

**LINKING SERVICES TO CONNECT PEOPLE:  
BC'S SERVICES TO PEOPLE WITH ALCOHOLISM  
AND DEPRESSION**

by

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## **ABSTRACT**

People who have mental health and addictions problems have traditionally struggled to find to services appropriate for their needs because services were not equipped to address them. Through a case study of health authority service plans and interviews with depression and alcoholism service providers, I sought to identify service gaps for people with mild-to-moderate depression and alcoholism and potential opportunities to address them. I looked for situations where intersectoral work could help in addressing service gaps.

Through this research, I saw that people with mild-to-moderate depression and alcoholism use their primary health-care provider for support, with inconsistent quality of care. Community based services available to this population vary in availability, program type, counselling, cost and target group across BC so connecting people to appropriate services is difficult. My findings suggest that support to people with depression and alcoholism can be improved by including people's existing social relationships in treatment plans and by using appreciative inquiry to build true partnerships at the health authority level.

**Keywords:** mental health; addiction; alcoholism; depression; concurrent disorders; partnership work; Ministry of Health Services.

## **EXECUTIVE SUMMARY**

People who struggle with depression often simultaneously struggle with alcoholism, with high human and economic costs. Further, one in five will struggle with mental health issues, and many within that group will also struggle with alcoholism. The British Columbia Ministry of Health assumed responsibility for addictions in addition to its coverage of mental health issues in 2002. Services to people with concurrent disorders are generally offered on higher level, upon the referral of general practitioner. In BC, general practitioners act as the primary service providers to people with depression and alcoholism, based on their assessment of patient's needs. The Ministry of Health Services plans to continue this form of service provision for people with depression. Community services outside of the formal health system exist on a spotty across the province to address the needs of people with mental health and addictions needs, though services are often unknown to physicians and not used to their maximum.

This study contains a case study of the five health authorities in the province of BC providing direct services. I observed the acknowledgement of the need for further integrated services for mental health and addictions on a large scale, with minimal planning for action to address this need. The case studies also revealed minimal work or understanding of other services available within

the community compounded with inconsistent documentation of planning or acknowledgement of service needs.

Following the case studies is a thematic analysis of eight one-to-one interviews conducted with front-line service providers in mental health and addictions with a focus on depression and alcoholism. The themes that emerged from interviews included:

- Working “Inside” – including discussions of work within silos, current approaches to integration and costs connected to a failure in service provision;
- Into and Out of Services – Issues surrounding transitions between and out of services, creating service gaps and thus silos;
- Social Issues – The effects of community supports and employment

I propose four potential policy options to address themes derived from the case study and interviews with service providers. These are: the provision of a person to act as a mental health navigator by health authorities, similar to those provided for people with cancer. A navigator would help those struggling with depression and alcoholism to follow-up with referrals from physicians, navigate any issues concerning work and insurance and to help relay information to their families and support networks. The second option is conducting a study of current practice in mental health and addictions work in each health authority in the province, producing an understanding of programs and services, in addition to a baseline for best-practices model for integrated service for the province. The next option is a partnership project, with the goal of establishing strategies and work plans for improved intersectoral work across all mental health and

addictions services users and service providers through the use of the appreciative inquiry process. The last policy option is a discussion of relational inclusion, where those receiving care would choose a support person to participate in their care planning.

Through an analysis of the policy options against measures of equity, cost, effectiveness, stakeholder acceptability (relative to those within government, outside of government and service users) and the affect of the given option in reducing the stigma associated with mental health and addictions, I recommend the partnership project with the inclusion of an important relation or supporter in the planning and execution of care plans.



## **DEDICATION**

For my parents, immersing me from the beginning on the virtues of community, understanding people different from me...and also for Devon, the person who gives a face to the complexity of life and happenstance.

Many thanks to the staff at the CMHA BC Division for the connections I needed to conduct this project, and the experience of working with you in addressing this very problem in your context.

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## GLOSSARY

Depression	A group of mood disorders, characterised by a disturbance made up of four types: bipolar 1 and bipolar 2, characterised by highs (hypomania) and lows (when the high fades and result in depression), cyclothemic disorder (where lows are not as low as with bipolar or major depressive disorder), dysthymic disorder (no manic or hypo episodes, with lows lasting two or more years) and Major Depressive Disorder.
Addictions	As defined by the Diagnostic and Statistical Manual, Fourth Edition. The word “addiction” is a combination of definitions of problematic substance use. Generally includes “substance abuse” and “substance dependence.”
Substance abuse	A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested in role obligations, putting oneself at physical risk, legal problems as a result of substance use and continued use, despite having social or interpersonal problems as a result of that use
Substance dependence	A maladaptive pattern of substance use, resulting in negative outcomes. Characterized by tolerance (needing more of the substance to obtain the same high), withdrawal from the substance when it’s not being used, multiple attempts to stop using the substance, significant time spent trying to obtain, use or recover from the substance, reduced time spent doing other activities in favour of time focused upon the substance
Concurrent disorder	The combination of an Axis-1 mental health disorder (psychotic variety) including: bipolar disorders, schizophrenia, major depressive disorder in combination with a diagnosed substance use problem
Health authority	A health authority is a geographic area determined by the province of BC
MOHS	Ministry of Health Services

Partnerships	Joint working arrangements of independent bodies cooperating toward a common goal through the creation of structures, shared knowledge, risks and rewards in the planning and implementation of a program or project.
CHARD	Community Health and Resource Directory, a closed electronic database available to health care professionals, with information on mental health and addictions, cancer expanding across BC. Pilot project began
SPMI	Severe and Persistent Mental Illness. Includes mental illnesses of Axis-1 variety from the Diagnostic and Statistical Manual IV-TR.

# **1: BACKGROUND**

## **1.1 Introduction**

Mental health and addictions are two issues increasingly on the minds of health and social policy makers (Health Canada, 2002, Rosenberg, 2009). The visibility and cost of treating people struggling with the most severe mental health and addictions problems is increasing (Single et al., 1998), and British Columbia has been forced to address mental health and addictions in a real way to confront a public “problem” of the Downtown Eastside in Vancouver. Much less visible, though also socially costly, is a group less likely to be addressed: a group of people struggling with both mild-to-moderate depression and alcoholism. This population can usually hold employment and tends to struggle in silence absorbing the costs privately and through family, sometimes seeking help, sometimes not for reasons including the presence of stigma. Once people have sought services, navigating between services and receiving services appropriate for their needs tends to be another difficulty, even though since the 1980’s, research has acknowledged that services provided together to address mental health problems and addictions needs at the same time tend to be most effective (Rush et al., 2008).

Service systems are organized to address the population most severe needs population, people with Axis-1 diagnoses and an addiction. People who have depression and alcoholism usually receive services from their general



practitioners and receive other community services as they have been referred by their physician or through services they seek out themselves. Finding the initiative and self-advocacy to seek out services is a specific problem for people struggling with mood disorders, making the process of seeking out appropriate help more difficult. To compound this issue, since the 2002 amalgamation of health services with addictions services in BC, little work has been done between addictions service providers with mental health service providers to work together (Association of Substance Abuse Programs of British Columbia, 2007).

Disjointed services mean service gaps for people with mild-to-moderate depression and alcoholism. My policy problem for this paper is that ***the province of British Columbia creates service gaps for support to people with mild-to-moderate depression and alcoholism.***

I will begin this paper with a discussion of the connection between mental health and addictions, some background of the organization of the health system and organizations who provide support to this group. The second section of the paper is the methodology section, where I explain the research methods used to examine service to people with depression and alcoholism. I conducted a case study of health authorities across British Columbia. These case studies will examine the services provided by each health authority and the language used to describe the services, the provision of mental health and addictions services, and key points from each service plan. I conducted interviews with a variety of service providers for programs and services for people struggling with both mental health problems and substance use problems, specifically those with depression and

alcoholism.

Following the thematic analysis of the results from my interviews is the section of the paper examining policy options to address the service gaps to British Columbians struggling with depression and alcoholism. The next section will examine those policy options to evaluate and work through those policy options in a practical manner. I argue that the Ministry of Health Services system provides very specific and exclusive entry points to the system with weak ties to non-MOHS services, out of line with their goals to provide holistic care. The last section will provide a conclusion to the paper with recommended policy options.

## **1.2 Scope of Depression, Alcoholism and co-occurring depression and alcoholism**

The impacts of mental health and addictions problems are great, even when the two problems are examined in isolation. The financial costs and the social costs include the lost productivity of those who would otherwise be working or diminished productivity if they can continue to work, the cost to private insurance programs when people who are struggling need counseling or time off from their work, the costs to their family and friends of caring for them, potential costs of treatment should they seek out treatment, in addition to other further costs, including court costs of behavior related to alcohol use or higher costs to other social supports. One in five Canadians will struggle with mental illness at some point in their lives, and about 20% of those will also struggle with a substance use disorder (Health Canada, 2002; Rush et al, 2008). In a British Columbia context, the British Columbia Medical Association estimated that as many as

870,000 (or 19% of the population of BC) people may struggle with a major depressive episode at some point in their lives, and as many as 960,000 may struggle with some form of mental illness (BC Medical Association, 2009, Health Canada 2002). At the highest level, the World Health Organization expects the costs of depression to be the greatest medical burden by 2020 (World Health Organization, 2008). The British Columbia Business and Economic Roundtable on Mental Health published the estimated costs depression alone in organizations of 1000 employees to be \$2,750,000 (BC Business and Economic Roundtable on Mental Health, 2009). When applied to the BC population at large, the cost to business alone because of depression is \$6.717 billion, given a labour force of 2,442,700 in 2010 (BC Stats, 2011). Depression and stress disorders are a growing problem for the workforce, in that the two together account for the fastest growing category of disability claims for Canadian corporations (Ministry of Health Services, 2002). These costs are greater than those associated with heart attack, stroke or diabetes (BC Medical Association, 2009).

British Columbia doctors are seeing increasing numbers of people because of depression, with some 8.5% of the population seeing their doctor to discuss issues related to depression (BC Medical Association, 2009).

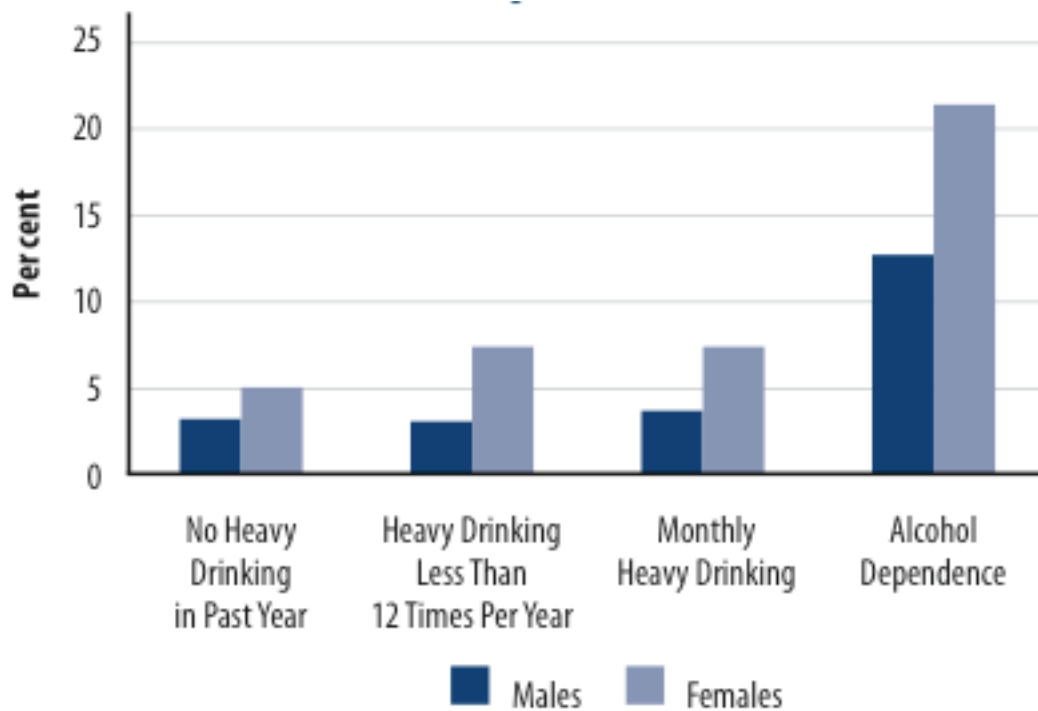
The costs related to alcoholism generally have also been known to be high, and alcohol abuse is high, such that 17% of British Columbians reported hazardous drinking (as measured by the Alcohol Use Disorders Identification Test) (Rehm et al. 2008). Research by Rehm et al. in 2002 measured the fiscal and social costs of alcohol use to be \$14.5 billion across Canada, accounting for

36.6% of the costs of substance use in the country (Rehm et al., 2006). In 2009, the BC Provincial Health Office estimated the financial and social costs of alcohol and alcohol abuse to be \$2.219 billion (Rehm et al., 2006). Relative to the rest of the country, British Columbia has the second-highest levels of alcohol consumption relative to the rest of the country (3.6% relative to 2.6%).

