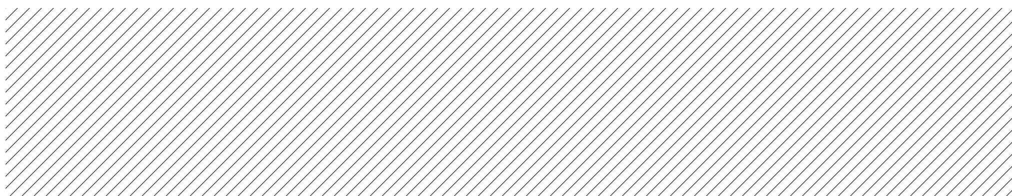
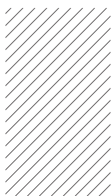
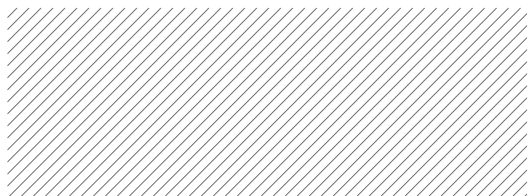
DISCUSSION PAPER #2

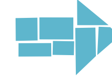
Staff perspectives

on improving care and working with health partners and agencies in the Downtown Eastside





Vancouver
CoastalHealth




VCH Introduction

THIS IS THE SECOND AND CONCLUDING DISCUSSION PAPER FROM VANCOUVER JOURNALIST CHARLES CAMPBELL. IN MANY WAYS, IT COMPLETES THE WORK HE BEGAN LAST FALL WHEN WE ASKED CAMPBELL TO MEET WITH OUR HEALTH SERVICE PARTNERS WORKING IN THE DOWNTOWN EASTSIDE.

As then, we have looked to him to provide an independent account of the issues that can often interfere with the delivery of quality health services and diminish our ability to raise health outcomes for local residents.

In his first paper, Campbell outlined a series of important challenges, namely that VCH improve its culture of communication and strive to work in a more integrative and genuinely collaborative fashion with our local health service providers.

In response to the first paper, senior executives and members of the VCH board met with more than two dozen DTES service leads, and launched a dialogue-based initiative with service managers to begin to define a vision for the future of health services in the DTES, and to identify immediate service improvements based on more clearly measurable outcomes.

In this second paper, Campbell looks within VCH to describe the concerns of VCH front-line staff and managers.

Like our first paper, the prospect of inviting a journalist "backstage" to probe the dynamics of our operations was not immediately popular. Nevertheless, I would like to commend VCH staff for their candor and contributions. It's important to remember that this discussion paper is in no way definitive; nor does it strive to reach consensus. Rather it is an opportunity to prompt further discussion and action to improve our culture and operations.

I think Campbell's report does at least three things very well:

1. **It reminds us that culture change is tough.** I believe VCH is home to some of the most dedicated and conscientious healthcare providers to be found in Canada — and this is true whether our staff members are meeting directly with patients or working in our administration. But we all recognize how bureaucratic impediments, often in the form of poorly designed and time-wasting processes, impact the flow of communication and initiative that are essential to a high-performing organization dedicated to patient-centred quality healthcare. Simply put, we need to drive these

counter-productive and cumbersome processes out of VCH, and to do this we need to free up our managers to get us working better and smarter.

2. **It reminds us of the importance of vision.** Many times Campbell cites the lack of a unified vision for the delivery of services, and for the future of the DTES, as a source of frustration and even resignation among staff.

   In every successful organization, vision drives strategy. Without vision, an organization simply becomes a platform for endless ad hoc responses to opportunity and crisis. Some of these interventions will be successful, others will fail. But without vision, knowing what to prioritize and where to direct resources becomes almost impossible.

   In the late nineties, the vision for providing services in the DTES was perhaps clearer than it is today. Inspired by the Four Pillars Drug Strategy and a newfound consensus on harm reduction, unprecedented public resources were mobilized to reduce the spread of HIV and heroin overdose. Today these goals have been largely achieved. Yet it's apparent that the degree of illness and suffering to be found in the DTES is still too great.

