeons website and support them in calling physicians’ offices. We also refer participants to Community Health Centres throughout the city, where they can access comprehensive care. Many of these centres have wait-lists but we can assist with application forms. While waiting to find primary care provider, we recommend participants go to a consistent walk-in clinic for continuity of care.

TRENDS

Accessing primary care continues to be a significant challenge for program participants.



2. Mental Health in Primary Care

Although mental health disorders are common, functionally disabling, and costly, most do not receive the treatment they require. A number of barriers contribute to inadequate treatment, including a lack of responsiveness amongst primary care providers (Davis, Meyers, Mathews, Moore & Zerth, 2016). Participants who are lucky enough to access primary care providers often report stigmatizing experiences that include doctors being dismissive of the severity of their concerns. Others have reported that their doctors wish to help them but state that they do not have the knowledge or resources to do so. In a study by Fleury, Imboua, Aube, Farand and Lambert (2012), most GPs reported difficulty working with patients with serious mental disorders and very few felt they were satisfied with the treatment they were providing. Similarly, only 46% of family physicians in a Canadian study reported that they were satisfied with the mental health care they were able to provide to patients (Clatney, MacDonald & Shah, 2008).

According to our program participants, many of their primary care providers do not know where to refer them. Some participants report that their primary care providers have been hesitant or unwilling to fill out the medical forms that are required to obtain PWD or other forms of disability support. Another enormous barrier is that some practitioners charge a fee for filling out disability forms. Most of our participants do not have the financial resources available to pay these fees. This barrier sometimes results in the loss of participants' income and housing, and leads to the deterioration of their health. The Ministry of Social Development and Social Innovation do cover the costs of physicians filling out PWD forms, but not all physicians and patients are aware of this.

RECOMMENDATION

- We recommend ongoing training for primary care providers in mental health and addictions, current mental health and addictions services within the system, and the completion of disability application forms.
- We recommend that primary care clinics hold monthly sessions with a mental health clinician and a peer to help bridge the gap between patients and mental health services.
- We recommend that resource lists for primary care providers are more comprehensive (especially concerning disability forms) and always kept up to date.

HOW WE HELP

In response to this barrier, Peer Navigators coach participants on how to communicate effectively with primary care providers. We share our own challenges in this area and explore strategies to improve communication. This may involve writing notes, role-playing, recording symptoms and side effects, and utilizing strategies to ease anxiety. Occasionally, we attend the initial appointment with a new provider to provide moral support and help alleviate anxiety. When participants have serious concerns about the way they have been treated, we can assist with filing a complaint and/or attaining a new provider.

TRENDS

Accessing adequate mental health care from a primary care provider continues to be a significant challenge for program participants.



3. Risk Assessment



Risk assessment continues to be a barrier for our participants. The Peer Navigator team often refers participants to clinical services, where they receive an initial assessment from mental health clinicians. Many participants are classified as low-risk because they are passively suicidal, even though they are experiencing acute distress. They are often referred to groups at Outpatient Psychiatry. Participants report that the wait time to get into groups can be up to a year. Researchers have suggested that nurses, social workers, and general practitioners perform a gate-keeping function, wherein they screen out services that are deemed unnecessary for particular patients (Dawber, 2014). Competing pressures and limited resources force gatekeepers to make tough decisions about eligibility based on first impressions and limited clinical information. In response to these pressures, clinicians are faced with having to resort to a flawed triage system based on risk assessment. Crucial decisions about who gets through the

gates and how quickly should not be made according to risk assessment and management procedures that are not supported by research findings.

Research has demonstrated that suicide risk assessments have a very low predictive value (2-4%) (Owens, Wood, Greenwood, Hughes & Dennis, 2005; Powell, Geddes, Deeks, Goldacre, & Hawton, 2000). Further evidence has also shown that the majority of suicides occur among those that have been assessed as low or moderate risk (Powell et al., 2000). We believe that risk assessment can serve as a helpful starting point to engage consumers in conversations about safety; however, given the lack of evidence supporting the technique, it should not be used on its own to make clinical decisions, particularly decisions related to access to care. The current reliance on risk assessment categories is a significant and unnecessary barrier to care.

Citing a number of studies, Wand, Isobel and Derrick (2015) wrote, “despite acknowledged risk factors for harmful acts such as suicide and violence, there is no evidence that identifying and responding to risk factors is useful in predicting, preventing or reducing risk of harm” (p. 148). In spite of this, 65% of the mental health practitioners that were surveyed supported the statement that there “is good evidence that risk assessment and management practices are effective in reducing risk in mental health care” (p.147). This false confidence in risk assessment runs contrary to evidence-based practice and may impede the development of positive relationships between providers and mental health consumers. The authors suggest that health authorities have a duty to inform providers about the lack of evidence for risk assessment practices and the culture of blame that it promotes in health services.

RECOMMENDATION

- We recommend that health authorities explore alternative approaches to assessing new patients that are more effective and evidence-based. Based on Undrill’s (2007) suggestion, risk assessment should be a “consensual process, with the patient and clinician striving towards a common language and conceptualization of the risk, then deciding how best to manage it” (p. 296).
- We recommend that all clinicians are educated on the lack of evidence supporting current risk assessment processes.

HOW WE HELP

While we cannot change the way assessments are conducted within the system, we can coach individuals on self-advocacy, validate their experiences, and conduct our own assessments in a more person-centred manner.

TRENDS

The AAC has provided many program participants that may be classified as low risk with quicker access to services.



Lynda's story

A Peer Navigator meets with Lynda for an intake. Lynda is quite hesitant about opening up, just touching on a couple of issues, such as her ID and income. Lynda's Peer Navigator tells her about their own lived experience with mental health issues. This makes Lynda feel a bit less intimidated so she shares a bit about her anxiety and depression. The Peer Navigator asks Lynda what her priorities are. She identifies income, housing, and getting ID as her main priorities. They schedule a follow-up appointment for the following week...

4. Health Assessment Approach

Our participants continue to express dissatisfaction with clinical assessments that are conducted in a rushed, interrogative style. Participants have identified how difficult it is for them to open up in these settings. Researchers have written about the crucial role that fear plays in the experiences of people within the mental health system (Sweeney, Gillard, Wykes & Rose, 2015). Sweeney et al. (2015) suggested that this may occur as fear of being arrested, hospitalized, or given forced treatment. Fifty-two percent of our BACE respondents reported that “fear of being put in hospital against my will” was a barrier for them accessing care. Seventy-seven percent of respondents indicated that “feeling embarrassed or ashamed” was a barrier to getting treatment. Given the prevalence of fear and shame, it is crucial that clinicians are sensitive in how they ask intake questions, which are often very personal and invasive. Our participants report that these questions are not always asked in a kind and dignifying way, which causes many to answer untruthfully and conceal how they are feeling due to fear. Program participants often disclose suicidal thoughts to us, and report that they would not disclose the same to a clinician.

Researchers have suggested that one of the core components of mental health assessment is engaging with the client and putting them at ease by “normalizing the process of assessment to demonstrate empathy and to relax the patient so that they feel comfortable discussing often-difficult issues” (Coombs, Curtis, & Crookes, 2012, p. 100). Expressing empathy in a calm manner and providing clear information about the treatment process would help individuals to open up more readily to clinicians regarding their symptoms.

52% 
of respondents
FEARED
being put
in hospital
AGAINST
THEIR WILL

77% of respondents felt
EMBARRASSED
or **ashamed** 



RECOMMENDATION

- We recommend that Vancouver Coastal Health provide training to increase health providers' awareness of how difficult the current assessment approach can be for clients. Further, this training should include evidence-based assessment approaches that are more effective at putting clients at ease.
- We encourage clinicians to verbally acknowledge the immense amount of courage that it takes for individuals to ask for help.
- We encourage clinical staff to consider applying some of the strategies that Procter et al. (2015) proposed for building trust:
 - adapting communication techniques to the needs of the individual,
 - adopting an honest approach,
 - facilitating choice,
 - working with others that the individual trusts,
 - portraying genuine care, and
 - offering practical assistance with other issues beyond mental health.

While clinicians may not have time to use all of these strategies, they provide some helpful ideas for engagement. In particular, our participants have highlighted that honest communication and an acknowledgment of the impact of extraneous factors on their mental health (such as income and housing) would be helpful for them in engaging with clinicians.

- We recommend Vancouver Coastal Health explore the possibility of integrating peers into the assessment process. Peer staff are particularly effective at normalizing mental health concerns and putting clients at ease.

HOW WE HELP

Peer Navigators provide peer support to help participants cope with the difficult assessment process. We find that our peer perspective allows participants to disclose difficult information more easily. Based on this, we can conduct our own assessments to explore participant needs. Even with these supports, many are discouraged by clinical assessments and choose not to continue with care. The Peer Navigator Program also plays a role in educating clinicians on this topic, which will hopefully lead to change over time. Peer Navigator staff have co-facilitated training sessions for VCH clinicians and administrative staff, as well as Occupational Therapy students.

TRENDS



Peer Navigator staff have observed clinicians at the AAC conducting assessments in a more patient and dignifying manner.