Direct results of alcohol use are often seen emergency rooms – the most costly health care – with conservative estimates approximately that between 10-30% of visits are connected to alcohol-related problems (Standing Committee on Social Affairs, 2006, 99). The indirect costs of alcohol, primarily related to lost productivity at work, were estimated to be approximately \$1.308 billion dollars across the country (Provincial Health Officer, 2009, 26).

Depression and alcoholism are often seen together, where their effects magnify. The Standing Committee on Social Affairs approximated that 37% of people with an alcohol use disorder also struggle with mental illness (Standing Committee on Social Affairs 2006, 38).

Many studies have shown a strong correlation between depression and anxiety disorders and alcoholism, such that a genetic link connected the two in 2004 (Geonomics and Genetics Weekly, 2004, 26). Conservative estimates are that in 2002, about 1.3% of the Canadian population over the age of 15 years (approximately 337,761 people) reported co-occurring major alcohol use and mental health disorders in the previous year (Rush et al, 2008). The prevalence of major mental health issues is positively and significantly correlated with high alcohol consumption (See Figure 1, below).



**Figure 1 – Prevalence of Major Depression by Frequency of Heavy Drinking, General Household Population, Age 15+, 2002. Adapted from Public Health Approach to Alcohol, BC Public Health Officer, 2009.**

Another element of the use of alcohol for people who struggle with depression is the use of alcohol as a relief from the stress caused by depression. Alcohol is known to temporarily “blunt” the effects of stress hormones, providing a self-medicating effect (Porche, 2005). Finally, gender norms affect how men and women exhibit depression, such that substance use in men may more accurately reflect underlying depression (Addis, 2008).

### 1.3 Treatment History and Culture

Services provided to people with depression and alcoholism has typically

been divided between the mental health and addictions communities (Visions Journal, Winter 2004, 12). For people dealing with mental health problems, general practitioners provided some care, and some were provided with referrals on to other specialists, as deemed necessary. Referrals took place on the basis of a physician's determination of need and treatment by physicians was based primarily on the use of anti-depressants. This continues to be the case (Ministry of Health Services, 2010).

People who were (and continue to be) struggling with mental health problems have had support from professionals, and – in situations of Axis-1 diagnoses – support provided by community support workers, hired to work with people themselves and any community contacts as necessary (including housing workers, medical appointments, other support providers' appointments). People doing these jobs are either nurses or specialist social workers.

As mental illness was seen as a "sickness", it was also seen to be incurable (Visions Journal, Winter 2004). In the past, there was also little connection to understanding of addictions though as alcoholism (specifically) began to be seen as a public problem, public health and social care providers became more aware of addictions, beginning with alcoholism (Visions Journal, Winter 2004).

Similarly, the addictions treatment world struggles to change historically held beliefs about treatment practices. Many of these beliefs continue, for example, that substance abuse treatment must be provided in a residential setting, or that community support (as opposed to support provided by the medical community) is always "faith-based." The goal in addictions treatment has

not been similar to that of mental health problems. The goal for addictions treatment came from Alcoholics Anonymous tradition of “recovery” and person-centred care (Davidson et al, 2008). Practically, it is possible for people to stop using drugs or alcohol, whereas mental illness is significantly more difficult to “get rid of.” Given that there is significantly more physical control involved in substance use, degrees of use are seen in “abstinence” programs and treatment beliefs centred around “harm reduction” where the goal is minimizing risk to the person while they use a substance.

Both treatment traditions have struggled, and some continue to struggle, with exclusionary practices regarding other members of the mental health or addictions community.

#### **1.4 Mental Health and Addictions Service Provision in BC**

People who are struggling with mental health or addiction needs in British Columbia generally first contact their family doctor for help (Ministry of Health Services, 2010, BC Medical Association, 2009). Depending on a person’s needs and the severity of their presenting issues, they may be referred on for more specific treatment by a mental health professional. Physicians refer their patients to programs and services dependent on the physician knowledge of:

- 1) existing options,
- 2) the programs and services available in their region,
- 3) who offers the services and

- 4) what contracts the local health authority may have with community service providers.

When people are referred on for psychiatric help, they face significant wait-times, often longer than the wait times recommended by the Canadian Psychiatric Association (BC Medical Association, 2009). Those who are referred on to other services are people who primarily struggle with Axis-1 diagnoses – the most obvious and expensive (to the health system)

Research on the treatment for depression, outside of screening, shows that:

- physicians continue to struggle to recognize and treat depression (Kilbourne et al., 2007).
- the majority of people needing help for depression see their family physicians and
- primary care physicians recognize less than half of the patients with depression. This may be related to the secondary effect of depression being related to chronic pain (among other side effects) (Cepoiu et al., 2008).

General practitioners have access to some education on best practices for addressing depression (General Practices Services Committee, 2009), however, physicians bill relatively little of their time for mild-to-moderate depression work. In cases of those with severe depression, general practitioners are provided with billing incentives to provide care plans.

Barriers to accessing services are not exclusively a service provider problem. Due to the nature of depression and alcoholism, people needing



services for depression – because of the illness itself – may:

- struggle with motivation to seek out the support they need,
- fail to recognize that they have a problem and
- fail to seek support because of the shame and stigma attached to being labeled with a mental health problem. Men especially may struggle with this (Addis, 2008).

Similarly, the stigma accompanying alcoholism adds a barrier to seeing out care (Mojtabai, et al. 2002). If general practitioners do not recognize depression or alcoholism, it may be more difficult for patients to seek out services from another care provider because of the above social and psychological issues.

The British Columbia mental health and addictions system primarily relies upon general practitioners to provide health care until the second phase of illness (See Figure 1.1), Secondary Prevention/Harm Reduction. The Ministry of Health's system begins in a primary caregivers' office, and moves through to the "tertiary" system (See Figure 1.1), along a continuum of needs. This range goes from prevention to long-term support hospitals. Of great importance for this paper is that those struggling with mild-to-moderate depression and alcoholism misuse would not qualify for the majority of services provided by the health authorities. Their care would remain with their general practitioners to the point at which they are hospitalized for an accidental injury (car accident, for example) or a suicide attempt related to their alcoholism and/or depression. In effect, preventative care and early intervention are rare.

Continuum of Services for Problematic Substance Use and Mental Disorders						
Health Promotion	Primary Prevention		Secondary Prevention/ Harm Reduction		Tertiary Prevention/ Harm Reduction	
	Universal Prevention	Selected Prevention	Indicated Prevention	Treatment, Monitoring & Relapse Prevention		
				Early Identification & Treatment	Treatment & Self-Management with Selected Supports	Intensive Treatment, Long-term Rehabilitation & Support

**Figure 2 - Ministry of Health Services, Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction**

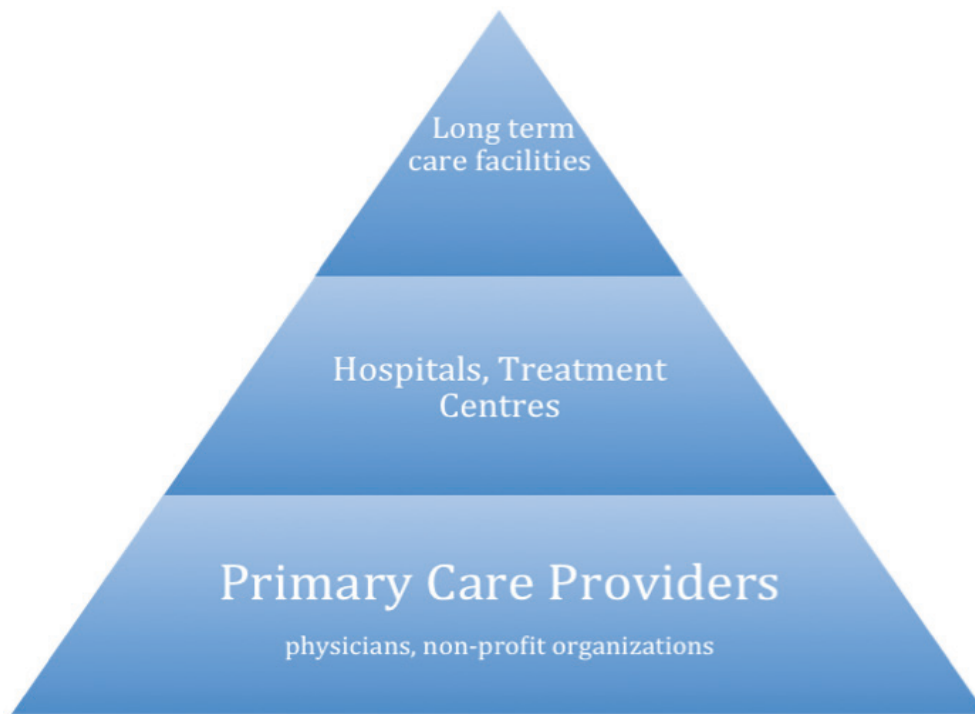
### System Organization

The organization of mental health and addictions services in BC has changed significantly since the mid-1990's. In 2002, twenty-six health authorities were amalgamated into their current form of five health authorities: Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health and Vancouver Island Health Authority, with one Provincial Health Services Authority. The province decided under this arrangement that it was to be a "steward of health services", responsible for financing and overall health direction, but not for direct management and local policymaking (Health Authorities Act, 2002).

In 2002, the province of British Columbia released the "Depression Strategy for BC." The uptake of the recommendations of this report was sporadic across the province, if they were addressed at all. Health authorities were left to implement the majority of this plan, and did not do so in a step-by-step process, the results of which have been care without strategic goals.

In the 2004 paper, *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*, the Ministry of Health recommended restructuring services with available resources to provide a continuum of services “designed to address what works across the lifespan, genders and a variety of communities” (Ministry of Health Services, 2004)

In October 2010, the province of British Columbia released its ten-year plan for mental health and addictions, *Healthy Minds, Healthy People*, which outlined the province’s intention to continue to base care for people with mental health needs with general practitioners. It also acknowledges the need for “a greater service emphasis on mild to moderate mental health and/or substance problems” (Ministry of Health Services 2010, 25) because the number of people affected is much higher, and because research links effective and early interventions as a way of preventing more intense and costly service needs. To deal with mental illness and substance abuse problems, various levels and services within and outside of the health system must work together, acknowledging that addictions and mental illness are not illnesses that affect the body exclusively but have social and psychological dimensions. Working together on specific programs requires that all involved organizations must ‘buy into’ the concept of intersectoral working, as well as allot time, energy and resources to partnering other organizations and measure their outcomes to provide comprehensive and appropriate care to those who need it. Importantly, such work is driven by an intended focus on person-centred care.



**Figure 3 - Continuum of Services**

## **1.5 Why Provide Integrated Care?**

*An extensive and robust literature has demonstrated that, compared to usual care, patients with depression who receive care from an integrated team of providers are more likely to report better adherence to medication, increased satisfaction with care, and improved health outcomes.*

- British Columbia Medical Association, 2009

In the 2008 paper, “Closing the Gap on a Generation,” the World Health Organization listed the “social determinants of health”; key factors which contribute in a significant way to long-term population health (World Health Organization 2008, 98). Many of the same elements of long-term health were included in the Royal Commission’s report, *Building on Values: The Future of*

*Health Care in Canada* (The Honourable Roy J. Romanow, Q.C.) and by the Senate Committee (“Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada”, The Standing Senate Committee on Social Affairs, Science and Technology, The Honourable Michael J. L. Kirby, Chair). The Romanow report discussed the need for coordinated approaches to health in the long-term with a specific need for doctors to work in teams to support inter-professional care. The committee behind *Out of the Shadows at Last* spent several years examining the cases of mental health, mental illness and addiction. For the first time in Canada, considerable attention was paid to the issue of mental health problems and treatment. The final report (known as “The Kirby Report”) emphasized the importance of considering the social determinants of health, including the importance of employment assistance, adequate housing, education and research, self-help and peer support (Senate Committee on Social Affairs, Science and Technology 2006, 6; Ministry of Health Services 2004, 45). The World Health Organization included stigma, lack of education, lack of availability of services, economic barriers to care and financial insecurity all as social determinants of health; issues often observed in mentally ill and addiction communities (World Health Organization 2008, 98). This work forwarded the agenda for treating people with mental health and addictions within a more holistic model of health and social care which also emphasized the role housing, education and employment play in terms of treatment and recovery. This is important because traditional mental health and addictions programs have concentrated more on the medical model of health

while research has shown that without support in facets of the social determinants of health, general health outcomes are poorer (Ministry of Health Services 2004, 45).

Both the Kirby Report (2006) and the Romanow Report (2002) called attention to unique aspects of the provision of mental health care. Specifically, both reports called for an end to 'silos' of service provision (The Honourable Roy J. Romanow, Q.C. "Building on Values: The Future of Health Care in Canada", 2002, xviii), wherein the primary diagnosis must first be established by caregivers before any treatment can be provided, and envelopes of care are provided in different locations by different teams. The recommendations of both studies called for the systems to work together in a systematic and long-term way, acknowledging that health and access to services needs to take place on a continuum of care, centered on a patient.

Indeed, the British Columbia government outlined the importance of the working across services in a person centred way to "meet people where they are", remove barriers to access and acknowledge the unique "strengths, needs and goals" of individuals (Ministry of Health Services 2004, 4).