   With the ebbing of the crisis, different visions for the future of this important Vancouver community, as well as different theories of care, have emerged and can often conflict. VCH needs to exercise the cultural competencies required to help reconcile these visions, while also setting forth clear goals for our staff and partners alike. We need to be clear about our priorities and our commitment to seeing them through.

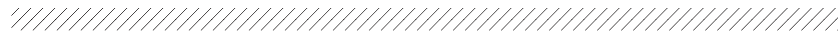
3. **Lastly, it reminds us of the importance of leadership.** Leadership is an important currency within any organization. Vision and strategy are not transmitted when leaders are unclear, or when the roles and responsibilities of those in positions of authority are unknown. I intend to work with my colleagues and our board to address these concerns.

My vision for leadership in the Downtown Eastside is fundamentally collaborative in nature. I believe that collaborative leadership is an important 21st century skill. It is the only form of leadership suited to dealing with the combined intricacies of the DTES's local history, human need, public policy, and active stakeholders and partners — it is an approach to leadership that values everyone at the table. Leadership-through-dialogue is a capability VCH is currently working to develop, and it is clearly emerging as an essential feature to our second generation strategy.

Ultimately my hope is that these two papers will be seen as an important first installment in a larger effort that will redefine our relationships and ways of working together to address the needs of DTES residents.

Dr. David Ostrow, President and CEO
Vancouver Coastal Health Authority

A note about this report



PERSPECTIVE COMES FROM LOOKING AT SOMETHING FROM DIFFERENT ANGLES. HEALTHCARE ON VANCOUVER'S DOWNTOWN EASTSIDE HAS A LOT OF ANGLES. IT'S ALL OF OUR SOCIAL CHALLENGES, BUT MAGNIFIED.

In this report, the second of two looking at how the Vancouver Coastal Health Authority delivers health services in the Downtown Eastside, I have drawn on 80 formal interviews and dozens of informal conversations.

As DTES agencies made clear in my first paper, *Working With Health Agencies and Partners on the Downtown Eastside* (December 2012), they want a better partnership: one that's more collaborative, goal-oriented and based on good quality data concerning health outcomes.

That paper deliberately excluded perspectives from within Vancouver Coastal Health, to ensure these agencies got an unfettered forum. This document offers the views of those who work within the health authority. Yet the ambitions and the frustrations of the VCH program managers I spoke to are remarkably similar to those who work with independent agencies and community groups in the Downtown Eastside.

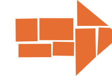
Of course, the emphasis varied. DTES agencies argued that they understand the issues better because they are closest to the people affected, and are able to respond more nimbly. VCH employees talked more about the importance of coordinating and optimizing the activities of agencies that are often in fierce competition with each other for VCH funding. Strengthening connectivity — better and more transparent record keeping, case management and communication — were key concerns.

However, VCH employees also spoke of the challenge of working in a bureaucracy where the leadership and structure are constantly evolving. There was a widespread and emphatic view that Vancouver Coastal Health needs to more clearly articulate its goals for the Downtown Eastside, that a coordinated overall strategy is required, that VCH senior leaders need to focus less on micro issues and more on macro issues, and that the health authority needs to follow through more effectively on initiatives it deems important.

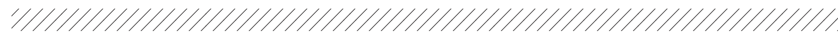
As such, this report begins by offering a long view — some historical and organizational context to put some of the policy challenges in perspective. It then moves on to some cornerstone policy issues, recapitulates or develops views on other areas of significant concern, and examines both previously explored and new ideas for advancing healthcare policy that will better serve the Downtown Eastside's citizens. I should also add that this report focuses almost exclusively on mental health and addiction, at the expense of other concerns.