Lynda's story



At their next session, Lynda's Peer Navigator shows her the Income Assistance website (MySelfServe) and notes a few things - Lynda needs her ID before she can apply for Income Assistance and with her part time job making \$800 this month, she makes slightly more than the threshold of \$610 per month so she cannot apply at this time. Lynda talks to her Peer Navigator about getting her ID. She says she will double check whether her mom has a copy of her birth certificate. Lynda's PN also walks her through the BC Housing website and application, noting the extremely long waitlist for housing. They also do a quick housing search on Craigslist, Kijiji, and Pad Mappers, and make a plan for Lynda to continue searching on her phone...

5. Presentation

One of the most common barriers that our program participants report is that they are assessed by clinicians based on the way that they appear during a short interview session, particularly on superficial characteristics, such as their hygiene, dress, tone of voice, facial expressions, and/or body language. Our participants report that clinicians are not always considerate of the range of factors that influence their presentation, such as introversion, social anxiety, difficulty talking about one's feelings, cultural background, and fear impact presentation and can cause people to conceal their problems.

Many program participants report that they have learned to hide and minimize their symptoms in order to present well and avoid stigma. This coping mechanism can carry across to meetings with professionals, where many individuals present as more well than they really are and struggle to open up about how they are truly feeling.

Seventy percent of BACE respondents reported that "being too unwell to ask for help" was a barrier to accessing care. Fifty-seven percent of our respondents reported that "dislike of talking

about my feelings, emotions or thoughts" was a barrier for them. This is consistent with research suggesting that individuals who are quiet and do not challenge practitioners are more likely to be dismissed or lost in the system (Wright, Rowley, Chopra, Gregoriou, & Waring, 2015).

Participants report that their experiences affect their ability and willingness to open up, particularly experiences with health care providers. Research has demonstrated that concealment and disclosure are influenced by past experiences with disclosing to health care providers, wherein negative experiences lead them to conceal and positive experiences lead them to disclose more readily (Bril-Barniv et al., 2017). In particular, experiences of rejection after disclosing promoted fear of rejection and further concealment. Along the lines of Bril-Barniv et al.'s (2017) study, sixty-two percent of our BACE respondents reported that "having had previous bad experiences with professional care for mental health" served as a barrier to accessing care and many report that this prevents them from disclosing information to service providers.

70% of respondents reported that "being too **unwell** to ask for **help**" was a barrier to accessing care.



Lynda's story



Lynda tries to go back to work for a few shifts to earn some money, but has several panic attacks while at work so is told to take more time off. She is running out of money, which is triggering more anxiety attacks. At their next appointment, Lynda's Peer Navigator refers her to the Access and Assessment Centre at Vancouver General Hospital to address her anxiety attacks. Lynda is afraid that she will be hospitalized but she is desperate to go back to work, so she makes a call to the AAC...

RECOMMENDATION

- We encourage physicians and other mental health care providers to give more value to the descriptions of symptoms that occur outside of the brief time-limited clinical assessment. These descriptions are often provided by our program participants themselves, family, friends, and support workers who know them well.
- We encourage clinicians to engage clients in conversations about how social factors, oppression, discrimination, and stigma have influenced them and their experiences with mental health issues. Accordingly, the Peer Navigator Program emphasizes that mental health consumers are experts on themselves and, as such, should be wholly included in all stages of their care.
- We recommend that mental health providers “initiate discussions with their recipients of services about disclosure and concealment practices and the related communication norms in their family of origin” as proposed by Bril-Barniv et al. (2017), given that those from families that value openness tend to disclose more readily, and those from families that conceal and minimize negative circumstances tend to conceal their illness. We would also recommend that practitioners ask participants about their experiences in the mental health system. This would provide practitioners with crucial information about the way their participants' present and whether they are concealing their distress.

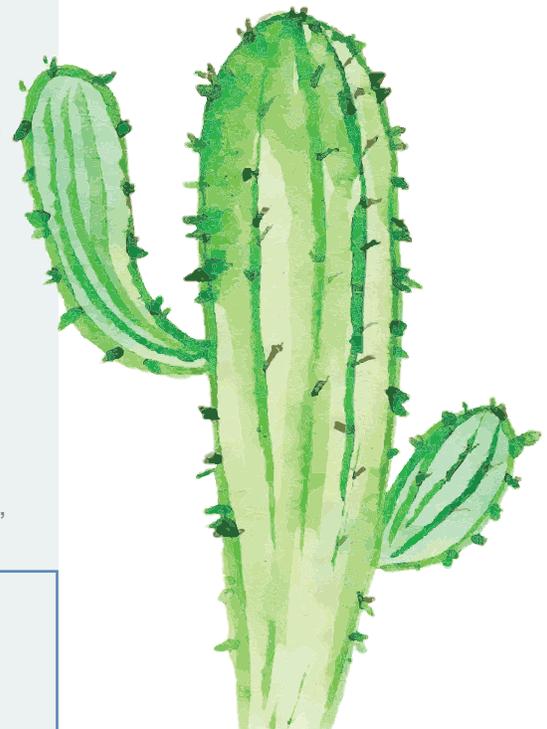
HOW WE HELP

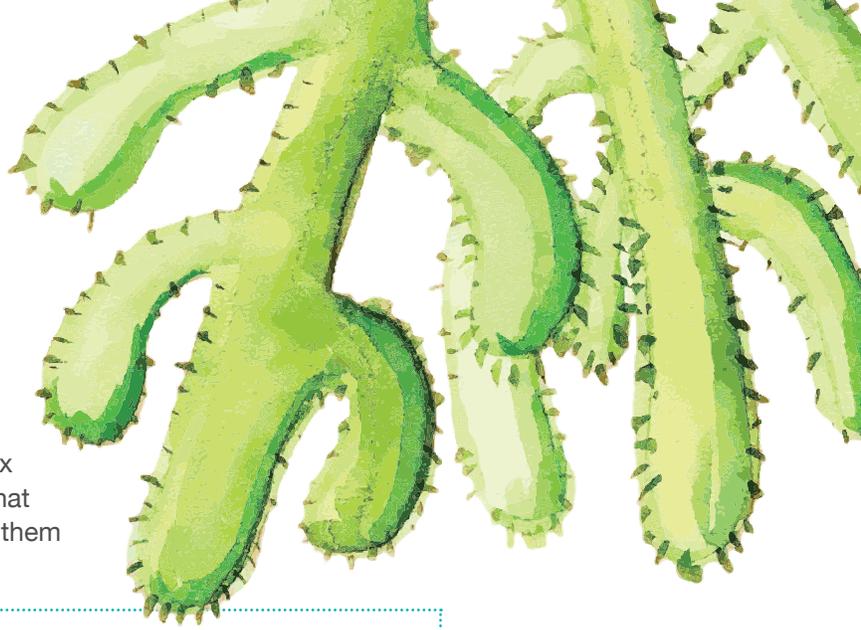
Peer Navigators take the time to listen to participants' stories and explore their beliefs and cultural backgrounds. We facilitate open discussions on how social factors, culture, oppression, presentation, and communication styles have shaped their experiences with mental health and addictions concerns. Participants report that this helps them develop more insight into their situation and empowers them to move forward in their recovery journey. It also provides a more accurate picture of their experiences. Again, Peer Navigator staff play a role in educating clinical staff on this barrier.

TRENDS

Program participants continue to report that they are assessed based on their external presentation.

57% 
of respondents
DISLIKED
TALKING
about feelings,
emotions or thoughts.





6. Navigation

Health and well-being are complex issues. As such, it makes sense that the systems designed to address them are equally complex.

90% of respondents **DIDN'T KNOW** where to go to get mental health care



The complexity of public and community resources continues to be a significant barrier for program participants. Ninety percent of our BACE respondents indicated that “being unsure of where to go” was a barrier to them receiving mental health care. Seventy-six percent reported that “having no one to help them get professional care” was a barrier to accessing services. Service providers are often unable to keep up with resources that are continually changing, which prevents them from giving out accurate information. Many

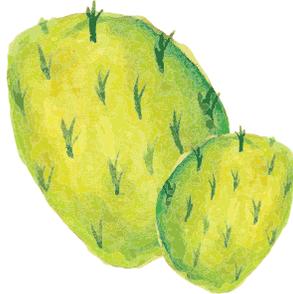
programs have strict eligibility requirements, which force participants to go to numerous places to find services. Some are not eligible for any of the services they attempt to connect with, and are left without service. Most of the mental health programs we know of require a referral from a primary care physician or psychiatrist and a psychiatric diagnosis. In light of the wait times to get a psychiatric diagnosis, many people are unable to access services.

Lynda's story



At the AAC, Lynda is assessed by a nurse who asks her if she has a GP. Lynda answers no and the nurse tells her to get one. Lynda's fear and anxiety prevent her from opening up because the nurse is not a peer and she does not feel comfortable. The nurse refers Lynda to OPT, and says to Lynda that there is a long wait list. Lynda leaves feeling very discouraged. She asks her mom about her birth certificate, but her mom says she does not have it...