The evidence reviewed above indicates that to effectively deal with mental health and addictions issues, support networks and other cross-organizational work is needed to cover an integrated continuum of care for both those with the most severe mental health and substance use problems to those struggling with simultaneous mental illness and substance use issues. These services ideally support people in varying degrees through the cycles of their lives: minimal

support in times of recovery with a case plan when their mental illness and/or substance use issues arise. Support to people with “concurrent disorders...requires a comprehensive, integrated and evidence-based continuum of addictions and health services. These services include health promotion, prevention, harm reduction, early identification, treatment, long-term rehabilitation and relapse prevention, community re-integration and support” (Ministry of Health Services 2004, 29). Supports do not necessarily have to be provided in any specific form or delivery model, and are to be divided by different levels of need. Literature reviewed so far indicates that services are not fully engaged in intersectoral work, and so fail to provide smooth transitions between services, nor do they deliver on the notion of person centred continuity of care for people with both mental health and addictions. This has been identified as particularly the case for people with depression and alcohol addition. As such, the policy problem identified here is:

***The province of British Columbia creates service gaps for support to people with mild-to-moderate depression and alcoholism.***

In order to address this policy problem the following research questions have been set.

## **1.6 Research Questions**

**What are BC health authorities planning with regard to improving services for people with concurrent mental health and addictions**

**problems? How far and in what ways do they focus on depression and alcoholism in particular?**

This research question drove a case study analysis of 5 health authorities. In addition the following research questions were designed to extend knowledge in the area:

- **What service gaps exist for people with mild-to-moderate depression and alcoholism?**
- **How do we close the gaps and provide more effective services to fill the identified gaps?**
- **How far does intersectoral working go to addressing the needs of people with depression and alcoholism?**

These questions were addressed in a set of stakeholder interviews in order to gain knowledge directly from professionals who work with people with mental health and addictions. Answering these questions were the guiding objective behind the data collection and analysis. Interview participants were made aware of the research questions to help guide the research appropriately.

In this capstone I argue that health authorities use the *language* and rhetoric of coordinated service provision, though there is little change in practice or measurement of how this happens, and that primarily services continue to be planned and delivered within traditional silos. These silos occur despite the understanding of the importance of holistic, person-centred care. Other service



providers work within and around formal health services, struggling to put the person at the centre of care.

## **2: METHODOLOGY**

### **2.1 Overview of Methodology**

*Why is this research qualitative?* This research topic was examined through a qualitative lens because of the difference in beliefs about, perspectives on and approaches to service provision for people with both alcoholism and depression including how to best treat, support and recover from both illnesses. Qualitative working enables rich contextual understandings of how current services are provided, the models underlying them and the different ways health professionals work together to provide services. This is important because service provision can significantly affect the quality of life and health outcomes of people living with both alcoholism and depression. Using qualitative research techniques enabled me to focus on the meaning and purpose of practices engaged in (Guba and Lincoln, 1994) by service providers, including their perspectives on organizational aims and values, as well as issues concerning intersectoral working. When I began this study, I did not know which issues were preventing more effective service provision for people with both alcoholism and depression, nor did I fully understand the dynamics of integrated work. The use of qualitative research methods allows for an exploration of these issues and a discussion of a variety of angles for specific cases.

Qualitative research provides a way to express the underlying significant and meaning of “normal” activities (Krauss, 2005). Understanding what’s “normal” aids in answering the research question because it examines why and how organizations work together in the ways they do. To better understand “normal” work in health authorities, I will use case studies to examine how health authorities approach service provision for those with both mental health problems and addictions (specifically depression and alcoholism) and how well this is working, and the problems associated with integrated care.

The way in which the services are provided and partnerships work is by nature, relative, and constructed by the people with whom I as the researcher speak. Their understandings will reveal the specific local nature of existing working relationship. The “knower” in the context of the discussions and their constructions of their relationships is understood to be malleable.

As the study progressed and there were further discussions between the “knowers” and the “inquirer,” realities and understandings were constructed between us as the investigation progressed. The meanings that I, as the inquirer attach to the issues being studied through my interpretation of the data is built between us, which, in its development, likely “chang(ing) both the inquirer and the knower” in the process (Guba and Lincoln 2004, 106). These constructions of understanding of the relationships are time and context dependent. As the study went on, inevitably different perspectives emerged enabling a more thorough understanding of the issues under investigation.

## **2.2 Research Design**

This study has two parts.

The use of cross-case study provides an opportunity to address “a how or why question about a contemporary set of events over which the investigator has little or no control” (Yin 1994, 9). This is valuable because health authorities provide mental health and addictions services themselves or through contracts with community organizations to their regions, as are deemed appropriate and “needed” to address their communities’ needs.

For this research, a case study will provide an in-depth examination of each health authority’s mental health and addictions system, as well as their work in mental health and addictions. I examined their service plans and available public documents (service plans for mental health and addictions). I have chosen to examine five of the six health authorities in the province with the exception of the Provincial Health Services Authority (PHSA). The PHSA was not included because it provides direct services to very specific populations around the province, for example, to those within the forensic psychiatric hospital, Riverview psychiatric facility, and BC Women’s and Children’s Hospital.

I conducted key stakeholder interviews with people in various roles in mental health and addictions, whereby stakeholders are defined as those with an interest in the area of concern (Sixsmith et al., 2003). Those interviewed were recruited from direct service providers, advocacy groups, addictions groups, mental health groups and health system evaluators. I spoke with people who were involved with service provision or service coordination to people with

depression, mental illness, alcoholism and/or depression. I recruited participants through the Canadian Mental Health Association, BC Division, and through telephone and Internet contact. The interviews themselves were, on average, one hour in length and took place in a number of different venues as chosen by the interviewee to maximize their comfort: the interviewee's office, via telephone and one took place in a coffee shop. These interviews were semi-structured in form, designed to answer research questions on how services were organized to serve those with mild-to-moderate depression and alcoholism and identify barriers and facilitators to intersectoral working within the context of person-centred approaches.

This format involved 6 open-ended questions with sub-questions (DiCicco et al. 2006), and was designed to allow the interviewees to explain their ideas and elaborate on important issues they felt were of relevance. I did this by inquiring into their roles in their organization, how organizations worked with other organizations in efforts to serve the same population, and where the current status quo of service provision succeeds and struggles. At the end of each interview, interviewees were given the opportunity to comment on any further issues they thought had not been addressed in the course of the interview. The majority of the interviews were recorded and transcribed. This was not possible for three of the interviews for which I took careful notes.

The Simon Fraser University Ethics Board approved this study.

## **2.3 Data Analysis**

Thematic analysis was used for both the case studies and the key stakeholder interview data. Thematic analysis allows for a meaningful breakdown and understanding of qualitative data and a method to identify, analyze and report patterns, or themes, within data. Often, this analysis goes further than examining themes “to interpret various aspects of the research topic” (Braun and Clark 2006, 79).

For both the case study and the interviews, I began by familiarizing myself with the data with several readings of transcriptions and documents. At this point, brief notes were made. Second, I identified codes within the data, noting their relevance to the research question. Then I organized the codes into tentative themes. The editing of these themes involves naming and defining each theme.. Finally, I provide an argument and textual basis for each theme and the connections between themes as relevant to the research questions and grounded in the literature (Braun and Clark, 2006).

See Appendices for Interview Schedule, Study Details, Telephone Consent Form, Case Study and Interview Themes.

### **3: CASE STUDY FINDINGS**

The Ministry of Health Services requires that each health authority produce service plans. For the most part, these service plans cover a period of at least two years; more commonly four. Some health authorities have service plans specifically addressing mental health and addictions, though this is not a requirement of the Health Authorities Act. For people seeking support, health authorities have specific websites with links to mental health and addictions services in their regions.

The research questions I wished to answer through this element of my research was: **What are BC health authorities planning with respect to improving services for people with mental health and addictions problems? How far and in what ways do they focus on depression and alcoholism in particular?**

See Figure 3 for the types of documents used to conduct the case study. I will take key issues from each of the health authority's service plans and discuss them in the following sections.

Health Authority	Service Plan 2010-2011/ 2012-2013	Mental Health and Substance Abuse Service Plan	Integrated Services Plan	Mental Health and Substance Use Work Plan (2011)
Northern Health Authority	☐			
Interior Health Authority (IHA)	☐	☐	☐	☐
Fraser Health Authority	☐	☐		
Vancouver Coastal Health (VCH)	☐			
Vancouver Island Health Authority (VIHA)	☐	Unavailable		

**Figure 4 Materials Used to Conduct Cross-Case Study**

Figure 4 highlights key points from each health authority in addressing: the population each health authority serves, the discussion of each health authority on housing, references and discussions within each service plan on community support, transitions between services, discussions of intersectoral work to address mental health and addictions, any mention of depression and alcoholism, and finally notable points from each service plan



Health Authority	Population Served	Environment	Housing	Community Support	Transitions between services	Intersectoral Working	Considers Services targeted at people with Alcoholism & Depression	Key Points
Fraser Health Authority	Urban	Growing quickly, highly diverse	No discussion	Effective care is integrated and community based”, includes schools, social services	Need to strengthen coordination, integration. People with concurrent needs have multiple caregivers	Discussion acknowledges the need for intersectoral working; no evidence of this in practice	No. Acknowledges depression exclusively	Considers families as needing services when members have been diagnosed.
Vancouver Coastal Health	Urban and rural, 25% of BC, economic gaps, many with addictions and mental health	Urban, specialized needs, tertiary care	Yes. Connected to high number of people with SPMI, addiction	Priority. Care based upon primary physician with “links” to community	“Services where/when appropriate.” No discussion of transitions	Plans to close current program & service gaps	Acknowledges depression exclusively as chronic disease.	Priority is homelessness and increasing numbers of people with severe MI and addiction
Vancouver Island Health Authority	Significant older population,	Serves communities only accessible by water, air – geographical barriers	No discussion	Need to connect community with service providers	Relies on connection between community service providers	Expresses desire to do this for benefit of people with “highest needs”	No. Acknowledges depression exclusively as chronic disease.	Discussion of mental health & addictions in context of community issues & integration
Interior Health Authority	Rural	Highest infant mortality in province, dispersed needs	No discussion	Counselling, support outlined in variety of settings	In context of high needs groups: children in poverty, Aboriginals, homeless	Discusses interdisciplinary teams, FIRM committee	No discussion	Mental health and addictions is a “core business area”
Northern Health Authority	High First Nations population, isolated communities	Worst health & social vitality in province, effects of economic downturn	No discussion	Integrated health networks for MI and addictions, specifically depression	Wants to address this through networks	Emphasis on coordinated care, not integrated	Acknowledges depression exclusively as chronic disease.	Regional basis of MH and addictions care, few resources

### **3.1 Family Involvement**

The key points arising from the case analysis of Fraser Health authority suggest that family members need services when their loved ones have been diagnosed with mental health and addiction issues. Including family members in care plans takes into account the need for supporters to be acknowledged in the process of mental health and addictions treatment and their important role.

Fraser's mental health and addictions plan describes three levels of need for family caregivers. The health authority describes the need for family caregivers to be provided with counselling and support. The effects of regularly coping with someone with mental illness are such that informal carers often need support to prevent feelings of being overwhelmed and to protect their own mental and physical health (Fraser Health, 2007). Further, mental health professionals can provide information, training and support to caregivers as well (Vogel et al. 2007). The service plan acknowledges that informal supports are not regularly included because of strained resources and wait times for mental health service providers. The second issue concerning family caregivers is the need for those in that role to be involved in care planning, given their important role in social networks, including family and peers in mental health recovery (Vogel et al. 2007). The reason this is not commonly actioned is related to issues around privacy. The Fraser Health Authority Mental Health and Addictions also pointed

to the need for informal carers to be involved in any discharge planning and to capitalise on the caregivers ability to support someone as their care and needs change and transition.

### **3.2 Homelessness, Severe and Persistently Mentally Ill (SPMI)**

The Vancouver Coastal Health Authority highlights an increasing number of people who are homeless in the health authority who are “burdened with a high degree of mental illness and addictions issues” (Vancouver Coastal Health Authority Service Plan 2009-2010/2011-2012, 5). A section of this service plan discusses the importance of social determinants of health with specific reference to the homeless population, acknowledging that people who are homeless are also more likely to struggle with mental illness and addiction. The VCH service plan says there have been improvements in areas including: “education, employment, income, housing, adequate nutrition, social supports and social networks” but that there are growing disparities between those of higher and lower incomes in the health authority. As the number of people in the lower income bracket grows, the service plan discusses the implications of living in poverty, which includes a greater likelihood of suffering from chronic conditions, mental illness and addiction.

The service plan does not outline specific objectives or projects to address homelessness and the population struggling with mental health and/or addictions services in the health authority. Planning to address this merely highlights the positive effect of housing linked to supports, including personal care, medication management and social activities.

Other health authorities do not discuss homelessness to the same extent as Vancouver Coastal. This is understandable, given that the Vancouver Coastal health authority service plan discusses the increasing number of homeless in the health authority. People who are homeless receive the health care they seek out from emergency rooms, a very expensive expenditure for health systems (Ministry of Social Development, 2000, 21). The cost of a growing number of homeless in the health authority is a large cost primarily absorbed by health. Other health authorities' have a smaller proportion of homeless, such that the costs of this user group are smaller. This health authority's primary focus is therefore on a smaller, albeit costly population. Interior Health Authority does discuss a break-down of what the "mental health beds" are made up of and where these beds exist, acknowledging the involvement of BC Housing explicitly.