The ideas put forward are not recommendations. This work is too broad an overview for that, and as such I humbly note that I often state the obvious. However, there are areas where the consensus and sense of urgency is clear, but action has been wanting. My hope is that this report simply improves mutual understanding, helps those responsible move forward where they recognize both the need and the solution, and contributes to a conversation that will foster innovation and success.

Charles Campbell
Vancouver, May 2013



Toward better partnerships, inside and outside



"YOU CAN CHANGE ANYTHING YOU WANT AS LONG AS YOU DON'T CARE WHO GETS THE CREDIT." — JIM GREEN

For the Vancouver Coastal Health Authority, evolution is a constant. Everything the health authority does in the Downtown Eastside needs to be considered in this context. Perspective on a complex problem is harder to achieve when all the parts are moving, so holding to the long view is critical. Otherwise, it's too easy to be distracted and even misled by the points of friction that arise in dissecting any particular problem. It's true for every aspect of the health authority's services, just as it's true for many of the Downtown Eastsiders it serves.

Here are a few of the changes the Downtown Eastside has seen:

When drug use, AIDS and Hepatitis C caused the declaration of a health emergency on Vancouver's Downtown Eastside 15 years ago, there was no Vancouver Coastal Health Authority — just the Vancouver Richmond Health Board. Since then, more than two dozen provincial health authorities were created, and subsequently consolidated to just six. VCH's own large adminstration is in constant flux.

The dozens of agencies operating in the Downtown Eastside also have long and complex history. May Gutteridge started what's now the St. James Community Services Society more than 50 years ago, and opened the first shelter for abused women in 1965. The stalwart Lookout Emergency Aid Society has been around since 1971. The Portland Hotel Society was founded in 1991, and has been at the forefront of housing and harm reduction initiatives. RainCity Housing and Support Society, which evolved from a shelter opened by St. James in 1982, was constituted under its current name in 2008. Key harm reduction initiatives — needle exchanges and safe-injection sites — were covert activities pioneered by the likes of the 15-year-old Vancouver Area Network of Drug Users (VANDU) not terribly long ago. Now they are widely accepted activities funded and supported by Vancouver Coastal Health.

Change in the makeup and dynamics of the Downtown Eastside community is also relentless. Strathcona Mental Health Team manager Gerry Bradley recalls a

time in the early 1980s when addiction and mental illness didn't cross over much. "The addicts were a faster crowd." That was before the discovery of AIDS. Now there is a huge underserved population of people with multiple addictions and newly defined mental disorders resulting partly from trauma and brain damage. For some of them, HIV infection has become just one of their chronic health conditions.

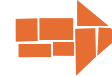
Against this backdrop of constant change, Downtown Eastside healthcare efforts have had their fair share of successes. Statistics suggest that on average people are living about 10 years longer than they were in 1996. There's a great deal of pride in HIV/AIDS prevention work, both in the DTES and throughout the city of Vancouver. There are also primary care services that simply didn't exist 15 years ago. Many potentially controversial health interventions, from the high-profile Insite safe injection site to the nascent managed alcohol program, are now widely accepted. There is innovation in food programs and improved support for people in residential hotels.

However, there is a widespread belief — inside and outside of Vancouver Coastal Health — that the Four Pillars narrative that drove efforts to prevent the spread of HIV and hepatitis C was only partly successful. Prevention, enforcement and, where the health authority is concerned, particularly treatment have not met the need. The consequences are now overwhelming the system. Some believe the current powerful narrative — the push to address homelessness, with all its complex underlying social and medical causes — is not driving enough improvement in treatment for mental health and addiction, the tipping points for many people who struggle to maintain a home and some meaning in their life in the Downtown Eastside and elsewhere.

The habits of Vancouver Coastal Health, as well as systemic impediments and restricted public health budgets, are all cited as reasons why VCH is not adequately meeting the challenge in the Downtown Eastside. Those impediments sometimes involve human ego. It shows up in the relationships between caregivers and patients, between funders and agencies, between agencies themselves, and between citizens.