 **76%**
of respondents had
NO ONE
TO HELP THEM
get professional care

The new Access and Assessment Centre [AAC] has helped significantly with this barrier. It acts as a central intake hub for mental health services and refers individuals to appropriate services. Unfortunately, due to many of the barriers outlined in this report, not everyone is able to access appropriate supports through the AAC and many have to look elsewhere.

Some program participants have tried to get onto mental health teams and been told that teams are only for people with psychotic illnesses, such as schizophrenia and type I bipolar disorder. Service providers have informed Peer Navigator staff that teams are now taking on more diverse clients, but our participants still report being told that they are ineligible for mental health teams because they do not have a diagnosis involving psychosis. This indicates that, in practice, some decisions about eligibility are still based on diagnosis. Research has demonstrated that illness severity, course, and prognosis are determined by distress, dysfunctions, and disabilities rather than diagnosis (Sanderson & Andrews, 2002).

RECOMMENDATION

- Service/program eligibility should be determined by participant need and program fit instead of diagnosis.
- We recommend that eligibility requirements for programming be broadened, so that individuals are not passed from service to service.
- We also recommend ongoing training for service providers on the various services and resources available in the community. This should include an orientation to the Peer Navigator program as a resource to assist with navigation.

HOW WE HELP

The Peer Navigator Program is designed to help address this barrier. We provide referrals to resources, develop navigation plans, assist with goal setting, provide practical information and bridge participants to relevant service providers. Our services are low-barrier and accessible to anyone that identifies as having mental health and/or addictions concerns. Thus, we can provide navigation services to those just beginning to access resources and those that are not eligible for other programs.

TRENDS

 The complexity of resources in Vancouver continues to be a challenge for our participants.



7. Emergency Services

Program participants have reported that the AAC is an enormous improvement over the Emergency Department in terms of mental health care. In spite of this, emergency services, including the AAC, still present a barrier to some of our program participants. Some participants have reported that their interactions with AAC staff and emergency services staff have been stigmatizing and dismissive. Even when Peer Navigator staff recommend participants access the AAC or the ER, a number of participants have been sent away without support or resources. Negative experiences with emergency services have led many program participants to avoid accessing emergency care, even when in crisis. Sixty-two percent of respondents to the BACE reported that “having had previous bad experiences with professional care for mental health” prevented them from accessing care.

Our participants’ experiences are consistent with prior research indicating that patients presenting with mental health issues tend to be triaged as less urgent than general medical patients (Clarke, Brown, Hughes, & Motluk, 2006). In a Canadian study, researchers found that almost 50% of mental health patients that were classified as non-urgent by triage nurses actually required hospitalization (Clarke et al., 2006). In a nation-wide study carried out by the Mood Disorders Society of Canada (2011), 50% of individuals who had visited the ER due to mental illness indicated that they were moderately to extremely dissatisfied with the care they received.

RECOMMENDATION

We recommend the inclusion of peer staff in emergency services.

HOW WE HELP

When program participants are in crisis, Peer Navigators use empathetic response and active listening strategies. We look for alternative ways of getting needs met in addition to the Emergency Department. When individuals do access Emergency services, we provide coaching to empower them in these settings. One of the ways that we help individuals develop self-advocacy skills is through Wellness Recovery Action Plan (WRAP) and PeerZone workshops, which provide useful frameworks to aid individuals in taking an active role in their care. Unfortunately, even with our support, it is common for our participants to report negative experiences with emergency services. We can provide peer support in these situations and assist with filing complaints.

TRENDS



The AAC is open 24/7 and provides mental health specific emergency care, which can be an alternative to waiting in the Emergency Department.



8. Transportation

In September of 2016, the Ministry of Social Development and Social Innovation (MSDSI) provided a monthly increase of \$77 to recipients of Persons With Disabilities (PWD) Benefits, which was mostly clawed back by an increase to \$52 per month in the cost of the program's annual bus pass. Many individuals who we serve struggle with getting to services and appointments because they cannot afford to pay for transit. While Canada Revenue Agency provides a tax credit for monthly bus passes, individual tickets remain prohibitively expensive. Some of our program participants have no other option but to cheat their way onto transit, exposing themselves to the risk of being fined and to the stress of conflict with the law. The BACE survey of program participants for 2016-2017 indicated that 77% of respondents faced problems with transport or travelling to appointments that reflected a barrier to mental health services.

77% 

of respondents
faced problems with
TRAVELLING
to appointments

RECOMMENDATION

We recommend that MSDSI provide annual bus passes at no cost for all individuals in receipt of Employment Assistance, PPMB and Hardship income assistance programs in addition to the already subsidized bus passes for Persons With Disability assistance recipients.

HOW WE HELP

Our program can provide a limited number of bus tickets to help with transportation to and from our appointments. We can also assist those that are eligible with getting a subsidized bus pass. Sometimes we refer individuals to Our Community Bikes for low cost or free bikes, though there is a wait-list for this resource. If required, we can help participants apply for mobility aids or HandyDART.

TRENDS

Changes to the annual bus pass for people receiving Persons with Disabilities benefits were confusing for many of our participants. Transportation continues to be a significant barrier for participants.

9. Counselling

Even though counselling is an evidence-based basic intervention for mental health concerns, it is not covered by the Medical Services Plan of BC (MSP). A significant number of our program participants would like to access psychotherapy but are unable to afford to pay for it. Ninety-one percent of our participant BACE sample indicated that “not being able to afford the financial costs involved” was a barrier to accessing care. Interestingly, our program participants reported being able to easily access addictions counselling, and that this form of counselling is funded through health authorities (though they do report there are significant barriers to accessing other addictions supports). In a study of approximately 25,000 Canadians, regardless of the mental health or substance use disorder, counselling was the most commonly reported mental health need (Sunderland & Findlay, 2013). Counselling should be accessible to those with mental health and addictions concerns. Research demonstrates considerable cost savings to government when counselling is integrated into mental health services (Cohen & Peachey, 2014).

91% of participants couldn't AFFORD financial costs involved. 

RECOMMENDATION

We recommend that evidence-based counselling services be covered by the Medical Services Plan of BC.

HOW WE HELP

The Peer Navigator Program maintains a list of low cost and free counselling services. Unfortunately, many on the list are still not affordable to our participants. Those that are typically have long waitlists and/or offer very few sessions. In addition, many have strict eligibility requirements. We can also refer participants to groups that are free or more affordable; however, these resources are still not affordable to our participants and may only provide partial care.

TRENDS

Staff have observed that the waitlists for many of the low cost and sliding scale counselling options have increased.

Lynda's story

Lynda asks her Peer Navigator for help finding a GP. Lynda's PN recommends a few community health centres for her to try. In terms of housing, Lynda has been looking on craigslist but cannot find anything in her price range. They talk about a few non-profit housing organizations...



10. Dental

In addition to a number of significant health-related consequences of poor dental care, lack of access to dental care also contributes to self-esteem issues and lowers quality of life (Chen & Hunter, 1996). This in turn affects individuals' ability to advocate for themselves. Those on PWD and PPMB receive limited dental coverage. Seniors in receipt of Old Age Security and Canada Pension Plan benefits, however, often have no dental health care coverage and face complex dental health issues that come with aging. This often means that seniors must opt to have teeth extracted because they cannot afford anything else.

RECOMMENDATION

- We recommend that the Provincial Government provide dental subsidies to low-income individuals, particularly seniors, that receive Medical Services Plan [MSP] premium assistance. This could be implemented in the same way as the Healthy Kids Program, which provides up to \$1,400 in dental coverage every two years to children of low-income families that receive MSP premium assistance but no benefits through MSDSI.
- We recommend that the dental subsidies provided to individuals receiving PWD Benefits and PPMB be increased.

HOW WE HELP

Peer Navigators refer participants to resources for low-cost dental care such as the UBC Dental Clinic, Mid-Main Dental, Reach Dental Centre, and Portland Community Clinic Dental. We also educate participants that are on Persons with Disabilities (PWD) income assistance about the limited dental supplements they can access. Many of these resources are still not affordable to our participants and may only provide partial care.

TRENDS

Many program participants, particularly seniors, continue to suffer from the absence of dental coverage available to them.

Lynda's story

Things continue to unravel in Lynda's life. She has a huge fight with her mom about her birth certificate and her mom kicks her out and tells her not to come back. She stays on and off with a few friends, but they are getting tired of her staying with them. She tries to stay up all night, but winds up sleeping in doorways for a couple of nights. Due to lack of stability and sleep, Lynda's mental, emotional, and physical health are deteriorating quickly. She is desperate for money so drops in to see her manager. She goes to a drop-in centre to shower and reassures her manager that she is doing better in order to get some shifts. Her manager schedules her in for a few shifts but, without sleep, she misses all of them and is laid off. A friend tells her about a shelter that is outside of the Downtown Eastside (DTES), so she goes there and is able to get a bed in a dorm...

11. Medication

Many of the individuals that we serve are struggling with low incomes. As a result, they often cannot afford to pay for their medication. There are two programs in BC that can help people to access medications: Fair Pharmacare and Plan G.