Vancouver Island Health Authority, another region with a higher proportion of homeless, acknowledges a need to better serve people "hard to serve" populations, which includes the homeless, through community partnerships.

### **3.3 Mental Health and Addictions as a community: Integration issue**

Vancouver Island Health Authority (VIHA) has a mental health and addictions services plan which was not accessible on the Internet. The general service plan touches on the importance of continuing the goals of the mental health and addictions service plan, which is focused upon community support. The general health authority service plan puts this discussion under its strategic

initiatives to improve health for 'high needs' communities. The way that VIHA proposes that community support is conducted is through coordination with municipalities, non-government and government organizations to serve people with the greatest need and at the highest risk. VIHA was the only health authority to discuss the need for specific attention to community support, and who should be included in the discussion of community supports. Similar to other health authorities, there was no discussion in the general services plan about who would be invited to participate, nor were there objectives for this group or any clear planning to ease community support and integrated services.

This same section of the service plan notes that resources should be distributed equally across the health authority, including two specific geographical communities of need in the health authority. Connected to the issue of community-based support, the service plan highlights a need for more continuous care following discharge from acute and tertiary care facilities, There was no discussion about how this would be undertaken, though this discussion may be encapsulated in the (unavailable) mental health and addictions plan.

### **3.4 Regional Basis of Mental Health and Addiction**

Northern Health Authority struggles to a significant extent with the level of isolation experienced by many of its communities. This struggle is compounded by a discussion within the service plan acknowledging the need for further mental health services in light of the recent recession and declining employment due to resource-based economy. Its current service plan has a health authority-based

system of organization for addictions and mental health, as opposed to community-based programs.

In discussions of primary care, skills to address mental health needs were highlighted as an element of care that should be provided in a primary care setting. There was no discussion of capacity building to address addictions or alcoholism for primary physicians. This service plan had no planning attached to the discussion on how the inclusion of mental health training would be provided to primary care physicians or how mental health workers (exclusively) would be included in primary care provision.

### **3.5 Mental Health and Addictions as “Core Business”**

The Interior Health Authority services plan identifies mental health and addictions as a “core business” area. In some way, this makes organizational sense: some health authorities provide mental health and addictions services on a regional basis (as opposed to community-based). Alcohol-related deaths are the fourth-highest leading cause of death in the health authority from 2001-2005, and self-reports of residents indicate higher rates of self-reported heavy drinking (25.4% relative to the provincial average of 21%) (BC Medical Association, 2009). The service plan itself devotes more physical space in the document to a discussion of mental health services, and outlines each service offered by the health authority. The service plan explains what a count of mental health beds means and what is counted. Others do provide the explanation with less clarity. Interior Health also produces a mental health and addictions service plan, emphasizing the importance of mental health and addictions services to the

health authority. The health authority includes an “accomplishments and initiatives” for mental health and addictions in the health authority. Interior Health Authority’s entire service plan is designed to outline accomplishments and initiatives for each strategic objective.

In working in their own communities, the health authority is involved in a “Partners of Community Collaboration” - a community partnership project involving 20 service providers with the mandate to remove access barriers to appropriate health care for “disenfranchised people”, including those with mental health and/or addictions issues. Access to further documents (including a work plan for three years for mental health and substance use) also highlighted plans for how integration would work for mental health and substance use projects, and the need to integrate primary caregivers in this process.

### **3.6 Case Study Themes**

To some extent, health authorities’ service plans reported many common concerns, goals and objectives, reflecting the province’s objectives and goals, outlined in the province’s health service plan. Health authorities with accessible mental health and addictions service plans were clearer in their provision of goals and objectives. All of the five health authorities clearly discussed the benefit of service integration, but did very little to outline how this would happen or key organizations or people in the process. Each health authority highlighted the importance of community support and a strong primary care network, with no discussion about how this would be done or how capacity would be built to

address knowledge gaps in mental health and addictions. Significantly, there was minimal discussion of addictions generally.

The measures of success for mental health and homelessness relied upon the growth in the number of homelessness beds that were provided by the health authority (which included hotel rooms and hospitals). Many of these weaknesses were addressed in a 2009 report from the BC Medical Association, entitled *Collaborating to Improve Services for Patients with Depression*, which used previous health authority service plans.



## 4: INTERVIEW DATA ANALYSIS

In this section, I analyse my discussions with various stakeholders by theme.

There are three overarching themes, as shown in Figure 4.1: ‘Working “Inside”’ (4.1), which includes discussions and the effects of working in silos (4.1.1) and current work toward integration (4.1.2). The next overarching theme is titled ‘Into and Out of Services’. This theme includes a discussion of issues around transitions between services (4.2.1), and pathways to community services and supports (4.2.2). The last overarching theme is ‘Social Issues’ (4.3). This section contains discussions on community supports (4.3.1) and employment (4.3.2) for people struggling with mild to moderate depression and alcoholism.

Group Theme	Section	Sub Theme
Working “Inside”	4.1.1	Working in Silos
	4.1.2	Current Approaches to Integration
Into and Out of Services	4.2.1	Transitions
	4.2.2	Pathways to Community Services
	4.2.3	Accessing Services
Social Issues	4.3.1	Community Supports
	4.3.2	Employment

Figure 5 - Themes and Sub Themes

## **4.1 Working “Inside”**

This theme has two parts, both describing the internally oriented focus of service provision to people with depression and alcoholism. Working “Inside” outlines sub-themes revealed in interviews including how service integration is seen from those providing services, and discusses the types of costs of working together.

### **4.1.1 – Work in Silos**

The traditional divide between services for people with mental health and addictions is further divided for services to people with alcoholism and depression.

The approach to work in serving this population is significantly different partly because of historically differentiated treatment traditions for alcoholism and depression (and mental illness generally). Alcoholism treatment is generally guided by a treatment community with an emphasis on changing the way you “live your life” (Penny, Interview, 2011), and organised at the grass-roots level. However, treatment for people with depression and mental health has been governed by a medical model (Hetherington, Interview, 2011). This tradition continues, as described by a Ministry of Health Services interviewee who referred to “faith-based” community treatments as the only option for the support of people with addictions that is provided by the Ministry of Health Services (Ministry of Health Services Interviewee B, Interview, 2011). On a practical, front-line level, however, the understanding for treatment needs tends to be the same, attention to a “biopsychosocialspiritual” model (Hetherington, Interview, 2011).

Those with Axis-1 diagnoses of mental health problems and addictions are supposedly seen through a “concurrent” lens by specialized services, able to serve all their needs (Manarovici, Interview, 2011). While there are likely many more people with mild-to-moderate depression and alcoholism, they are less visible in the public sphere, and rarely move beyond the services of their primary caregiver. Little work has been done to address the holistic service needs of groups outside of the most severely mentally ill or addicted. In interviews with service providers, I saw that physical health was prioritized over mental health. When the two forms of health are not seen as one and the same, a historical tendency toward working in silos is reinforced; those who are experts in one problem are not considered in planning for other aspects of health.

A lack of understanding of the nature of mental and physical health can “undermine the relationship between doctor and patient and often result in a refusal to consult a psychiatrist or clinical psychologist, or to countenance a potentially effective treatment” (Kendell 2001, 490). A partial answer to such problems is, in the longer run, better education of both the general public and doctors themselves (Kendell 2001, 492). Experts in physical health (primary care providers) may have less training and in mental health relative to physical health, making it more difficult for them to identify mental health or substance abuse when issues present themselves (Goldberg 1998, 102). This builds a reliance on medication, the “tool in their toolbox” (Shields Interview, 2011), regardless of people’s general desire to use counselling and non-medical interventions to address depression (BC Medical Association, 2009). Interviewee Duncan Shields

points out that while physical health practices have begun to do work in prevention, similar work is in its infancy in the mental health field, such that general issues of depression are difficult, if not impossible, for primary caregivers to identify.

Traditional work in silos also means that services that work together do so on the basis of historical patterns, with little knowledge of other programs and services. In discussions with the clinical nurse practitioner for mental health and addictions for the North Shore region, I was told that there was one option for people who struggle with both depression and alcoholism. She identified that knowing other programs and services outside of those provided by the Ministry of Health Services was an on-going issue (Manarovici, Interview, 2011).

Illustrating the disconnect between services for alcoholism and depression, Penny said that she had never “met a drunk who wasn’t depressed” (Penny, Interview, 2011) though she said the services she and her fellow AA members sought out to help address the depression which accompanies alcoholism tended to be from the alcoholism support community. Her experience with the medical system in addressing depression was not positive (Penny, Interview, 2011).

#### **4.1.2 Current Approaches to “Integration”**

Current approaches to integrated services are primarily done in the case of severe and persistently mentally ill and/or addicted. For people who have severe and persistent mental illness and/or diagnosed concurrent disorders, these transitions take place primarily within Ministry of Health Services programs

and could be smoother. This client group also has the help of case managers, designed to act as system and program navigators for times when service users are unable to navigate services and programs themselves. Case managers can follow a person for a few months and up to several years to help through periods of illness and equip them for future illness (Manarovici, Interview, 2011). There was no mention of community supports external to MOHS services and programs when discussing case managers. The expansion of the online database, the Community Health Resource Directory (CHARD), may provide general practitioners with what they would consider more trustworthy knowledge of available resources for people with mental health and addictions, in addition to guidelines for referrals.

Throughout all interviews, there were varying discussions of the importance and emphasis on training as a way to integrate services. Some saw training as the ideal way to work across organizations and to understand other's services, in addition to a database of available treatment programs and services (Manarovici, Interview, 2011). Ministry of Health officials saw training as an element of person-centred work. Interviewee A from the Ministry of Health Services discussed an integration project specifically to address working across mental health and addictions. The federal government has seen this need in the addictions community, given the variety of roots from which these programs come. These are the roots behind the Knowledge Exchange Project, a five-year federally funded project, designed to encourage knowledge exchange between, across and through addictions treatment programs and services in BC.

While training can be an important element of collaborative care for those with mental health and addictions, the 2002 Report on Depression in BC stated that not all approaches to collaborative care have been effective, and that those based on exclusively on guidelines and education were not as effective in improving outcomes for people with depression. Ministry of Health Services Interviewee A referred to training as being the “back door” way of addressing the need to work between all forms of mental health and addictions service providers.

To better enable effective integration, Tom Hetherington of the Provincial Health Services Authority (PHSA)’s Addictions Knowledge Exchange project suggested that the two community’s traditions could meet in discussions concerning “content relative to experience” (Hetherington, Interview, 2011). In general, there is a reliance on physicians and medical personnel to know about alcoholism, and its effects and to work with people struggling with its use, but a balance in valuing the role that those with experience have in treatment as well. This treatment would bring together both the mental health counselling with addictions treatment approaches in the emphasis on the person, and starting with their understanding of their situation and problems. A person does not come to their problems alone, however. The influence of organizations like the Canadian Mental Health Association has had an effect on the treatment of mental health problems (Interviewee A Ministry of Health Services, Interview, 2011) such that family and individual supports are to be considered in mental health planning (Ministry of Health Interviewee B, Interview, 2011).

### **4.1.3 Costs of not providing treatment**

Costs for the treatment of mild-to-moderate depression and alcoholism are increasing, but not necessarily within the budget of the Ministry of Health Services. The most recent mental health and addictions plan for the province has a wider view of mental health and addictions, accounting for costs and impacts of Ministries outside of Health. The costs of alcoholism and mild-to-moderate depression are less visible than health spending for services and support to people with severe and persistent mental illness. Spending on this group would be included in health spending but also would be absorbed as externalities into the rest of the social and health systems, private insurance, and private spending which has the potential of creating a heavier social cost than if costs alone were absorbed by Health and Ministries involved in social care generally. In its measure of avoidable costs of alcoholism alone, the costs of alcoholism alone are \$2.219 billion dollars per year in the province of BC (Rehm et al., 2008)

Stress is the leading cause of short-term disability, such that workplace insurance providers are beginning to spend more time and energy in examining the need for services to address depression and anxiety. The cost to the insurance companies of significantly increasing rates of leaves taken has encouraged many companies to participate in awareness campaigns on addictions through organizations they work with. Often, these screens include specific attention to risky drinking.

In a relatively “simple” case of anxiety, some change can be expected in 48 hours of counselling, but depending on the person’s length of time struggling

with their illness or depression, coping techniques and behaviour patterns are more difficult to re-learn (Shields, Interview, 2011). This treatment time assumes that in going to counselling, the person involved is engaged in the process and fully discloses their struggles. For example, underlying issues of abuse may take months to disclose, especially with men (Shields, Interview, 2011). When people are paying for counselling through insurance provided by their employers, the timeline of supported counselling is relatively short (Tebbutt, Interview, 2010). This leaves people to pay for services themselves or to leave their treatment plans.