And yet, while many people criticize the health authority, in both this report and the last one, almost none of the criticism of VCH is personal. There are no easy villains or scapegoats in this story. Everyone is interested in a system that works better to meet key goals. More productive partnership, which is a key theme in *Working With Health Agencies and Partners on the Downtown Eastside,* is also vitally important to VCH staff, although the words used are slightly different: Vancouver Coastal Health staff want clear objectives and the power to act together to achieve them.

Change is afoot, of course. This report is just one small part of the effort. Management is being restructured to draw addiction treatment and mental health services together, to involve senior doctors more in decision-making, and to retool the contracting system to create more flexibility and security for the many agencies that deliver health services. VCH intends that those changes will facilitate other reforms. There is a broader context as well. The health authority as a whole, which believed its past budget shortfalls were impairing its ability to get funding for new projects it deemed important, has spent four years controlling costs — and now feels its finances are in better order.



Staff almost universally understands and accepts the health authority's financial limitations. Many acknowledge the areas of progress. However, frustration over the absence of clear, cohesive policies in some key areas is no less acute than it is among the agencies in the Downtown Eastside. Staff believes, most critically, that vulnerable people looking for ways to cope with complex mental health and addiction issues are still being under-serviced.

There are a host of specific policy concerns: Record-keeping, results measurement, methadone limitations, addiction treatment access, equal and respectful treatment for women and aboriginals, effective youth services, and public accountability for independent agencies are just a few. Then there are the issues that arise where Vancouver Coastal Health's mission overlaps with other provincial government agencies, such as BC Housing, the Ministry of Children and Family Development, or with other governments, as is the case with the current devolution of federal health transfers to a new B.C. aboriginal health authority. Sometimes the problem is that VCH's mission overlaps with other health authorities, particularly the Provincial Health Services Authority, which controls some mental health and addiction services that are important components of an effective strategy for the Downtown Eastside. Pretty well everyone, from health authority leadership to frontline staff, appreciates and acknowledges these issues.

However, the people I spoke to emphasized one central concern that underlies all of them: the absence of a clear, cohesive mission that staff can act on to address widely acknowledged gaps in care. "We are the blind people touching the elephant, and we created that elephant ourselves," says Soma Ganesan, VCH's medical director of mental health services. The patchwork solutions have created silos, he says. "We lacked a global overall vision from the beginning."

The size and range of the challenges are huge, of course. The organizational complexity is daunting. The lack of money to fund key initiatives is discouraging. However, the most frustrating thing for most staff is the lack of action on key initiatives where there's widespread agreement.

No single issue illustrates the frustration better than the shared desire for a low-barrier methadone clinic. Everyone who spoke to the proposal believes it is a key piece of any effective strategy in the Downtown Eastside. It has the potential to improve methadone retention, clients' connection to other elements of healthcare, accountability to the public, and the health authority's credibility in the community. As well, money can be saved inside and outside the healthcare system by managing methadone programs more effectively. To open such a clinic, according to addictions medical director Garth McIver, VCH needs about $1 million in development capital.

Why hasn't it happened? "We spend the money patching whatever pops up," says one observer.

Rolando Barrios, VCH's senior medical director for community health services, came to his current position two years ago from St. Paul's, and worked directly for VCH from 2000 to 2004. As a Guatemalan immigrant he spent some time during his first days in Canada picking up needles and condoms in the Downtown Eastside. He believes following through on initiatives, such as the low-barrier methadone clinic, is a key program objective. He acknowledges that better partnerships with Downtown Eastside agencies are important. However, he says it's also necessary for Vancouver Coastal Health

to get its own house in order. Realigning the organization's leadership is a key part of that effort. Creating better systems of measurement so results can be properly assessed is another cornerstone.

One more critical priority for Barrios is ensuring that existing Downtown Eastside services do a better job of connecting with those who need its services. His objective is simple: "You come, we serve you today." And if you don't come, someone will do their best to find you to ensure you have the care you need.