Applying for Fair Pharmacare requires that applicants have their income tax returns up to date. Many individuals we serve have been unable to organize themselves to get this done for various reasons. Due to homelessness, stress, mental illness, isolation, and lack of resources their taxes remain unfinished. In addition, many do not know that Fair Pharmacare exists; they report that their doctors are either unfamiliar with or fail to recommend them to the program.

Plan G, which provides insurance coverage for psychiatric medications, requires a physician to sign the application. Many of our program participants were not informed about Plan G until we made them aware of it, and some of our program participants encountered challenges with their primary care professional being unwilling to sign the application form or charging fees to do so. In addition, some medications are not covered under either program. It can be difficult to get special authority to cover these medications, and often participants are forced to switch to cheaper medications first in order to rule them out. Such medication changes can be very destabilizing for the individuals that we serve, and can be a major setback.

RECOMMENDATION

We recommend that Vancouver Coastal Health increase the number of professional and public education sessions about medication subsidies. Perhaps, info about medication subsidies can be displayed in medical waiting rooms and at pharmacies in order to increase awareness.

HOW WE HELP

Peer Navigator staff make participants aware of Plan G and Fair Pharmacare. We often provide participants with a copy of the Plan G form to take to their doctor. We also assist them with the application for Fair Pharmacare. Many are placed on brand-name medications, and are not aware that generic (and cheaper) options exist. We suggest that participants discuss generic options with their doctors and pharmacists. If a special authority request needs to be submitted to attain covered medications, we can assist with the process. We also provide coaching on how to discuss the affordability of medication with doctors and pharmacists.

TRENDS

Education surrounding medication coverage options is still not consistently provided to many of our program participants.

Diagnosis



1. Wait Times

The Canada Health Act mandates that all Canadians have access to timely treatment for all health care issues regardless of their income and ability to pay (Canadian Medical Association, 2007). Many of our participants have been placed on long wait lists to get an assessment from a psychiatrist, and are not able to access timely treatment. Many require an assessment in order to complete the physician portion of disability benefits applications. Because of the long wait, it is common for our participants to be left without an income for long periods of time. This often leads them to lose their housing. The lengthy wait times create stress and cause participants to lose hope, which in turn worsens their condition.

In reviewing the listings on the College of Physicians and Surgeons website, Peer Navigator staff counted 336 psychiatrists practicing in Vancouver, which is up from the 297 counted in 2011 (Goldner, Jones & Fang, 2011). Given Vancouver's population and the high incidence rate of mental illness (20%; Smetanin et al., 2011), the supply of psychiatrists is not sufficient to meet the demand, resulting in long wait lists. In a nationwide study conducted by the Mood Disorders Society of Canada (2011), 35% of consumers had to wait more than 12 months to get a diagnosis.

Research demonstrates that increasing psychiatrist supply may not be enough to solve access problems. A study in Ontario found that areas with higher numbers of psychiatrists per capita did not necessarily have shorter wait-lists to see a psychiatrist (Kurdyak et al., 2014). In well-supplied areas, psychiatrists had far smaller caseloads and saw these patients more frequently than in poorly supplied areas. The United Kingdom and Australia have made several modifications to increase access for new patients wherein psychiatrists function primarily as consultants and ongoing care is provided by psychologists and other health care workers. These providers are covered by public insurance. This set-up improves access for new patients seeking diagnosis. It also comes at a lower cost than funding psychiatrists to provide ongoing care because psychiatrists cost more per hour than other providers do.

RECOMMENDATION

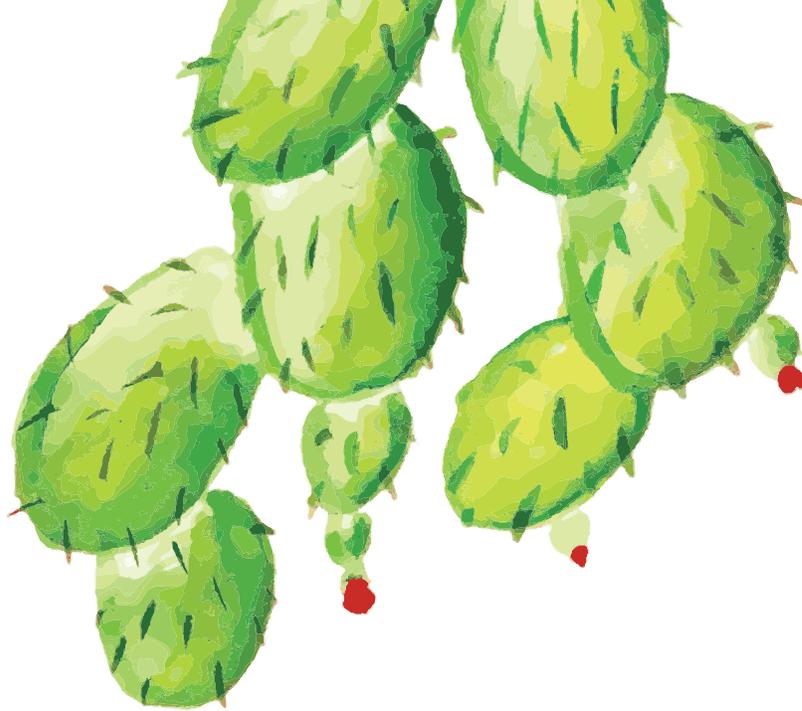
- We recommend that more psychiatrists be trained and hired.
- We recommend that clinical psychologists be hired in greater numbers to supplement the supply of trained diagnosticians. These providers could also take on some of the ongoing care work currently provided by psychiatrists, and free up psychiatrist time to focus on diagnosis and consultation.

HOW WE HELP

We provide peer support to those waiting for services, and can help explore coping strategies to use in the meantime. If participants are unable to wait, we refer them to rapid access services such as the Access and Assessment Centre and the Mood Disorders Association Adult Psychiatry Clinic. Unfortunately, even these can have long waitlists. We also coach individuals on how to advocate for themselves to get their needs met on an urgent basis if needed.

TRENDS

The AAC has helped some program participants access an assessment on an urgent basis. However, the waitlists for many community psychiatry programs have stayed the same or increased.



2. Doctor-Client Engagement

Peer Navigator Program participants report that psychiatrists do not always take the time to explain diagnoses or engage with them to explain how they reached their diagnosis, despite participants indicating that they want to be included in the diagnostic process. Some report that they are prescribed medication without being told their diagnosis or potential side effects of the medication. Even though it may be contrary to physicians' code of ethics and perception of their practice (Canadian Medical Association Code of Ethics, 2004), those we work with very commonly express this experience. Some participants are lucky enough to have collaborative relationships with their psychiatrists, but many others are not. Accordingly, past research has highlighted that stigma is enacted through "poor communication, negative prognoses, and failures to describe options and potential side effects of medications" (as cited in Stromwall, Holley, & Bashor, 2011, p. 473).

Not only is it dangerous for individuals to be on medication without proper instruction, but it can seriously impair people's ability to move forward. Eighty-one percent of our

BACE respondents reported that "concerns about treatments available (e.g. medication side effects)" had been a barrier for them, so this conversation is especially important. Many program participants report that often they were given their diagnosis after only one appointment. Many feel that their psychiatrists do not know them well enough to decide on a diagnosis after one session. Often participants would prefer to engage in an ongoing conversation about diagnosis in order to understand their condition, and to participate more actively in treatment. Participants report that this lack of engagement leaves them unable to move forward in their recovery.

81% 
of respondents were
CONCERNED
about treatments available

Lynda's story

After being laid off from work, Lynda starts to fall apart. She drops in to see her Peer Navigator in crisis. She still has no ID, so they work on getting her ID together. She has a tiny bit of money left to spend to cover the delivery fee to get her birth certificate. The PN and Lynda also start the online application for Income Assistance. Lynda's Peer Navigator asks if she wants to indicate on the application that she will be applying for disability benefits. Lynda does not want to see herself or have others see her as "disabled", so she says no. They have a conversation about disability, which makes Lynda feel a bit better about getting the help she needs. With all this, Lynda has been feeling suicidal. The PN asks if she would be open to talking to the AAC and they make the call together...

RECOMMENDATION

- We recommend that Vancouver Coastal Health, the College of Physicians and Surgeons, and medical schools adopt Callard's (2014) recommendations, in which psychiatric diagnosis is viewed as a collaborative process that includes consumers in a conversation over time, instead of being a one-sided assessment. This may involve psychiatrists seeing clients for more than one session before providing a diagnosis.
- We recommend that Vancouver Coastal Health expand the use of Registered Clinical Psychologists to assist with the diagnosis process as this may allow the diagnostic professional to spend more time with each client.

HOW WE HELP

When the individuals we serve experience this barrier, we typically engage them in a discussion about it. Often this involves sharing our own experiences of being excluded from the diagnostic process, as well as our experiences of being treated as active partners in our care. We often engage in dialogue about the experience of being diagnosed, and receiving a psychiatric label. Through this dialogue, we may brainstorm strategies for self-advocacy and self-management. We also increase consumer engagement through psychoeducation. For example, we facilitate Wellness Recovery Action Plan (WRAP) workshops. In addition, we educate participants on their right to ask questions about their diagnosis and treatment. We may also recommend or provide relevant reading, resources, and worksheets. Further, we may refer our participants to consumer resources such as Gallery Gachet, National Empowerment Center, the Icarus Project, and the Hearing Voices Network.