#### **4.7.3. Organizational Costs**

An interviewee from the Ministry of Health Services (Interviewee B Ministry of Health, 2011) discussed the nature of program evaluations within the Ministry of Health Services. Understanding how services work for people with substance use, in this case alcoholism, is exacerbated by the constant shifting of substance abuse between Ministries. Interviewee B from the Ministry of Health Services said that evaluations are based on specific program's "effectiveness" regarding specific criteria, without examining health as a system or any work with any other programs. The nature of this kind of evaluation, she said, was a tendency to work "within silos" (Interviewee B Ministry of Health Services, Interview, 2011). Further prohibiting any higher-level examination of function and programs across the province, there have been few resources in recent health budgets to undertake this work. The interviewee said that if this kind of project were undertaken, there would be a basis/base line measure to organize ways to



address issues which she says, are often known issues of inconsistency in programs (Ministry of Health Services Interviewee B, Interview, 2011).

## **4.2 Into and Out of Services**

### **4.2.1 – Transition between services**

Reflecting the BC Ministry of Health’s 2010 mental health and addictions plan, services must be accessible “where and when” they are needed, with flexible and smooth entry and exit points. In the case of people with alcoholism, the general belief is that residential programs are required in order to address alcoholism issues. When people struggling with depression and alcoholism seek out counselling, the transition following the end of services is one of the most difficult and time-consuming aspects of treatment, says Duncan Shields, though it is also one of the most important (Shields, Interview, 2011). Without good follow-up care and smooth transitions, treatment is “useless” (Hall, Interview, 2011). “Unless the person takes the work they done here (in the counselling sessions) out into their everyday life, this means nothing.” Transitions back to a healthy lifestyle are not simply about living without alcohol, said Penny. There are behavioural changes that must happen; no one wants to be a “dry drunk” (Penny, Interview, 2011).

Transitions between service providers often take place along historically established lines - paths of least resistance - in a formulaic pattern. Similarly, depending on how long a person has been struggling with depression and alcoholism, behavioural patterns are harder to “unlearn” and require continuity in

services to design plans to prepare for periods of ill health. To ensure transitions are not formulaic, the focus of care should be on the user. While service providers are aware of this, it is more difficult to implement.

Regardless of the types of treatment being provided – residential programs, day programs or even counselling, transitions between services are an opportunity to focus on client-centredness, but are also risky service “joints” for people who are depressed in their lack of motivation to seek out services they may need. While some level of “initiative” is needed, relying on “initiative to see out the services they need” may be difficult for someone struggling with depression (Manarovici, Interview, 2011).

#### **4.2.2 – Pathways to Community Services**

Depending upon one’s income, the province of BC will pay for residential substance use treatment (Interviewee Ministry of Health B; Interview Hall, 2011). When the person seeking treatment uses social assistance, treatment is covered. The costs for most forms of treatment are significant, as are the wait-times for follow-up treatment. The province does not cover or subsidize counselling with a psychologist for depression or alcoholism. One interviewee attributed this to the understanding the nature of the public versus private “problem.” While mental health problems are beginning to be seen as public issues, this is less the case for addiction problems (Hetherington, Interview, 2011).

**4.2.3 - Accessing Services** - People struggling with depression and alcoholism and their supporters face significant barriers in knowing what services and supports are available to them. Given that general practitioners generally do

work with people with depression, there is pressure for GPs to know what services exist in their communities. To address this need, the General Practices Services Committee (GPSC) introduced a program called Changeways in 2009, a session, which is the “most highly demanded of all available training” (Interviewee B Ministry of Health Services, Interview, 2011). This session provides a preliminary basis for cognitive-behavioural therapy (CBT), on the grounds that “evidence-based psychotherapies for depression, like CBT, produce improvements equivalent to anti-depressants that persist over a longer period of time” (BC Provincial Depression Strategy, 2002).

People who wish to seek out services for depression and alcoholism themselves have one option in the North Shore segment of Vancouver Coastal Health Authority. While a doctor’s referral is not necessary to access this service, to find it, service users must call a 1-800 telephone number and speak to someone who searches a local database to find the “most appropriate” service. “All programs can deal with concurrent needs, but depending on (the caller’s) primary need, they will be sent to one program or another” (Manarovici, Interview, 2011). Prioritizing “primary” need therefore isolates alcoholism from accompanying issues of depression or depression from alcoholism, falling into traditional treatment paths. This toll-free number was cited as the way in which to find out about available services for the health authority.

In acknowledging GPs dominance in addressing the need for services to people with mental health problems and addictions, the province of BC is unrolling a Community Health and Resource Directory (CHARD) to support

doctors. Since services around the province vary, it is difficult for any service provider to know the extent of available services, referral processes, or treatment approaches (CHARD website, 2011). In early 2009, a pilot project began on Vancouver Island (VIHA health authority), designed to address GP's knowledge gap for services regarding mental health and addictions (among others). This online tool is available to those deemed eligible by the Ministry of Health Services – those involved in the formal medical system.

Hospitals can be difficult to navigate in cases of emergencies. This has been reflected in literature, in addition to this study. The Standing Committee on Social Affairs and Science and Technology's 2006 report, "Out of the Shadows" quotes a mental health services consumer who said,

*"I have had occasion to sit in Regina General Hospital emergency with people from my group. We have gone home in despair. Unfortunately, we are not a priority and I do not know why. Maybe if we had blood coming out the sides of our heads, we would become a priority."*

(Standing Senate Committee on Social Affairs 2006, 17).

This research encountered similar experiences:

*"We got him (our son) to the Centre for the Centre for Concurrent Disorders because we'd already had a contact there and he saw the psychiatrist there who said, 'Yes, he's obviously having a psychotic episode, he should be going into the psych ward at UBC.' ... The psychiatrist at the Centre (for Concurrent Disorders) was not able to have... committed to the UBC psych ward. What he had to do was to go to the Vancouver General Hospital and he had to go to emergency and he had to wait for 10 hours to get a psychiatric assessment at VGH because only VGH could refer him to UBC. It's that kind of thing that drives you absolutely bonkers... It doesn't even work in an emergency."*

## **4.3 Social Issues**

### **4.3.1 – Community Supports**

Sometimes, low intervention community supports are the extent of the people need. Penny, a member and speaker for Alcoholics Anonymous, discussed the implications of an exchange with an emergency room doctor who asked her about AA, “She saved my life. Nobody had ever suggested Alcoholics Anonymous to me” (Penny, Interview, 2011). Penny was at the hospital because of her second attempted suicide, brought on by depression and alcoholism after several years of seeing a counsellor.

Community supports, programs and services for people with mild-to-moderate depression and alcoholism struggle to some extent because the same treatment methodologies applied use for people with severe mental health and addictions problems are applied in inappropriate cases for people with addictions needing less (Hetherington, Interview, 2011).

In many situations, lower intensity community supports can be sufficient, though supports are not as commonly provided or used at this level, a fact acknowledged by the province’s new mental health plan (Ministry of Health Services, 2010). Ministry of Health Interviewee A pointed out that services for people with depression have historically not been emphasized. On a regional basis, only the Lower Mainland of the province has had a population big enough to support more specific programs. The same applies to psychiatrists, and psychologists and their location around the province. A shortage of these mental health professionals in the community may present further challenges to attempts to be more extensively “community based.” Even provincial community-based

programs like the Canadian Mental Health Association vary in location, programs and availability (Canadian Mental Health Association, 2010).

Although they may be the most appropriate, community services and programs struggle with long wait times especially for counsellors. In attempts to make public counselling services more available to those who need it in a shorter time frame, the Ministry of Health Services has moved toward group counselling sessions. In the process, there have been difficulties surrounding confidentiality and a variety of treatment needs.

Often in depression treatment, community-based social elements are left out, as is support from other service users (Hetherington, Interview, 2011; Shields, Interview, 2011; Interviewee B Ministry of Health, Interview, 2011). Research shows that long-term mental health recovery requires community support and participation, social elements (jobs, education) though treatment plans have not historically included these elements of health (Standing Committee on Social Affairs, 2006).

#### **4.3.2 – Employment**

People struggling with depression and alcoholism issues who have taken a period leave from their jobs sometimes struggle to receive understanding from their insurance providers provided through their work (Shields, Interview, 2011; Tebbutt, Interview, 2010). In these cases, those with the mental health problem and/or addiction have little, (if any) help in coordinating documentation, services and occasionally even conflicting treatment recommendations in order to advocate for themselves when working with insurance companies, while sick with

illnesses which affect their ability to advocate and seek services. In the most extreme cases, people who have needed extensions from their work have been forced back to work before their doctors would have recommended, situations unlikely in the context of physical illness (Shields, Interview, 2011). Upon their return to work, there may be issues concerning their “performance” or behaviour prior to their absence, likely connected to co-worker lack of understanding about what has happened (Tebbutt, Interview, 2010).

#### **4.4 Ministry of Health Services foci**

Working in partnership and across organizational boundaries was an issue that is well understood and discussed by interviewees involved in the Ministry of Health Services. Those involved with the Ministry of Health Services agreed that primary caregivers should continue to be the point of contact for people with mild-to-moderate depression and alcoholism, but acknowledge that at this time, that this population will struggle to receive any real attention. The reason for this is that the MOHS has identified those who demand the most from the health system. For this reason, people struggling with Concurrent disorders with an Axis-1 mental health diagnosis and a diagnosed substance abuse problem continue to be the primary focus. The General Practices Services Committee is interested in building in screens for depression into general practitioners’ regular appointments. MOHS officials have heard interest in designing risky drinking screens for regular appointments as well (Ministry of Health Services, Interviewee A, Interview, 2011).

## **5: POLICY OPTIONS**

The implementation of all policy options (with the exception of the status quo) would require the province to set new standards for care, establish new provincially accessible programs or projects, or require health authorities to take on specific projects. The policy options I discuss are: the status quo, a mental health navigator, knowledge exchange across mental health and addictions, a partnership project and relational inclusion option.

### **6.1 Status Quo**

If the status quo option were chosen, general practitioners would continue to support people struggling with mild-to-moderate depression with minimal focus on cognitive-behavioural counselling and a primary reliance on medication with little or no community service or social support. Some voluntary training would support GPs, conducted by the General Practices Services Committee of the MOHS. Any further counselling support would be paid for privately. Generally, mild-to-moderate depression and alcoholism would receive little formal MOHS attention apart from efforts by primary care providers or local community resources. People struggling with alcoholism would address alcoholism alone, with their doctor to some extent, or with the help of whatever community resources they might seek out themselves regardless of its appropriateness (Penny, Interview, 2011). Services available to those who want it will depend on current community capacity, as was historically defined.



Financial costs of both depression and alcoholism would be primarily absorbed privately to the point where some of the alcoholism/depression population may require secondary care interventions (hospital or residential care facilities), the cost to the social system through work and productivity and costs associated with the judicial system.

Doctors across the province can choose to participate in the Practice Support Program (PSP) and enrol in the mental health module. Doctors who are aware of the program may refer their patients on to self-directed support programs like Bounce Back. Other low intervention programs depend on resources available on the basis of community and health authority.

## **6.2 Mental Health Navigator**

In this option, the province would implement a program wherein a team of people would be provided on a per capita basis to each health authority to act as individual supports for people with depression and alcoholism, working “on their side.” An individual case worker would support service users as they move through the mental health and addictions system by participating in discussions with private insurance providers and undertaking any coordination of support services, and providing information about available community service groups, in addition to acting as an advocate when needed. This ‘Navigator’ would provide a place where service users may ask questions of someone who understands the system. Navigators would also be able to advocate for issues on behalf of service users and/or their families, and attend appointments and case planning with people as needed. This program is comparable to mental health workers,

currently provided exclusively to people with Axis-1 mental health diagnosis or severe addictions problems.

This system-navigation role exists to some extent for those coming from other parts of the province to the Lower Mainland for breast cancer treatment. Victoria has a program called the Breast Health Patient Navigator, a team of nurses with expertise in breast health and cancer. “They assist by answering questions, preparing people for treatment visits with specialists, informing people of community supports, helping people navigate the cancer care system, and providing emotional support” (Breast Health Patient Navigator, Accessed online).

This option would also address the changing field of services, which may or may not at any given time provide services specifically for people with depression and alcoholism. Primary caregivers struggle with staying current on treatment options inside and outside of their communities, and a Navigator system would both have access to an online database (the same as general practitioners), but they will have further knowledge about specific community program’s attributes and strengths

The province is extending access to an online database of services to physicians across the province to ensure medical professionals are aware of accessible services, and understand requirements to be admitted to programs (the Community Health and Resource Directory - CHARD). A Navigator would provide a personal face to the computerized system for the benefit of service users.

### **6.3 Knowledge Exchange across Mental Health and Addictions**

In this option, the Ministry of Health would conduct an evaluation project across the province in each health authority to provide a program and service “map.” Understanding in a standardized, specific way the way in which services and programs and contracts exist on a specific level would be a basis for planning future work in mental health and addictions on a provincial and health authority level.

This map would examine the services provided to people with mental health and addictions, programs available and staffing patterns, and would necessarily include a discussion of contracted community agencies. These community services (both organizations with health or social service mandates) with contracts with the Ministry of Health to either people with mental health concerns, addictions exclusively and/or concurrent needs would be asked to participate. Each health authority would be asked to identify service partners, as well as where they see gaps in services.

Following a survey analysis, examination of project successes, struggles in and between partnerships, and needs for programs and services would emerge for each health authority. Each region would be broken down by service needs (depression and alcoholism, formal Concurrent Disorders, and other mental health and addictions issues).