However, the impediments to all this change are manifold: old and new grievances, layers of bureaucracy, funding silos that hamper efforts to economize, pilot programs that drive innovation but skew funding allocation and program coordination, overwhelmed staff that don't have time for effective long-term planning, suspicion regarding program reviews that can go in circles, strong public narratives that often ignore key components of success … the list is long.

Apprehension about new initiatives is well earned. "Don't go halfway and come back," says one manager, who has seen programs run off the side of a desk and then deemed a failure, such that VCH simply retrenches to the status quo.

Sometimes a simple, clear often-repeated objective — providing a continuum of care is one — risks becoming a homily in the face of the enormous challenge. For example, addiction treatment has so many poorly connected moving parts that the word *continuum* just doesn't apply. Accountability, timeliness, effectiveness, equitable access and meaningful outcome measurement are all serious shortcomings, notwithstanding the best efforts of those involved to improve the services.

It's no surprise that VCH middle managers are frustrated. They are often very proud of work the health authority does, directly and through its partners. "On the ground, a lot of the clinicians and staff have developed really good relationships with each other, and that goes across agencies," says one program manager. The challenge is to build a more collegial sense of partnership among more senior managers, both internally and with agencies in the community.

How much is enough?

Then, of course, there's the matter of money. Pretty much every VCH operations director and program manager recognizes that the health authority must make the best use of the money it's getting now, and that the VCH budget for Downtown Eastside services is not likely to increase. Some believe, however, that concern about money has resulted in a sort of organizational paralysis, where small pots of money are moved from a lower priority area to a higher one, until the move causes problems where the money was cut and must be found again.

Most people I spoke to argued in one way or another that in trying to control expenditures, the health authority has made spending the central narrative for managers working on Downtown Eastside issues. "I was told over and over, healthcare is a business," says one. "We need to be careful about saying that. We need to take models from business, but we need to make sure that doesn't become what we talk about."

Another argues money can be saved if services learn to work together more effectively, but only if the goal is to work together for the benefit of the clients. "You can only achieve [savings] through that lens."

> "You must relate the amount of money to the amount of need, but we don't have appropriate capacity planning."

Yet another says that the level of need — particularly among those suffering from brain injuries, personality disorders and drug-induced psychosis — is substantially underestimated, and the health authority has to accept that financial challenge. "You must relate the amount of money to the amount of need, but we don't have appropriate capacity planning."

Too many staff feel the focus on costs emphasizes what can't be done instead of what can be done, and that the money narrative needs to be supplanted by a health narrative. Vancouver Coastal Health talks often about the $66 million envelope it spends delivering some of the services provided in the Downtown Eastside, but middle managers know how incomplete that picture is. There are funding silos all over the place: in police, ambulance and hospital emergency ward services overburdened by the addicted and mentally ill; in the difference between a gainfully employed ex-addict and a crackhead ward of the state.

For many dedicated individuals, who have chosen their work because they want a sense of mission and accomplishment, the past inability of management to articulate clear, tangible long-term goals, and communicate them effectively to the organization and the community at large, has created real frustration. "I don't know what direction we're heading in," says one. Says another: "Vancouver Coastal Health has to decide 'What is our role on the Downtown Eastside?' "

"Vancouver Coastal Health should be the leader," says yet another. "We have the opportunity because we contract so many services on the Downtown Eastside, but we don't have a coordinated vision."

The depth of frustration is widespread and acute. People talk about feeling paralyzed by the workload and the lack of direction, and they don't see a way forward. "People are willing, but you have to give them something to get behind." And that something, says another, has to have some scale. "We need to do something big to turn this around."

Right now, staff believe Vancouver Coastal Health needs a mission that is based less on how finances constrain it and more on how innovation can enable it. *Working With Health Agencies and Partners on the Downtown Eastside* explored examples among service organizations in the neighbourhood. Another lies in the relationship between the Centre for Excellence in HIV/AIDS, the Urban Health Research Initiative and Providence Health Care.