TRENDS



Engagement with psychiatrists continues to be a challenge for program participants.

3. Reluctance to Re-assess

Some program participants have asked clinicians about the possibility of misdiagnosis or a change in their condition over time, and have reported they were denied access to a re-assessment. Even though all health care consumers should have a right to a second opinion (Canadian Medical Association Code of Ethics, 2004), many participants report being told that they have already had an assessment recently and do not need another one. Clients also report that certain stigmatized diagnoses are treated as permanent, particularly Borderline Personality Disorder, despite research that suggests that personality disorders are no more stable over time than anxiety disorders, and thus may merit reconsideration (Durbin & Klein, 2006).

RECOMMENDATION

As noted above, we recommend that the supply of psychiatric diagnosticians be supplemented with Registered Clinical Psychologists.

HOW WE HELP

When Peer Navigator participants experience this barrier, we typically talk about their right to a second opinion and the complaint process they can access if they wish to.

TRENDS

Participants continue to report being unable to access a re-assessment.

Lynda's story

Lynda speaks with a social worker, who asks her to come in the next day for an assessment. She is afraid to go back to the AAC after last time but is desperate for help, so goes anyway. Her Peer Navigator gives her some bus tickets to get there and back. The social worker at the AAC asks her lots of personal questions about her suicidal thoughts, her family history, and the trauma she experienced as a child. She is triggered by the conversation but forces herself to open up. The social worker books her in to meet with a psychiatrist the next week. She meets with the psychiatrist for a 50-minute session. The psychiatrist seems rushed, so she does not tell him everything about her history of trauma. After the session, the psychiatrist tells her that she has Generalized Anxiety Disorder, Major Depressive Disorder, and Borderline Personality Disorder. He prescribes her a medication and refers her to Outpatient Psychiatry for group treatment...

Treatment

1. Gaps in Service

Program participants have stressed that gaps in the system are very common, especially for people who do not fit neatly into the parameters of the services available. Consistent with this, Canadian studies have demonstrated that a large proportion of those that require mental health care do not receive treatment (Kohn, Saxena, Levav, & Saraceno, 2004). In particular, 45% of those with Major Depression, 62% of those with Bipolar Disorder, and 40% of those with Generalized Anxiety Disorder did not receive treatment in a series of Canadian studies (Kohn et al., 2004).

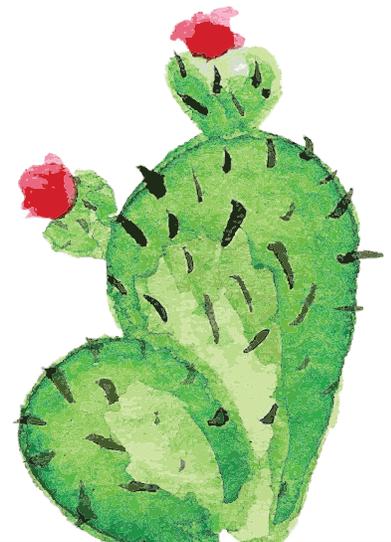
There are very few psychiatric services for individuals diagnosed with anxiety, bipolar disorder, and depression that are not group-based. Many of our participants do not attend groups because of social anxiety, or because they do not find the groups to be helpful for them. Others do attend but feel they require more support, particularly in monitoring medications. Most of the groups offered are short-term and leave individuals with no support after completion.

A number of our participants have reported experiences of discrimination based on their diagnosis of Borderline Personality Disorder. Along these lines, researchers have found that psychiatric nurses tended to perceive service users with Borderline Personality Disorder negatively, and display lower levels of empathy to them than to those with schizophrenia and depression (McGrath & Dowling, 2012; Koekkoek, Meijel, Schene, & Hutschemaekers, 2009). Most of our participants with Borderline Personality Disorder diagnoses have struggled to get into treatment, even though research has established that Dialectical Behavioural Therapy [DBT] is extremely effective for those with the diagnosis (Koekkoek et al., 2009).

The Peer Navigator Program is not aware of anywhere that their participants can access free or low-cost DBT without long waitlists. Accessing DBT privately is unaffordable for most of our participants. Given the high rate of suicide and the intensive use of mental health services amongst people with this diagnosis, appropriate treatment programs are essential (Koekkoek et al., 2009).

Researchers have recommended that individuals with this diagnosis be considered a special subgroup, wherein professionals working with them require specific training, more direct support, more indirect support (such as care guidelines) and a better organizational structure (such as shared caseloads and specialists that are easy to access) (Koekkoek et al., 2009).

In addition, a very large proportion of Peer Navigator participants have experienced trauma. We are not aware of any trauma-specific mental health services funded by the health authority. Individuals that struggle with PTSD or Complex PTSD may benefit from a variety of treatments, but are unable to get the help they need.



Lynda's story

With the long waitlists for housing, a GP, Income Assistance, and Outpatient Psychiatry hanging over her head, Lynda goes out to a friend's party. She takes something that is laced with fentanyl and wakes up in the hospital after overdosing. While in the ER, a clinician sees the diagnosis of Borderline Personality Disorder on her health record and her history of drug use. She stigmatizes Lynda as an "addict" and discharges her back to the shelter. Lynda is starting to lose hope and is feeling fed up with the system. She continues to party to take her mind off things and have a place to crash at the end of the night. She is still struggling to sleep and is becoming increasingly paranoid...

RECOMMENDATION

- We recommend that the eligibility criteria for mental health teams be changed to be based on participants' needs as the primary factor rather than diagnosis.
- We recommend that more individual-based programs (programs that are not group-based) be developed and implemented for those who are not ready or able to participate in groups.
- We recommend that programs be developed that combine individual and group sessions to support those that struggle with group settings.
- We encourage Vancouver Coastal Health to create specialized easy-to-access treatment programs for individuals diagnosed with Borderline Personality Disorder.
- We recommend the development of specialized trauma programming to meet the needs of individuals who have histories of trauma.

HOW WE HELP

Gaps in service are an enormous barrier for those that we work with. The Peer Navigator Program can provide emotional support to participants and help them to search for alternative services. Beyond this, we can provide feedback to the system about the gaps in service that our participants experience, which is one of the reasons for the creation of this report.

TRENDS

Gaps in service continue to inhibit our program participants from getting the support they need.

2. Physical Health

Program participants report that their mental health diagnoses serve as a barrier to physical health care. Many of the individuals we work with have chronic physical health conditions that interact with and aggravate their mental health issues. Participants report that their mental health supports do not always consider their physical health issues, even though they have a strong influence on their mental health.

When seeking treatment for physical health issues, many participants feel they are not taken seriously, due to their mental health diagnoses. This has been termed “diagnostic overshadowing”, where a mental health diagnosis distracts providers from recognizing a legitimate physical health issue (Chadwick, Street, McAndrew, & Deacon, 2012). Research has demonstrated that inadequate health assessment and treatment leads to a greater risk of physical illness and death among those with mental health diagnoses (Van Den Tillaart, Kurtz, & Cash, 2009). People with mental health diagnoses are also less likely to be referred by health providers for mammography, inpatient hospitalization following diabetic crisis, or cardiac catheterization (Corrigan, Druss, & Perlick, 2014).

People with mental illnesses die, on average, 7-24 years earlier than the rest of the population, even when controlling for deaths by suicide (Chesney, Goodwin, & Fazel, 2014; Lawrence, Kisely, & Pais, 2010). This reduction in life expectancy is as large as, or larger than, that of heavy smokers (8-10 year reduction). Many of these deaths are the result of respiratory and cardiovascular conditions (Lawrence et al., 2010). In this light, it is essential that the health care system address the physical health needs of mental health consumers.

RECOMMENDATION

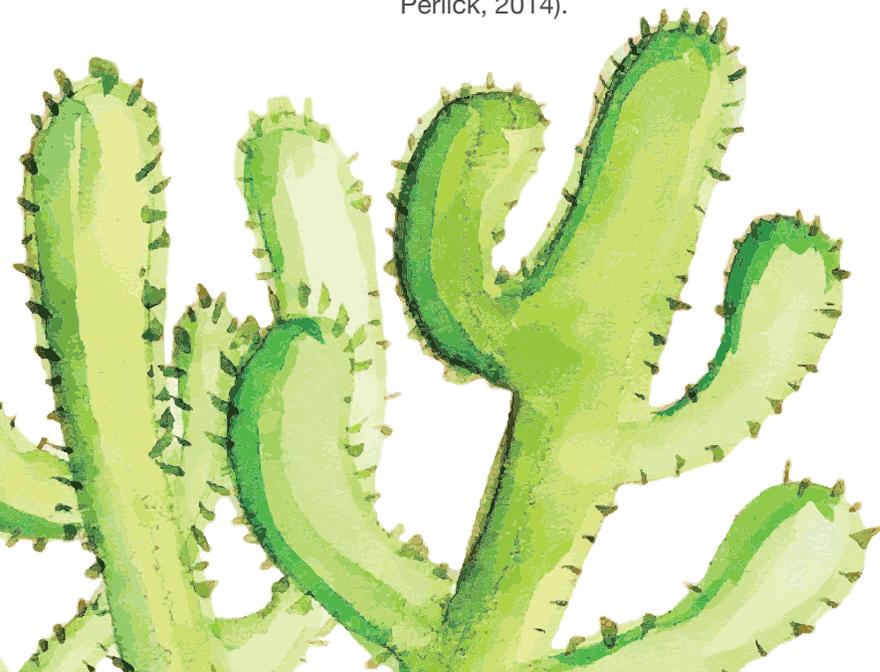
We recommend focusing an anti-stigma campaign around the issue of neglect of physical health issues among mental health patients being served within the larger health system.