This option would identify the use of evidence-based practice for working with people with concurrent service needs through referral patterns and service gaps. A survey of contracted organizations and referral patterns would reveal

how service providers and the medical field are addressing the need for service integration - an important issue identified in all service plans. This option would provide the Ministry of Health Services with information on its capacity to address alcoholism and depression within each health authority, and with information on systemic needs across the province and potentially successes or needs for the inclusion of other Ministries and programs. A knowledge exchange of this type also provides grounds for a dialogue in success and struggles in service provision in many different contexts.

Following this survey and “mapping” exercise, the province could establish best practice standards, and work to improve high-level integration work between mental health and addictions, while health authorities would have a better understanding of their own needs and service gaps relative to one another.

## **6.4 Partnership Project**

The goal of the partnership project would be to establish strategies and work plans for improved intersectoral work across all mental health and addictions services users and service providers. This work would take place within of the context of Functional Integration Regional Meetings (FIRM) for a five-year pilot project in communities that agreed to participate.

By nature of the parties involved, the education required and treatment history between the mental health and addictions community, the underlying power dynamics involved within the medical world and between the addictions service community in providing service to people with depression and alcoholism

affect the way a dialogue will take place. To do appreciative inquiry, all parties involved in providing service to people with depression and alcoholism must be considered and included. To minimize the effect of power relationships and draw participation from all parties, the partnership project would use appreciative inquiry; a facilitated approach to understanding how and what works well within organizations, and building upon its strengths. This approach to planning assumes that in every system, something is working well.

The process of appreciative inquiry has four phases: discovery, dream, design and destiny (Cooperrider and Whitney, 1997). The discovery phase involves an investigation of what is going well, an “appreciative” stage. The next phase is the “dreaming” phase of envisioning results, and “what might be”. Third is a co-construction of “what should be”, and what the ideals for the group or organization are. The final (and vital phase) sustains the work of the first three steps; the “destiny” phase. This is when the learning about how to empower further work and learn to adjust and improvise takes place.

Given that each health authority has acknowledged the need for better community participation and integration of services, this appreciative inquiry process would take place in the context of integration service plans. Functional Integrated Regional Meetings (FIRM) are designed to improve and lead integrated work, and involve a variety of service providers (See Figure 5.1 for participants in Interior Health’s FIRM committee). Interior Health has an active FIRM committee designed to address mental health and substance use in that health authority, already involving many of the parties that would be beneficial in

this dialogue. This committee would take place in the context of each health authority's FIRM committee, though it would include additional community groups designed to support people with alcoholism and low mood. This may mean the inclusion of community groups like the Mood Disorders Association of BC or Alcoholics Anonymous, as well as social supports through Ministry of Social Development and Ministry of Children and Families, as determined by the programs and services available in each area.

Each health authority would conduct appreciative inquiry in the context of their integration work. By conducting this work in each health authority, each area would have its specific goals, which account for varying needs and available resources. In the early days of the appreciative inquiry, participants would be encouraged to invite other community organizations to the committee, pending support of at least two other organization's representatives.

**Figure 6 - Functional Integrated Regional Meeting Core Members, Interior Health Authority,**



***Figure 5.1 Functional Integrated Regional Meeting core members, Interior Health Authority, 2010***

## **6.5 Relational Inclusion**

The inclusion of informal networks of support has been shown in interviews and through research to be integral to long-term health for people with mental health and addictions. Those support systems are often the most successful and meaningful supports, having the greatest effect on outcomes (Kawachi and Berkman, 2001).

In this option, people struggling with depression and/or alcoholism would be asked and encouraged by their primary formal support provider (their family doctor, for example) to have someone from their own support networks participate and contribute to their treatment plans. Those who would be chosen have a vested interest in the person's health, and will likely be in a person's life

for significantly more time than any service provider. This chosen person would also be involved in advising what treatments (social, medical, pharmaceutical, et cetera) do and do not work. These support people would need to sign confidentiality agreements in order to participate. Some consideration would need to be given to the power of the privilege of information and the potential to abuse this role, though they would not necessarily need to be a part of the treatment and counselling itself, merely in planning. Supporters would need to be able to change their “supporter” role as they wish. People in the supporter role would need to be given flexibility to contact community and medical support networks on their own. The supporter would be able to advocate for further services and attend all meeting related to the “supportee”’s care.

This option would include the provision of counselling to service users needing the social support, in addition to their families and support networks, as is being considered by the Ministry of Health Services at this time.



## **6: CRITERIA AND MEASURES**

In this section, I will describe the ways in which the policy options will be examined to determine the recommended option. The four criteria I have identified are: equity, cost, effectiveness, stakeholder acceptability and impact on stigma reduction.

Each policy option assumes that the province would implement specific guidelines or best-practice standards because health authorities would have to see it in their interest to implement these changes.

### **5.1 Equity**

Each policy option will be examined by its potential to affect equity of people with mild-to-moderate depression and alcoholism. My measures of equity include: equitable access to services, equitable provision of services and equitable after-service care. This measure of equity does not look at comparisons of equity across other groups of people with mental illness and addiction. The measure of equity will be “not acceptable,” “somewhat equitable” and “equitable”.

### **5.2 Cost**

There will be three measures of financial cost and each will be measured on a scale of high/medium/low costs. The costs of depression and alcoholism will be measured in three ways: the financial costs to initiate the policy, the wider

social costs of those who do not receive appropriate service, and the potential law enforcement costs for those who do not receive services

### **5.3 Effectiveness**

An effective policy will address service gaps for people with depression and alcoholism and make services more person-centred. Person-centred service will facilitate integration, ease transitions and encourage prevention and earlier intervention. Person-centred service in vision-oriented partnerships (+3), person-centred approach in current context (2), no change (0)

### **5.4 Stakeholder Acceptability**

The stakeholders involved in any policy designed to address those with mental health problems and addictions will be: general practitioners (GPs), psychiatrists and psychologists, service users, informal support networks, and community mental health and addictions networks.

Service providers in the medical field (psychiatrists, psychologists and general practitioners) have significant status and power in the treatment community and their opinions and desires will be very public. General practitioners stand to lose power, and may have significant learning to do in some options. Options may affect their ability to refer their patients on to other services. The BC Medical Association (a voluntary professional association) works closely on an annual basis on the General Practices Services Committee, binding agreements between the two bodies.

Psychiatrists have status in the medical field, and may see patients filtered away from their programs and services.

Psychologists are not funded through the Ministry of Health, so their responses to policy change will be different from psychiatrists.

Service users may be more or less affected by policy change in their ability to access services and support.

Informal support networks have more of a formalized role in some of the policy options.

Community mental health and addictions programs and organizations may face increased demands and may necessarily develop more extensive connections to health authorities and other community programs.

Each stakeholder group will receive a measure of high/medium/low acceptability for each option.

## **5.6 Impact on Stigma Reduction**

The public sentiment and (to some extent) fear of people struggling with mental illness, affects the treatment options available and people's willingness to see out support from either support system provided (Golberstein, Eisenberg and Gollust, 2008). This criterion will be measured with the degree to which the policy encourages holistic, individualized health approaches delivered in the least intrusive manner by a variety of supports. No change (0), more holistic views within health system (1), more holistic views delivered by variety of supports (2).

Criteria	Description	Measure	Rating
Equity	Equitable access to services, provision of services, provision of follow-up care	Improvements to equity relative to status quo	Equitable
			Somewhat equitable
			Not acceptable
Cost	Costs are made up of 3 types: implementation costs, social costs, and legal costs	Relative to status quo costs.	High
			Medium
			Low
Effectiveness	Effect of policy on improving services, minimizing gaps, easing transitions	Person-centred focus	Person-centred in integrated services
			Person-centred in current context
			No change
Stakeholder Acceptability	Acceptability of the adoption of each policy option to each stakeholder: government service providers, non-government service providers, service users	Degrees of acceptability in a points system for each group	High
			Medium
			Low
Impact on Stigma Reduction	The effects the policy has on the public and service-system stigma	Degrees of improvement in holistic, integrated and socially acceptable provision of service	Socially acceptable, positively affecting stigma
			Socially acceptable, no affect on stigma
			No change

**Figure 7 - Criteria and Measures**

## 7: POLICY ANALYSIS

### 7.1 Status Quo Analysis

**Equity:** The continuation of the status quo would provide no change in equity. Access to programs and services across the province would be based upon historically established services for people with alcoholism or depression, with very little crossover. Mental health services for people with depression would be offered by general practitioners, based upon GP's individual but patchy knowledge of available resources and training. Some GPs refer their patients on to Bounce Back, a low-intervention self-guided program offered by the Canadian Mental Health Association in conjunction with the Ministry of Health Services. People with depression and alcoholism are screened out on the basis of excessive alcohol use. Accordingly, this option is designated "not acceptable."

**Cost:** Because there would be no change in programming or services offered, this option would rank "low" in costs for implementation (equal spending), but with "high" social costs in perpetuating poor quality of life and health outcomes for people with depression and alcoholism and "high" legal costs in the prosecution of incidents involving drinking and driving and other misdemeanours.

**Effectiveness:** This option is not effective at addressing the needs of people with alcoholism and depression because services continue to be separated via organizational silos (Weiss et al, 2009) and problems prioritized and treated within the dominant medical model and without an adequate holistic,

person-centred approach, although health authorities are increasingly focusing on this issue. This option ranks “no change.”

**Stakeholder Acceptability:** While many stakeholders in the mental health and substance abuse community understand that the service system for people with alcoholism and depression needs to change, the status quo is the simplest and least difficult to implement and continue. On this basis alone, this option ranks “medium” in its acceptability. Government has run this system so would support it (“High”), non-government service providers would support its continuation on a “medium-to-low” scale. Service users would rank the status quo “low” in its acceptability.

**Impact on Stigma Reduction:** The status quo maintains a very medicalized view of both depression and alcoholism, failing to provide supports in the social arena or combat stigma, though they have acknowledged the need for such change. The status quo would provide no change.

## **7.2 Mental Health Navigator Analysis**

**Equity:** Given that no change would happen in the way service is provided, with a tendency to continue a focus on medicalized care and with the potential to minimize the impacts of alcoholism, this option is “somewhat equitable.”

**Cost:** The involvement of another person in case planning for those with mild-to-moderate depression and alcoholism bears minimal time costs for service providers. There is a potential for time savings and service repetition because

those involved in seeking services would have access to a person to help interpret their instructions and would have a clear idea of what services are available to address their specific needs set. This program would involve hiring and running a new provincial program, which would require funding with “high” implementation costs. There stands to be cost savings in the social cost of depression and alcoholism because of this option because of smoother transitions between care providers. Those needing services would have a better idea of what was available to them, requiring less “system” supports. The effect of the existence of a Navigator program has unknown effects on legal costs. This will be “low” as a result, in a conservative estimate of cost differential.

**Effectiveness:** This program would increase knowledge of programs and services to service users and potentially their families. This policy would not affect or encourage further movement toward person-centred care. This policy could connect people to the services they might not otherwise know about or find approachable, and provide a connection between service professionals and the community. This option would rank “person-centred in current context.”

**Stakeholder Acceptability:** Support for this policy will vary. The province would likely support the policy change in furthering its goals to be “patient focused” but health authorities may find funding the presence of a Navigator a significant burden. Psychiatrists, psychologists and medical personnel may find the program to be some nuisance, though would likely not object significantly (“Medium-low”). Community networks, supports and programs who may work with people with depression and alcoholism would likely support this move.

Responses from service providers outside government may be divided, but would generally support (“High”) . The people involved in the care themselves would support this move in that it would help them understand what options they had available (“High”)

**Impact on Stigma Reduction:** This policy may not affect systemic stigma of people with depression and alcoholism on a large scale, but could provide small gains on an individual basis in ensuring that people understand their care plans, and what they need to do, encouraging more positive views within service communities. This ranks “socially acceptable, positively affecting stigma.”

### **7.3 Knowledge Exchange Across Mental Health and Addictions Analysis**

**Equity:** In this option, there would be no change in how or whether services are accessible to the regions in the province. There may be changes in accessibility, targeted services and determining communities of the highest need in the future, but no equity change will take place immediately because of this policy.

**Cost:** The cost of this study would be significant with returns that would be difficult to measure. Any potentially large social cost savings would be difficult to measure in the short-run because the results of the research would need to be implemented, affecting future system needs. No legal cost savings will take place as a result of this policy.

**Effectiveness:** A knowledge exchange would allow for small and large partnerships to be discussed and examined in order to provide contextual



evidence for the improvement of existing partnerships. Knowledge exchange would provide practice-based evidence, which would support person-centred care. This option would encourage both “person-centred care and integrated services”.

**Stakeholder Acceptability:** The province would likely object to this project, given that it would need to provide the funding for this option (“Low”). Health authorities and community service providers would need to be open to having their programs and services examined and compared. This group would rank “Medium” in acceptability. There would be some disruption to general work if this project were to take place. Service users depression and alcohol-related programs would likely be impartial or support this option, seeing little effect on them or services in the short run (“High”).

**Impact on Stigma Reduction:** There will likely be little reduction of stigma from either service providers or the public as a result of this policy option. Perhaps action taken in the future could affect stigma. In the short run, this option ranks “No change.”