There's a wide range of opinions on Providence, the faith-based agency that operates St. Paul's Hospital under VCH's auspices. Providence is lauded for being more open to patients with complex needs and personalities, but criticized on the same count for the failings of its emergency room. It's lauded for its work in the harm reduction field, except when its Catholic tendencies prevent staff from distributing condoms or advising women on reproductive health.

However, one view frequently emerges: "Providence's great strength is they don't overthink things," says a VCH manager. "They identify work that conforms with their values and they just do it."

There are several likely reasons — Providence's history, size and position among them. However, the relationship between the BC Centre for Excellence in HIV/AIDS and the affiliated Urban Health Research Initiative is clearly a big part of this. The Centre has provided much of the impetus and expertise in AIDS treatment and harm reduction, and their success and experience in the Downtown Eastside should be integral as Vancouver Coastal Health creates strategies for the future.

One manager lauded the way they generate ideas, create models for innovation and find the money to execute them. However, she also noted that Vancouver Coastal Health still delivers the programs, and does far more than it gets credit for doing. Sometimes, she says, ideas are brought forward that VCH has actually been executing for 20 years. "It wouldn't happen without us, but we don't have a brand," she says, arguing that's not entirely a bad thing. She cites a quote from the late Jim Green: "You can do anything you want as long as you don't care who takes the credit."

Vancouver Coastal Health needs to strengthen its partnership with Providence so that people see their work as better aligned. It also needs to cultivate a stronger relationship with the Centre for Excellence and the Urban Health Research Initiative.

How can that relationship be built? Some feel the current Stop HIV/AIDS initiative suggests that when you put hierarchy aside and truly build the relationship around delivering care, partnerships can be very successful.

When the focus is on the patient and the goals are clear, things go well. It's understandable that, as the health authority tries to balance its significant financial challenges with complex social challenges in the Downtown Eastside, it hasn't welcomed into its sometimes fractious structure every new idea or open process that might assist its mission. Nor should it be expected to go public with strategies it is still assessing. However, now that the health authority is focusing on DTES solutions, many staff believe it must be not just more collaborative but more open and transparent.

Many argue that Vancouver Coastal Health must draw on newfound collaboration to articulate clear goals that both Downtown Eastside agencies and its own divisions and staff can rally behind — in the same way that various governments and agencies have rallied in Vancouver to address issues such as AIDS and homelessness.

Several people say that renewed collaboration must more effectively involve both the City of Vancouver and the provincial government. As with the health authority's partnerships with some Downtown Eastside agencies, the relationships need work. "You don't fix a relationship by focusing on its disfunctionality," argues Brenda Prosken, the City of Vancouver's general manager of community services, referring to the relationship VCH has with some of its partners. She believes that has impaired the health authority's focus, and that it spends too much energy looking at where it's been and not enough on where it's going. She wants Vancouver Coastal Health to identify policy objectives clearly so the city can assist in meeting them.

What Vancouver Coastal Health needs to do is obviously not just a matter of systemic objectives, like better record-keeping and measurement. And it's not just a matter of principles, like saying there needs to be a greater continuum of care in addiction treatment.

It's about building better relationships around specific goals. Those goals, and the plan to achieve them, need to be clearly articulated. For example, by what date will Vancouver Coastal Health open a low-barrier methadone clinic? What collaborative process will determine its shape? When will it establish a clear protocol on medical records with agencies in the Downtown Eastside that deliver services? How can an acceptable protocol be created? What are the specific targets for improving care for those with mental illness who are not currently accessing service? How will that be funded?

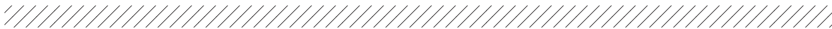
Just as the Assertive Community Treatment (ACT) Teams have succeeded by bringing key decision makers to the table to meet the very complex but specific needs of those who are hardest to treat, many argue VCH must work with all its partners to establish very specific objectives and tools — sometimes VCH's tools and sometimes the tools of its partners.