HOW WE HELP

Peer Navigators coach individuals on how to communicate with their doctors about their physical health, and how to advocate for themselves in order to have their questions and concerns taken seriously. We can also assist participants with seeking out a primary care provider.

TRENDS

Program participants continue to report that their physical health needs are not being adequately addressed.



3. Mental Health and Substance Use Silos

Participants with concurrent mental health and substance use issues often struggle to receive integrated care that acknowledges the impact of both mental illness and substance use on their wellbeing, even though it is very common for the two to occur together. The mental health and substance use systems have traditionally been segregated. When seeking help for mental health, many are not eligible for programs because of their substance use, or are told that they need to treat the addiction first. When seeking help for addictions, psychiatric symptoms may be ignored. Though there are efforts being made to provide more integrated care, many participants still struggle to get the help they need.

RECOMMENDATION

We recommend an expansion of concurrent disorders services to address the vast need for integrated mental health and substance use care in Vancouver.

HOW WE HELP

We serve many individuals with both mental health issues and addictions concerns. The Peer Navigator team includes individuals with lived experience with addictions as well as mental health concerns, who can provide peer support. We also provide referrals to other community resources that address both mental health and substance use issues.

TRENDS



The Access and Assessment Centre addresses concurrent disorders, and has helped to alleviate this barrier. Participants still struggle to access services that take into account both their mental health and substance use concerns.

Lynda's story



Lynda sees her Peer Navigator a few days later and breaks down. She discloses that she has been feeling paranoid and on edge. She does not know what to turn to other than drugs to numb her emotional pain, but is terrified after the overdose. She cries and states that she wishes the overdose had killed her. The Peer Navigator shares some information about their own suicidal thoughts in the past, which makes Lynda feel a little bit more hopeful that things may get better for her. She says she wants to stop using drugs. They talk about some resources that may be useful for her - trauma counselling, addictions counselling, and Narcotics Anonymous (NA) groups...

4. Informed Consent

Under current mental health law in BC, individuals with mental illness who have been involuntarily committed to hospital under the Mental Health Act do not have the right of informed consent to medical treatment that other residents of the province have (RSBC, 1996). This is also true of individuals placed on extended leave from hospital. Fifty-two percent of BACE respondents reported that “fear of being put in hospital against my will” was a barrier for them. Many of our program participants have complained of not being told what their diagnoses are, what alternative treatments are available to them, and what the side effects of their medications might be, information that is legally required under provincial legislation outlining informed consent. Such an authoritarian approach to treatment may prompt a patient into medication non-compliance as well as undermining trust in the physician/patient relationship.

RECOMMENDATION

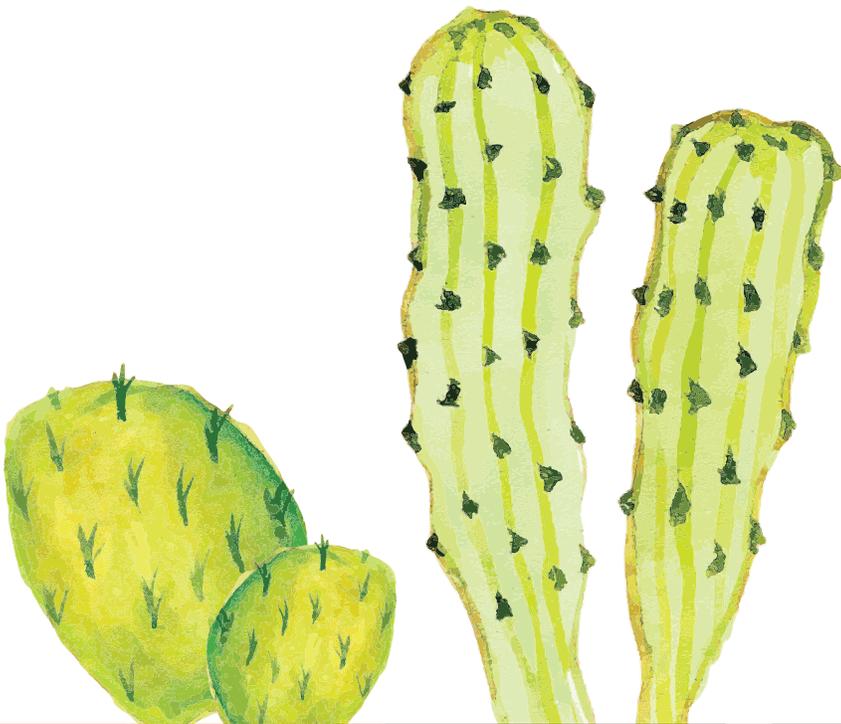
We suggest a review of the possibility of enabling people with a mental health diagnosis to appoint a legal representative to advocate on their behalf under the Representation Agreement Act of BC. The Representation Agreement Act is a piece of personal planning legislation enacted in 2000. At this time, it still excludes individuals committed under the Mental Health Act to all the rights included in the legislation. Provincial legislation needs to be adjusted so that individuals committed to hospital under the Mental Health Act have choice in their treatment.

HOW WE HELP

Peer Navigators coach individuals on proactive and collaborative communication with physicians. We ensure that our participants are aware of their right to informed consent, and what informed consent entails. As such, we can assist with the complaint process if informed consent is not provided, or refer to legal support available in the community such as the Community Legal Assistance Society.

TRENDS

Program participants continue to report a lack of informed consent in their care.



Systemic

Systemic barriers are those that occur broadly throughout most of the mental health and addictions systems. These barriers are embedded within the very fabric of the mental health and addictions systems – in patterns of behaviour, practices, policies, procedures, culture, and program configuration. Because they are not enacted on an individual level, systemic barriers are often covert and difficult to detect. They interact with one another to restrict the opportunities of those suffering from mental health and addictions issues. Their pervasiveness and insidious nature make them difficult to address.

1. Psychoeducation

Many participants reported that they felt that they were left in the dark while on waitlists to access treatment. Some program participants noted that even when they were finally able to see a mental health practitioner, the practitioner did not provide adequate information about their illness, treatment, and recovery. In addition, Peer Navigators have encountered a number of program participants who face language barriers, based on both educational level and English as an additional language.

Research has demonstrated that psychoeducation, particularly in a group setting, is related to lower rates of non-adherence to treatment, lower rates of relapse, fewer hospitalizations, increased social and global functioning, better client satisfaction, and improved quality of life (Lyman, et al., 2014).

Psychoeducation should include a discussion of the positive aspects of mental illness. Discussing the potential positive aspects of mental illness does not necessarily mean minimizing the negative impact that it has on consumers' lives, but rather exploring the nuances of mental health. In a survey of over 3,000 adults with bipolar disorder, only 54% said they would definitely push a hypothetical button that would get rid of their illness altogether (Lobban, Taylor, Murray, & Jones,

2012), which suggests that there are positive elements of the disorder. Focusing wholly on the negative aspects of mental illnesses perpetuates the perspective that they are wholly negative experiences, reinforcing stigma (Lobban et al., 2012). It has been suggested that giving individuals with mental health concerns information about the increased creativity and positive attributes associated with mental illness should be included in standard education about mental illness, in order to help reduce internalized stigma and foster a positive self-image (Johnson, Moezpoor, et al., 2016).

Posttraumatic growth is a term used to describe how individuals may experience growth after a traumatic event, particularly a heightened appreciation of life, the feeling of relating more to others, an exploration of newfound possibilities in life, a sense of personal strength, and spiritual change (Mazor, Gelkopf, Mueser, & Roe, 2016). There is evidence that posttraumatic growth occurs in individuals with PTSD, as well as those that have experienced serious mental illnesses and psychotic symptoms. Highlighting posttraumatic growth, in the right context and without dismissing the severity of people's conditions, may decrease internalized stigma and facilitate recovery from mental health concerns.

RECOMMENDATION

- We recommend that practitioners give their patients information about their diagnoses and treatment plan on an ongoing basis. We recommend that this information includes content on posttraumatic growth and possible positive attributes associated with mental illness.
- We recommend that individuals waiting for mental health and addictions services be given access to peer-run group-based programs, such as the Wellness Recovery Action Plan (WRAP) program and the PeerZone set of workshops.