## **7.4 Partnership Project Analysis**

**Equity:** If this project were undertaken and the results implemented, there would be an improvement in equity, as service providers and service users would participate in visioning and the construction of objectives for services - a first step in partnership work (UK Audit Commission 1998). People providing and using services would identify where potential for improvements are and where people

with depression and alcoholism are finding services unhelpful or non-existent. Given that this option would improve equity, it will rank “equitable”.

**Cost:** The cost of this option would be greater than the status quo because it would involve a time commitment from all stakeholders to participate in appreciative inquiry. This may mean a total of several days over each year from each participant on the health authority level. These are “high” implementation costs, though there is potential for social cost savings, in that there is less likelihood that similar work will be replicated and participants in the process will understand and build relationships with the rest of their service community (“low”). There will be no effect on the legal costs of depression or alcoholism (at least immediately) because of this option (“low”).

**Effectiveness:** This option will address the potential for improvements in programs and services. Each region will have the opportunity participate in designing an objective and a plan to address their own region’s strengths and needs. This option will be more person-centred and services will be integrated as a result.

**Stakeholder acceptability:** It may be somewhat difficult to ensure buy-in from government early in the process (“Medium”), though it would support the goals of integration at a high level. The work of the FIRM will be acceptable to service providers (“High”) and service users (“High”), though the implementation of the results of the appreciative inquiry may be more difficult.

**Impact on Stigma Reduction:** This option will address stigma within the service provision community through the process of appreciative inquiry. This

option will be socially acceptable, though it will not affect levels of public stigma in the short term (“Socially acceptable, no affect on stigma”).

## **7.5 Relational Inclusion Analysis**

**Equity:** The inclusion of informal support networks will improve access and use to services, though it will not address geographic issues. In the inclusion of the relation in planning, some equity may be improved, though power relationships are not addressed. This option is “somewhat equitable.”

**Cost:** The cost to implement this policy option would be minimal (“Low”) and may result in fewer social costs and repeated visits and demands on formal support services (“Low”), in that informal supporters (who would have existed even outside of this policy option) would be better informed in available services, and able to participate in services offered. Ministry of Health Interviewee B discussed the potential for family counselling in this context. The supporter, understanding the needs of the service user, would be able to work with private insurance, understand care planning, in addition to acting as an information hub for the “supportee” in times where they are not able to. There would be “Low” legal cost as a result of this policy.

**Effectiveness:** Services may improve and gaps may be minimized because of the presence of a supporter and their ability to advocate. They would also be a voice for the impact of poor transitions. On an individual basis, this may aid in person-centred service provision, but for the most part, this option will only address “person-centred in current context.”

**Stakeholder Acceptability:** Governments would tend to support this initiative as part of a “client-centred” focus (“High”). Non-government service providers, namely doctors, psychiatrists and psychologists may object in that it complicates and likely makes appointments and work with people with depression and alcoholism longer, and could affect their powerful role. With doctors as the exception, service providers from both mental health and addictions fields have openly discussed the importance of the inclusion of peer and informal support networks in long-term health (“Medium” support). Service users would likely full support this option, with careful attention to privacy issues (“High”).

See following page for Policy Analysis comparison table.

	Status Quo	Mental Health Navigator	Knowledge Exchange Across Mental Health and Addiction	Partnership Project	Relational Inclusion
Equity	Not Acceptable	Somewhat Equitable	Not Acceptable	Equitable	Somewhat Equitable
Cost <i>* Implementation Costs</i>	Low	High	High	Medium	Low
<i>* Social Costs</i>	High	Low	Medium	Low	Low
<i>* Legal Costs</i>	High	Low	High	Low	Low
Effectiveness	No Change	Person-centered in current context	Person-centered and integrated services	Person-centered and integrated services	Person-centered in current context
Stakeholder Acceptability <i>* Government Service Providers</i>	High	Medium-Low	Low	Medium	High
<i>* Non-government service providers</i>	Medium-Low	High	Medium	High	Medium
<i>* Service Users</i>	Low	High	High	High	High
Impact on Stigma Reduction	No Change	Socially acceptable, positively affecting stigma	No Change	Socially acceptable, no effect on stigma	Socially acceptable, positively affecting stigma

## **8: POLICY RECOMMENDATIONS**

The difficulty in providing person-centred care is that in British Columbia, change must happen both at a higher, systems level and a front-line level. The Ministry of Health Services is aware of the needs at both ends of the spectrum, as are community services providers and most importantly: service users for whom all programs and services exist.

As one interviewee emphasized, single-focused training and community relationships between services designed for people with depression with services for people with alcoholism cannot address person-centred care or integration in that they are service-focused with internal measures of success. Training provides a surface answer to problems that are rooted in organizational culture, geography and a 'siloes' approach to health: "mind" versus "body."

The recommended options from this study are two-fold: examination of systemic issues through appreciative inquiry (the partnership project) and the inclusion of people's informal support networks in depression and alcoholism treatment plans and programs (relational inclusion).

Best practice encourages the inclusion of people's informal support networks in care plans, acknowledging that this access to information may make the greatest difference in providing the best care possible for their loved one (Standing Committee on Social Affairs, 2006, 31). This would help supports to ensure a continuity of care is consistent. Family members would help with

ensuring people keep appointments, meet deadlines for any private insurance needs, among other things. Formal service providers do not have the time to ensure this follow-through.

A series of appreciative inquiry workshops conducted through Functional Integrated Regional Meetings (FIRMs) would strip away power roles generally associated with both the alcoholism field and especially the medicalized world of mental illness and depression. In the context of this committee, joint visioning could take place, as could goal setting through time. This process would build on partnership relationships and encourage further growth of partnerships that would support person-centred, recovery-based care.

I would recommend that the Ministry of Health Services encourage all regional health authorities to put together a mental health and addictions services plan. To date, a mental health and addiction service plan is not a requirement through the Health Authorities Act. In the context of service plans and reports, I would encourage a measurement beyond homelessness beds, which is the standard measure of the success or failure of a mental health and addictions services. I would recommend a more accurate medically and socially oriented performance indicator, for example changing to relative numbers of hospitalizations connected to depression and alcohol-use.

A significant service gap identified in the study included the lack of public funding for treatment with psychologist. Given the effectiveness of cognitive-behavioural therapy primarily done in this setting, further examination of the role of psychologists would be advisable.

## **9: CONCLUSIONS**

This capstone has highlighted the need for a balance between grass-roots improvements and systemic change in service provision models. At grass roots, the inclusion of informal support networks – people’s true supports – together with a systemic view of what works well can be built upon to create health regions with a variety of services targeted towards improving the lives of people with concurrent alcoholism and depression.

The combination of these two options would address gaps in service faced by individuals, and include their own support networks in navigating these gaps. The inclusion of support networks may, on an individual basis, help those receiving services to better understand and follow through with instructions from their service providers, help to smooth transitions between programs and services and ensure that follow-up supports are available.

Providing holistic care is not an issue for just one Ministry or organization, and requires work between organizations in the form of good partnership work. While it is not a surprise, to make this happen is more difficult, and needs more than protocols and the guidance of best practice. Conducting appreciative inquiry workshops at the level of service providers and commissioners in health authorities would bring service organizations from both medical and social backgrounds closer together with shared aims and values to address systemic issues specific to each region and organizational cultures, as well as



acknowledge the difference in needs for people with concurrent alcoholism and depression in a process that minimizes some of the negative impacts of imbalanced power dynamics. The work of appreciative inquiry workshops to develop shared aims, values and ways of joint working could be continued through committees designed to progress integrated work.

Finally, the numbers of people struggling with mild-to-moderate depression and alcoholism are high, though minimal work is done on prevention or early-detection. This is an issue for entire service communities, not just health authorities. As in physical health awareness and prevention, mental health promotion could help the public generally to identify and address their own problems before needing external support.

General practitioners have a significant role to play in services for people with depression and alcoholism, in addition to others with mental illness and addictions. The General Practices Services Committee (a committee of Ministry of Health Services and the BC Medical Association) supports some training, though this training is brief and cannot address systemic issues or very specific community knowledge.

## **9.1 Study Limitations**

This study was limited by the variation in services and documents provided by each health authority and each region of each health authority. Even within health authorities and regions, service providers were uncertain of treatment paths outside of their own historical working patterns. Further to the

issues of services regionalization, the results of this study may have differed had I been able to obtain the same documents for the case study from all health authorities. Some health authorities required requests through Freedom of Information while others did not resulting in different knowledge bases and gaps in information which has informed this study.

My results may have also been somewhat different if I had been able to interview general practitioners through the British Columbia Medical Association (BCMA). To date the majority of the care, planning and community connections for people with depression and alcoholism is done through general practitioners. The recent Ministry of Health Services mental health and addictions plan is clear in its intention to continue this treatment approach. No one from the organization returned my request for a representative's call and so the GP perspective has not been represented in this work.

## **9.2 Next Steps**

In follow-up research, I would recommend a full cost-benefit analysis be conducted on services for depression and alcoholism in this province, given the two are so closely linked. While national studies have examined both substance use (including alcoholism), and national and provincial studies on depression, the close link between the two warrant their own cost study, providing a fuller examination of the social costs of the co-morbid struggle. This costing strategy could also be applied to the selected policy option within the context of smaller-scale pilots. To best address concerns of costs of any policy change, the

selected policy option could be launched in a smaller-scale pilot context, from which a further cost-benefit study could assess its costs and benefits.

Several interviewees mentioned an important service gap: counselling. This is not covered by public insurance. Acknowledging that psychologists are trained in cognitive behavioural therapy (CBT) and that this form of treatment is highly effective in addressing issues of depression and anxiety, the Ministry of Health Services should examine issues concerned with funding more extensive counselling services for people with both depression and alcoholism, in the spirit of providing “the right treatment at the right time.”

While the Ministry of Health Services strives to provide a “person-centred” approach to health care, this is to some extent stymied by continued dependence on general practitioners together with information hubs which serves to reinforce the medical model and service-focused rather than person centred organizations. More research needs to be conducted into ways in which equal partnerships across health and social care can be promoted and silo mentalities challenged such that more holistic support can be offered to people with both depression and alcoholism.

## **APPENDICES**

## Appendix 1 – Interview Schedule

### Topic Areas:

Role description:

- describe own job
- describe organization
- referrals from...?
- refer to...?
- screen for substance abuse (if a mental health organization)/mental health (if a substance abuse organization)

### Role in mental health/addictions community:

- Primary organizations with whom they work. In what context?
- How are relationships with other organizations made?
- How does working together work? Formalized working relationships (contractual?, personal relationships, case-by-case)?
- What barriers exist when working with other service providers? What facilitate joint working?
- Are the groups who need to work together to provide help all around the same table? If not, why not?
- What could make working relationships better?

**Describe own organization's work with other service groups.** What is the basis of the good work that they do together? In what ways is that relationship successful? (e.g. maintaining commitment/involvement, getting tasks done, making good use of the staff involved in partnership work, building trust between the partners, keeping focused on the outcomes of the work together, etc)

Regional function of mental health and addictions services:

- For whom does the system work best?
- Who's the biggest loser/winner? What is being done to address this?
- Which services they think are the most effective and why

General thoughts/perceptions on service provision to people with concurrent disorders, comment on mild-to-moderate depression group.

- Organizations which deal with alcoholism?
- Organizations which deal with depression?
- Perceived service gaps for this group
- Ideal service organization for mild-to-moderate depression people with alcoholism

Thoughts on new mental health plan.

## **Appendix 2 – Consent Form**

### **CONSENT FORM**

You are invited to participate in a research study being conducted by Meredith Shepherd, a student in Simon Fraser University's Master of Public Policy program. This research will complete a requirement to earn a Master of Public Policy degree. The supervisor for this research is Professor Judith Sixsmith, Public Policy program, Simon Fraser University.

#### **Purpose of the Study**

Research shows that people who struggle with depression are also likely to struggle with alcoholism at some point during their lives. The British Columbia government joined the province's mental health and addictions services to address the service gaps people with concurrent disorders face. Support for people with mental health and addictions can be provided in many ways, but when it is not provided effectively and involved organizations fail to work together, health outcomes overall for this group decreases. This study will identify options to improve coordination of the work done to support people in their treatment for depression and alcoholism.

You are invited to participate because I would like your opinion on what is and isn't working in the treatment and support for people living with depression and alcoholism problems. I would like your suggestions and ideas about what would help the mental health and addictions systems to be more integrated and to work better together. You have been asked because of your involvement or provision of services in the mental health or addictions treatment system.

#### **What it Means to Participate in this Study**

If you agree to participate, you and I will arrange an interview which will take around 45 minutes to an hour at a location to be arranged between the two of us. With your permission, the interview will be audio recorded. To preserve your anonymity, your name will be removed from all the documents and reports written about this study.

I don't expect that there are any risks associated with participation in this study. You may choose to cancel or stop your participation at any time or choose not to answer any questions without providing a reason. You can ask for a copy of the report by contacting me directly, [meredith.shepherd@sfu.ca](mailto:meredith.shepherd@sfu.ca)

This study has been approved by the Department of Research Ethics at Simon Fraser University. If you have any concerns or complaints, please contact Hal Weinberg, Director, Office of Research at [hal\\_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or 778-782-6593.

### **Questions about Participating**

If you have any questions about participating in this study you can contact me, Meredith Shepherd at [meredith.shepherd@sfu.ca](mailto:meredith.shepherd@sfu.ca) or by phone at 604 803 6442 or my supervisor, Judith Sixsmith at 778 782 8671, by email at [judith\\_sixsmith@sfu.ca](mailto:judith_sixsmith@sfu.ca) or by mail at: Simon Fraser University at Harbour Centre, 515 West Hastings Street Suite 3271, Vancouver, British Columbia, V6B 5K3. From December to March, Judith can be reached at [j.sixsmith@mmu.ac.uk](mailto:j.sixsmith@mmu.ac.uk) (Manchester Metropolitan University, UK).

### **Consent**

I have read or heard aloud the details of the study and what it will mean if I participate. I have had a chance to ask questions and all of my questions have been answered. I understand that the interview will be audio recorded and transcribed to make sure that my responses are reported correctly. I also understand that parts of the interview may be included in the final capstone report or other publications, although my name and identifying information will not be included. I understand that I can stop or cancel my participation at any time by contacting Meredith Shepherd.

This study has been approved by the Department of Research Ethics at Simon Fraser University. If you have any concerns or complaints, please contact Hal Weinberg, Director, Office of Research at [hal\\_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or 778-782-6593.

By signing below, I agree to participate in this study.

**Participant Name**

**Participant Signature**

**Date**

## **Appendix 3 – Study Details**

### **SFU Study Document**

Principal Investigator – Meredith Shepherd

Supervisor – Judith Sixsmith

Public Policy -Director Nancy Olewiler

**Title of Study:** Linking Service to Connect People: BC’s services for people with alcoholism and depression

#### **Purpose of Research:**

The purpose of this research is to examine the long-term services and barriers in service to BC residents struggling with concurrent depression and alcoholism. The goal of this research is to develop policy alternatives that will alleviate barriers to effective intersectoral work which will provide long-term support for people with concurrent depression and alcoholism.

#### **Methodology Used:**

##### *Informational Interviews*

Informational interviews with mental health and addiction service providers will be the primary methodology of this research. Interviewees will be read the consent form and will be asked to sign it (see attached Ethics Interview topics and Interviewees). Interviewees will be asked to comment on what they see to be the primary barriers to effective partnership work between long-term mental health and addiction services and will be asked to give their opinion on policy options that may overcome these barriers to interwoven mental health and addictions services for people with concurrent disorders (specifically depression and alcoholism).

##### *Secondary Data Collection*

Much of the information pertaining to mental health and addictions and the need for integrated services, in addition to government plans to integrate service is available on the public domain and is publicly available in peer-reviewed journals or in government publications.

#### **Interview Participant Group**

Participants for the interviews will be service providers from both the mental health and addictions systems, and officials from regional health authorities. Please see attached Ethics Interview topics and Interviewee forms.



### **Recruitment of Participants for Interviews**

Service providers will be selected from treatment providers for both mental health and addictions, substance abuse treatment providers, Alcoholics Anonymous and a representative from regional health authorities. Interview participants will be recruited via email and telephone requests. Contact numbers will be taken from public sources, such as organizational websites and publications and potentially through personal contacts.

I will have the interview participants read the Consent Statement for In-Person interviews. I will email consent forms to participants prior to conducting telephone interviews with them. I will ask participants to fax their signed copies to me prior to the interview. I will record the telephone conversations with a recorder. Because the nature of telephones is that they are not completely secure, I will inform those involved in telephone interviews that I cannot guarantee confidentiality.

**Interview information:** The objective of this interview is to gain an understanding of the structural barriers to effective support for people struggling with alcoholism and mild-to-moderate depression. The information acquired will be used to develop and inform a public policy report by Meredith Shepherd, a Simon Fraser University graduate student as a part of her degree requirements.

All interview data will be stored on a flash drive, which will be kept in a locked drawer when not in use. In following university policy, the data will be stored for a period of two years following the completion of the study and then be destroyed. If you have any concerns or complains, please contact Dr. Hal Weinberg, Director at SFU's Office of Research Ethics, at [hal\\_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or 778.782.6593. Research results can be obtained by contacting Meredith Shepherd at [meredith.shepherd@sfu.ca](mailto:meredith.shepherd@sfu.ca)

**Stopping participation:** The consent form states that participants may, at any time, stop the interview by simply verbally requesting to stop.

**Storage of Interview data:** All interview data (transcripts and audio recordings) will be stored on a USB key and will be locked in my apartment where I am the only key holder. Data will be stored for two years and then destroyed.

### **Confidentiality**

Confidentiality for the interviewees has not been guaranteed unless they request on the consent form to have their name changed. Interview participants will indicate on the consent form if they consent to having their names used in the following manner:

Do you consent to having your name used when referencing your comments on services provided to people with depression and alcoholism? Please check one.

Yes \_\_\_\_\_ No \_\_\_\_\_

In the even that participants do not want their names used, names will be changed to an alternate unidentifiable name.

**Risks to Interviewees**

There are no foreseeable risks to participants as a result of this study.

## **Appendix 4 – Telephone Consent Form**

You are invited to participate in a research study being conducted by Meredith Shepherd, a student in Simon Fraser University's Master of Public Policy program. This research will complete a requirement to earn a Master of Public Policy degree. The supervisor for this research is Professor Judith Sixsmith, Public Policy program, Simon Fraser University.

### **Purpose of the Study**

Research shows that people who struggle with depression are also likely to struggle with alcoholism at some point during their lives. The British Columbia government joined the province's mental health and addictions services to address the service gaps people with concurrent disorders face. Support for people with mental health and addictions can be provided in many ways, but when it is not provided effectively and involved organizations fail to work together, health outcomes overall for this group decreases. This study is trying to identify options to improve coordination of the work done to support people in their treatment for depression and alcoholism.

You are invited to participate because I would like your opinion on what is and isn't working in the treatment and support for people living with depression and alcoholism problems. I would like your suggestions and ideas about what would help the mental health and addictions systems to be more integrated and to work better together. You have been asked because of your involvement or provision of services in the mental health or addictions treatment system.

### **What it Means to Participate in this Study**

If you agree to participate, you and I will arrange an interview which will take around 45 minutes by telephone. The interview will be audio recorded. Your name will be removed from all the documents and reports written about this study unless you indicate otherwise (see page 2). I cannot guarantee complete confidentiality because of the nature of telephones.

Permission has not been gained from your employer to conduct this study. We don't expect that there are any risks or benefits associated with participation in this study, outside others you may encounter in daily life. You may choose to cancel or stop your participation in this study at any time or choose not to answer any questions without providing an answer.

You can ask for a copy of the report by contacting me directly, [meredith.shepherd@sfu.ca](mailto:meredith.shepherd@sfu.ca)

This study has been approved by the Department of Research Ethics at Simon Fraser University. If you have any concerns or complaints, please contact Hal Weinberg, Director, Office of Research at [hal\\_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or 778-782-6593.

### **Questions about Participating**

If you have any questions about participating in this study you can contact me, Meredith Shepherd at [meredith.shepherd@sfu.ca](mailto:meredith.shepherd@sfu.ca) or by phone at 604 803 6442 or my supervisor, Judith Sixsmith, at 778 782 8671, by email at [judith\\_sixsmith@sfu.ca](mailto:judith_sixsmith@sfu.ca). Contact by mail can be sent to Simon Fraser University at Harbour Centre, 515 West Hastings Street Suite 3271, Vancouver, British Columbia, V6B 5K3. From December to March, Judith can be reached at 00 44 161 247 2545 UK (Manchester Metropolitan University, UK).

### **Consent**

I have read the details of the study and what it will mean if I participate. I have had a chance to ask questions and all of my questions have been answered. I understand that the interview will be audio recorded and transcribed to make sure that my responses are reported correctly. I also understand that parts of the interview may be included in the final capstone report or other publications, although my name and identifying information will not be included unless I indicate otherwise (below). I understand that I can stop or cancel my participation at any time by contacting Meredith Shepherd.

This study has been approved by the Department of Research Ethics at Simon Fraser University. If you have any concerns or complaints, please contact Hal Weinberg, Director, Office of Research at [hal\\_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or 778-782-6593.

Do you consent to having your name used when referencing your comments on services provided to people with depression and alcoholism? Please check one.

Yes \_\_\_\_\_

No \_\_\_\_\_

By signing below, I agree to participate in this study.

## Appendix 5: Chronic Disease Model

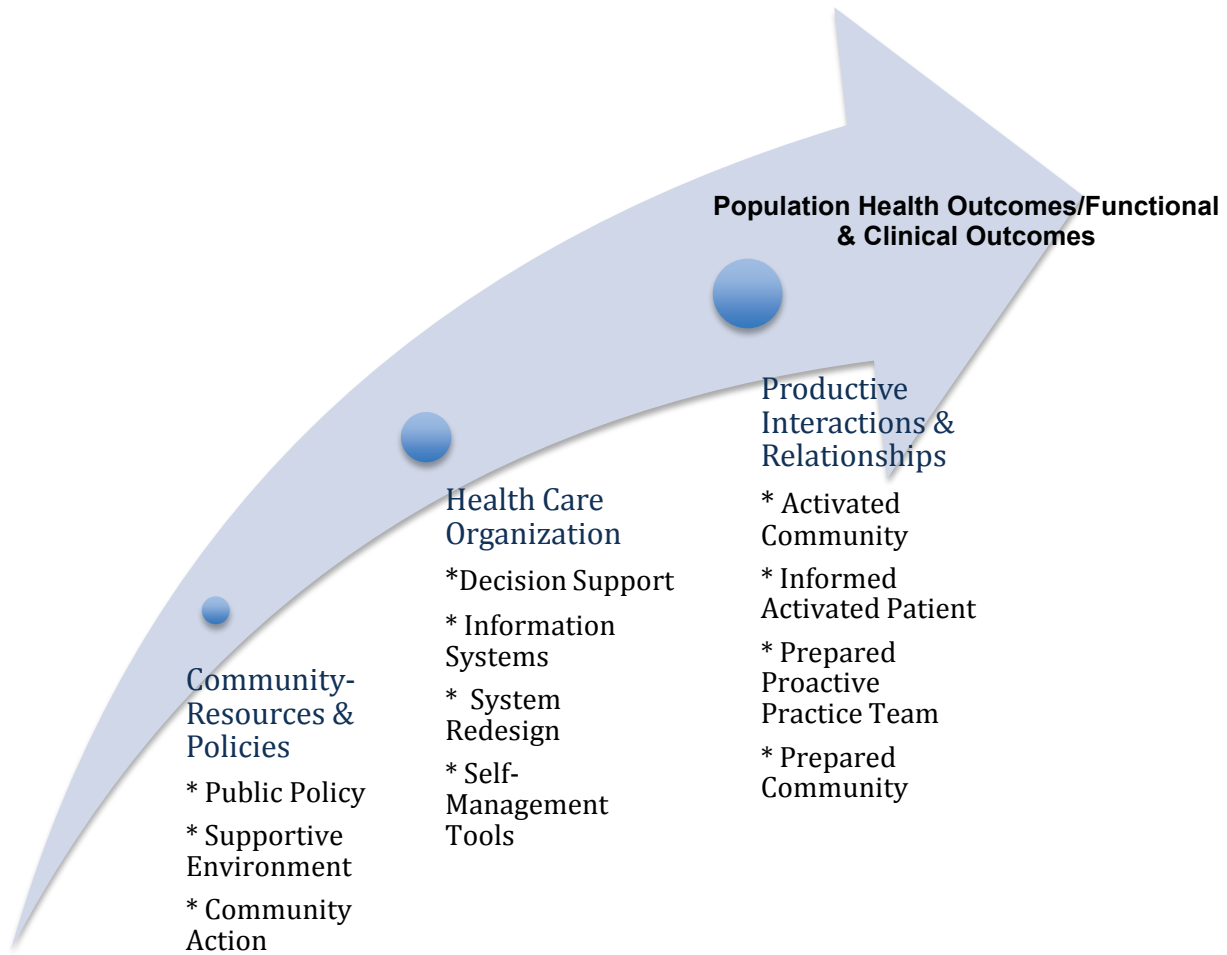


Figure 6.1 – Chronic Care Model, Adapted from *The Impact of Diabetes on the Health and Well-being of the People of British Columbia*. Province of British Columbia, 2004.

## Appendix 6 – Policy Analysis Table

	Status Quo	Mental Health Navigator	Knowledge Exchange Across Mental Health and Addiction	Partnership Project	Relational Inclusion
Equity	Not Acceptable	Somewhat Equitable	Not Acceptable	Equitable	Somewhat Equitable
Cost * Implementation Costs	Low	High	High	Medium	Low
*Social Costs	High	Low	Medium	Low	Low
*Legal Costs	High	Low	High	Low	Low
Effectiveness	No Change	Person-centered in current context	Person-centered and integrated services	Person-centered and integrated services	Person-centered in current context
Stakeholder Acceptability * Government Service Providers	High	Medium-Low	Low	Medium	High
* Non-government service providers	Medium-Low	High	Medium	High	Medium
* Service Users	Low	High	High	High	High
Impact on Stigma Reduction	No Change	Socially acceptable, positively affecting stigma	No Change	Socially acceptable, no effect on stigma	Socially acceptable, positively affecting stigma

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