HOW WE HELP

The Peer Navigator Program emphasizes psychoeducation. We facilitate peer-based groups such as WRAP and PeerZone to encourage consumers to seek out the information they need to stay well.

TRENDS

Program participants continue to report that they are not given educational information about their diagnosis and treatment.

Lynda's story



Lynda gets her birth certificate and is able to get a BCID now that she has it. She is accepted for Income Assistance. Because Lynda is in a shelter, she did not qualify for the shelter portion (\$375 per month) of Income Assistance, so only receives \$235 per month which she spends on food, transit, and counselling. She finds a practicum student for trauma counselling that she really likes. She only gets 6 sessions, on a sliding scale rate, but would not be able to afford counselling otherwise. She gets a call from one of the community health centres she applied to and goes in for her first appointment with a GP. The GP does not know her well but seems well intentioned...



2. Waitlists/Treatment Lag

As discussed throughout this report, waitlists are an enormous barrier for the individuals that we serve. Waiting weeks and sometimes months for access to services is a common experience for many program participants. Sometimes this results in individuals giving up trying to access services from a particular agency. Other times they simply wait to be called while enduring homelessness, financial insecurity, food insecurity and isolation. Waiting for weeks and months for the provision of a given resource also increases people's feelings of powerlessness and worthlessness.

Lynda's story

An outreach worker at Lynda's shelter finds her a place in a Single Room Occupancy hotel on Granville Street. The conditions are poor but she is happy to have some privacy. During all of her recent struggles, she has not had a place to work on her artwork so she is excited to be able to start drawing again. She finds a few cockroaches in her suite, which makes her paranoia even worse. She cannot stop feeling like there are bugs crawling on her while she is trying to sleep. She is trying to stay clean but the only people she has in her life use drugs and she finds it hard to be around them without using. She tries a few Narcotics Anonymous groups to meet people but finds the religious component of the groups to be too much for her and feels alienated based on her sexual orientation...

RECOMMENDATION

- We recommend that clinicians maintain contact with the people on their waitlists to maintain an awareness of client needs over time.
- We recommend that the Provincial Government and Vancouver Coastal Health make reducing waitlists a priority and implement strategies to reduce wait times.

HOW WE HELP

The Peer Navigator team recommend that our participants call services that they are on waitlists for to verify that they are still on the waitlists, and to update staff of any changes in their situation. This can sometimes alleviate some of the anxiety of waiting. We also provide peer support and referrals to alternative services. Waitlists are a tremendous barrier for the people we serve, and unfortunately, our program is unable to resolve this issue.

TRENDS

Through the AAC, some program participants are now able to access a psychiatric assessment relatively quickly. Unfortunately, after the initial assessment, participants report that they are placed on waitlists for group treatments. Many waitlists are getting longer with increased demand.

3. Early Intervention and Prevention

Program participants report that there is a lack of comprehensive early intervention and prevention in mental health care. Many seek services when they begin to become unwell, but are denied service or placed on waitlists until they reach the point of crisis. Often, our participants want to prevent crisis, but are denied access to the supports that enable them to do so. Many state that resources are devoted to crisis intervention, even though it would be more helpful and economical to prevent crises in the first place. As a public campaign that began in the United States and has now been launched in British Columbia indicated, in mental illness as in physical

illness we need to treat the symptoms before they reach Stage 4 (Mental Health America, 2016; see also: <http://www.b4stage4.ca> for the BC-based campaign). This refers to the fact that most physical illnesses are treated before they progress to the most severe stage, and indicates the need for intervention when symptoms of mental illness first arise. Taking a proactive approach promotes quicker recovery, more cost-effective service, and better, more fulfilling lives for those experiencing mental health and addictions concerns.

RECOMMENDATION

- We recommend that the Provincial Government implement all 10 recommendations of the b4stage4 campaign.
- Vancouver Coastal Health's Early Psychosis Intervention (EPI) program has had great success in supporting individuals experiencing their first psychotic episode. EPI programs have been widely successful across Canada for more than a decade (Osuch, Vingilis, Fisman, & Summerhurst, 2016). We recommend the implementation of a similar early intervention program for Mood and Anxiety Disorders, such as the First Episode Mood and Anxiety Program (FEMAP), initiated in London, Ontario (Osuch et al., 2016). The cost to health authorities of not treating mood and anxiety disorders when they first begin is far greater than the cost of an early intervention program, which seems to reduce later Emergency Room visits and hospitalizations (Osuch et al., 2016).

HOW WE HELP

The Peer Navigator program is one approach that emphasizes early intervention to prevent crisis. We see individuals in all stages of recovery and help to build their capacity for self-management. When required, we advocate for participants to receive services in a timely manner within the healthcare system. We also educate clinical staff about the importance of an early intervention and prevention approach. It will take broad systemic change to ameliorate this barrier.

TRENDS

Many participants continue to report that they are unable to access services until they have become unwell enough to need crisis services.



4. Health Care Provider Stigma

Stigma within the healthcare system continues to be one of the most significant and pervasive barriers our program participants face. Sixty-two percent of our BACE respondents reported, “Having had previous bad experiences with professional care for mental health” was a barrier to accessing mental health services. Along these lines, Bates and Stickley (2012) wrote, “Many users of mental health services have identified encounters with health services as being among the most stigmatizing and distressing experiences of their lives” (p. 570). Stigma is linked to inadequate access to proper treatment, the breakdown of therapeutic relationships, and avoidance of health care (Ungar, Knaak, & Szeto, 2016).

Corrigan (2016) wrote about the negative effects of pity and the belief that people with mental illnesses are incompetent, leading to practices that prevent people from pursuing their life goals. All of these mechanisms may occur without providers’ awareness, wherein they believe these attitudes are founded in reality, and therefore justified. Holley, Tavassoli, and Stromwall (2016) highlighted a number of avenues through which this stigma plays out: through condescending and infantilizing speech, disrespectful language, violations of privacy (i.e. asking personal questions in the waiting room), and presumptions about lack of intelligence.

Training mental health providers about the positive attributes associated with mental health conditions could help to change the idea that mental health consumers are

incompetent. Researchers have identified a number of positive experiences associated with mental illness. In particular, perceptual sensitivity, creativity, focus, a greater sense of connection to others, a greater understanding and empathy for others, increased sensitivity to others’ needs, an increased range and depth of emotion, an increased appreciation of beauty, a love of learning, ambition, productivity, increased spirituality, and resilience (Flaherty, 2011; Lobban et al, 2012; Galvez, Thommi, & Ghaemi, 2011; Ma, 2009). Studies of famous Jazz musicians, poets, writers, artists and famous individuals that have excelled in various domains show elevated rates of bipolar disorder, bipolar spectrum traits, and mood disorders (Johnson, Murray, et al., 2012). Educating clinicians on these qualities would encourage a more nuanced perspective on mental health.

We recognize that many healthcare providers are doing amazing work to combat stigma, and that, similar to us, they are conducting this work within a system that does not make it easy. Many have their own lived experience with mental health concerns. In order to combat stigma in the healthcare system, changes need to be made to the culture in health care to enable clinicians with mental health and addictions histories to disclose their own experiences. Portacolone, Segal, Mezzina, Scheper-Hughes, and Okin (2015) argued that “to facilitate the empowerment of users of mental health services, all the care providers who serve these persons must feel empowered as well” (p. 692).

62% have had previous
BAD EXPERIENCES
WITH PROFESSIONAL CARE



Lynda's story

Lynda checks in with her Peer Navigator. She is still on the BC Housing list and has to call them every six months - if she does not, she will be taken off the list. She wants to go to rehab, so her Peer Navigator helps her look into options for this. Unfortunately, there is a long wait list and there are no beds available. Private rehab is far too expensive. Lynda's trauma counselling runs out, so she seeks help from an addictions counsellor, who seems nice. Lynda's Peer Navigator tells her about SMART Recovery, an alternative to NA that does not have a religious component. She says she will try it...

RECOMMENDATION

- We recommend that the health authorities implement training on implicit bias and stigma for healthcare professionals. This could be modelled based on the two-step approaches Zestcott et al. (2016) wrote about, wherein participants are made aware of their implicit biases and then educated on strategies to counteract them.
- We recommend the implementation of health care provider training outlining research on the many positive attributes association with mental health issues.
- We recommend the inclusion of discussions regarding stigma throughout the hiring and training process for clinical staff.
- We recommend that mental health consumers be welcomed into professional roles, and that experience with mental health and/or substance use concerns be considered as an asset when recruiting staff.
- We recommend that peers be incorporated into clinical training and onboarding to new roles, as well as clinical services during all stages of program development and delivery, as a means of increasing positive contact. Researchers have highlighted social contact with people with lived experience as one of the most effective strategies for reducing stigma (Ungar et al., 2016; Corrigan, 2016). It has yielded better results than education-based anti-stigma programming, and is more effective when contact occurs in person.
- We recommend that clinicians have contact with individuals living with mental health issues and addictions in all stages of recovery, in order to counteract the effects of constant exposure to people in crisis.

HOW WE HELP

Stigma is a broad societal problem that cannot be solved by our program alone. We play a role in combatting the stigma that our participants, all mental health consumers, and we ourselves experience when accessing services. We explore alternative treatment options with participants who have experienced stigma within health care services. We also brainstorm ideas for managing stigma within a clinical environment, be it through self-advocacy or coping strategies. The Peer Navigator team experiences a considerable degree of stigma from other health care staff due to our label as peers. As a program, we strive to model professionalism and competence in our work to exemplify the potential of peers. Peer Navigator staff have also delivered training sessions to clinical staff to help combat stigma.

TRENDS

Program participants continue to identify stigma from healthcare providers as a significant barrier to their wellness.



5. Inequality

Program participants who belong to marginalized communities experience additional barriers to care. Many have multiple identities within which they experience oppression. In particular, many experience marginalization and discrimination based on their gender identity, sexual orientation, race, ethnic background, Indigenous background, faith, disability, socioeconomic status, and age. Theorists have recommended adopting an intersectional approach to address these barriers (Powell Sears, 2012). Such an approach would account for and explore the way stigma and discrimination due to mental health and substance use concerns interacts with and compounds other forms of oppression. Many of our program participants who are members of multiple marginalized groups report having experienced discrimination within the mental health care system.

Research has demonstrated that health care providers tend to hold more negative attitudes towards people of colour, First Nations individuals, gay and lesbian people, people of low socioeconomic status, injecting drug users, and individuals that are determined to be overweight (Zestcott, Blair, & Stone, 2016). These biases, which may occur outside of conscious awareness, often have a significant effect on health outcomes (Drewniak, Kronos, & Wild, 2017). However, research has also demonstrated that some providers make concerted efforts to address health disparities and are effective in meeting the needs of minority populations (Drewniak et al., 2017). Accordingly, some Peer Navigation participants have described very positive encounters with specific mental health providers. They often

refer to one or two individuals that have been exceptions to otherwise negative experiences within health services. Encouragingly, participants report that these positive experiences have a significant impact on their mental health.

The Peer Navigator Program has worked with a number of individuals that belong to ethnic minorities, many of whom are refugees or immigrants and face unique barriers in accessing mental health care in terms of lack of health coverage for medical expenses, language difficulties, and not knowing where to go. Many program participants that are not new to Canada also face discrimination based on their ethnic background or race. Consistent with this, numerous studies have demonstrated that persons of color are perceived more negatively by health care providers than White patients, and receive differential care for the same symptoms (Zestcott et al., 2016).

A number of Peer Navigator Program participants identify as trans or non-binary, and describe experiencing discrimination from health care providers who often misgender them. A study conducted by Simeonov, Steele, Anderson and Ross (2015) found that a large number of LGBT respondents stopped accessing mental health services after negative experiences related to their gender or sexual identity. Receiving services from a practitioner with a LGBT-specific mandate is associated with higher satisfaction with services for individuals that identify as LGBT (Simeonov et al., 2015).



Lynda's story

Lynda shows her Peer Navigator some of the artwork she has been working on, which she is very excited about. They talk about a few resources in the community that Lynda might find useful, such as Art Studios and Qmunity. She likes SMART Recovery, and has attended a few times this week. She continues to feel paranoid about cockroaches and the SRO is very loud at night, so she is still not sleeping well. Some days, she feels more hopeful. Other days, the thoughts of suicide persist. Lynda's file remains open. Like many program participants, she still has not been able to access the help she needs.

RECOMMENDATION

- We recommend that social services provide education sessions for individuals that are new to Canada on the health services that are available to them.
- We recommend that health authorities and/or community agencies implement specialized care clinics to provide necessary health care to individuals waiting for refugee status or landed immigrant status and who therefore do not have health insurance. These clinics could be linked to community settlement services that are already in place.
- We echo Simeonov et al.'s (2015) recommendation that mental health services with a LGBTQ2S-specific mandate be implemented, and that these mandates be clear, accessible to patients in waiting rooms, and online.
- We recommend that clinicians receive ongoing education on cultural diversity, intersectionality, and gender inclusivity. These sessions should include content on implicit bias and strategies that can be employed to provide more equitable care.
- We recommend that all mental health services locations provide access to gender-neutral washrooms with appropriate signage.

HOW WE HELP

Peer Navigator staff have connected with resources in the community that support individuals that are new to Canada and members of ethnic minorities. We also conduct in depth research to try to connect individuals to services to meet their basic needs. We have received ongoing training in cultural competency and gender inclusivity. We have also built connections with resources individuals can go to that are inclusive of gender diversity.

TRENDS

Though this barrier was referenced throughout last year's report, we have added inequality as a new section this year as we have observed an increase in the number of participants identifying inequality as a barrier.

6. Structural Stigma

Stigma is not solely enacted on an individual basis. It is embedded in the structure of various institutions in our society. Theorists have identified several key avenues through which stigma occurs, including “separating ‘us’ from ‘them’ and an imbalance of power” (Weiss, Gross, & Moncrief, 2016, p. 95). The separation of ‘us’ from ‘them’ and the imbalance of power are embedded in societal institutions. The structure of the psychiatric system reinforces these power imbalances and program participants report that they feel disempowered in the mental health system. They are assessed by experts, given diagnoses without necessarily having input into them, prescribed medications without any discussion about side effects or other treatment options, and referred to services that professionals feel they need, without having a say into where they would like to go. Some are hospitalized against their will and/or legally mandated to take medication. Clinicians are trained to maintain an emotional separation from their clients, where they do not disclose anything personal about themselves. This furthers the power differential between patients and those deemed to be experts, enacting structural stigma.

Along these lines, participants in a study conducted by Wright (2015) reported that in their experience as consumers, it is the organizational context, and not individual clinicians, that drive stigma and remove the compassion from mental health care. A component of the organizational context that is not often discussed is the fact that mental health clinicians primarily see individuals that are in the midst of mental health crises because people are less likely to access care when they are doing better (Stromwall et al., 2011). This may lead to a false impression that people do not recover from mental health concerns. Incorporating peer staff into mental health services may be helpful in facilitating positive contact with individuals in recovery. Similarly, implementing strategies to reduce burnout and better support the morale of overworked mental health professionals promotes a

compassionate organizational culture, which, in turn, facilitates care that is more compassionate and less stigmatizing.

RECOMMENDATION

- As outlined in the b4stage4 campaign, we strongly recommend more funding overall for mental health and addictions services.
- In addition, we recommend participant or client involvement from start to finish of health authority innovations be a guiding principle, and not an afterthought. This should include peer staff in order to promote positive interactions with individuals who have lived experience.
- We recommend integrating peer staff into mental health and addictions services in order to promote positive interactions with individuals who have lived experience throughout the health care continuum.
- We recommend the implementation of programs to prevent burnout amongst clinical staff and promote a healthier workplace culture.

HOW WE HELP

Though structural stigma is far larger than our program’s reach, the Peer Navigator team strives to structure the program in a way that is more helpful for the people that we serve. For example, an advisory committee that includes participants guides the future of the Peer Navigator Program.

TRENDS

We are hopeful that the many initiatives that are working hard to improve structural stigma, such as the Peer Navigator program, are gradually making positive changes.



Conclusion

There are a number of tools that the Peer Navigator team uses to empower participants in navigating through barriers within the system, but the barriers that our participants experience are real and ongoing. Many participants are successful in navigating around the barriers they face, but many are not. The process can be incredibly discouraging, disempowering, and traumatic. Many participants become disillusioned with the system and isolate themselves from the services that they require, eventually giving up on their hopes and dreams. This leaves participants feeling hopeless, helpless, and often more unwell than they were before accessing services.

As Peer Navigators, we are familiar with the obstacles that our character Lynda has come up against, not only in our roles as Peer Navigators, but also through our personal experiences with the mental health and substance use systems in Vancouver. Although the details of everybody's story are different, the negative effects of interacting with a complex and often-confusing system are far too common. Many of our program participants are resilient and have positive outcomes. Others, however, are not so lucky.

Many of those we work with feel that mental health is not seen as a priority within health care overall. Despite the high prevalence and disease burden of mental health issues, only 7.2% of total health care spending is allocated to mental health care, which is

considerably below many other developing nations' contribution of over 10% (Lurie, 2014). Similarly, less than 5% of funding for health-related research is allocated to mental illnesses, although "every dollar invested in depression and anxiety research has a \$4 return on investment" (Merali & Anisman, 2016, p. 220). Financial support from government and health authorities, policy changes, structural mandates, and support from people in leadership roles are crucial to success in combatting stigma and improving the mental health and substance use systems. We are hopeful that with the provincial government's new Ministry of Mental Health and Addictions there may be some positive changes forthcoming.

Broad systemic change will require the collaboration of many. Stigma and discrimination are still very real features of the current mental health and addictions systems. Even our identification as peers has led to resistance to our program in both community and clinical settings. We hope that, through our work, we can help shift the culture of the clinical environment by writing new scripts of what people with mental health and addictions concerns are capable of.



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