We've learned in the Downtown Eastside that when tangible key goals are established and pursued — reducing HIV infection rates or overdose deaths, providing shelter and housing for the homeless — we can get results. There are more clear, unmet objectives in the Downtown Eastside. If solutions are developed based on a reasonable consensus, are clearly articulated and methodically acted upon, and are funded in a sustainable way, Vancouver Coastal Health can continue to make a real difference.

"We did it for HIV," says one manager, who is quite typically still game for the fight. "There's no reason why mental health can't do it, why addiction can't do it."

We've learned in the Downtown Eastside that when tangible key goals are established and pursued — reducing HIV infection rates or overdose deaths, providing shelter and housing for the homeless — we can get results.

Tools for better partnerships



HOW VANCOUVER COASTAL HEALTH CONSULTS, PLANS AND MAKES DECISIONS IS OBVIOUSLY CENTRAL TO ITS EFFECTIVENESS.

The Downtown Eastside community agencies and partners and internal staff speak with one voice on this matter: an excess of hierarchy and control has damaged working relationships and the community's ability to achieve key objectives.

In the Downtown Eastside, where work is highly collaborative and complex, it's critical that all the participants — from partners to staff — feel they have a meaningful role in the policy-consultation and decision-making process. The consultation process for this report indicates a willingness on VCH's behalf to do business differently. So does the resulting effort to reform how VCH tenders and manages contracts with Downtown Eastside agencies.

Almost everyone argues that solving the problem requires better systems for compiling and sharing information while being mindful of the burden that can impose. They say it also requires more effective engagement and planning — with agencies, clients and internal staff. As well, many emphasize that any such processes must be productive and goal-oriented.

Engaged, empowered and connected leaders

Several people say that while better information systems and communication structures will help, there is no substitute for engaged leadership. Views on the form of leadership, however, diverge somewhat. Some people argue the DTES requires a strong leader focused solely on DTES challenges. Others suggest the person who could fill that unforgiving position does not exist. One argues that the health authority shouldn't concentrate too much power in one place. "The more we have one person in charge, the more we are in trouble." A few contend that several programs that serve the Downtown Eastside also serve other communities, and that a narrow geographic focus has the potential to undermine prevention initiatives, treatment programs and other elements in the system, such as housing, that need to be city-wide.

Several people advocated for a single operations manager dedicated to Downtown Eastside programs. They want a team leader who is highly visible in and connected to the community, has real decision-making authority, is accountable for reform efforts, and is passionately vested in their success.

This debate takes place against a backdrop of frustration. Just as many Downtown Eastside agencies complained that VCH's organizational structure is unclear and they don't know who's really in charge, internal staff often expressed concern that they lack authority and they don't know who is really answerable for inaction on initiatives such as low-barrier methadone. Many staff argue that those who have authority need to delegate their power, particularly on minor financial and policy issues, and focus instead on establishing and articulating policy goals and program priorities.

People want the sense that Vancouver Coastal Health is more present in the Downtown Eastside, and most particularly that its senior managers are present. "The managers need to be on the ground," insists one. Of course, many veteran DTES program managers have worked long years on the frontlines in the areas they administer, yet they are widely seen as lacking power.

Maintaining or improving connection needs to be an ongoing process that actively involves key decision-makers and constantly builds on the connections that exist. Some people argued strongly in favour of tools such as job exchanges, or for managers working a day a week directly with clients in the neighbourhood. Many nurses and doctors already do this, but it is not always encouraged.

Several people emphasized the importance of community engagement, about talking directly to clients about how services can best work for them, rather than allowing that conversation to be defined unduly by "brokers" — the agencies that deliver services on VCH's behalf. That can be as simple as a senior manager attending, say, a VANDU meeting to talk about methadone programs. These things happen, but key people need to make them a more regular component of their outreach.

Whatever route the health authority takes, the consensus is that VCH leadership still has a lot of work to do to build confidence among its staff and its partners in the Downtown Eastside.

Ultimately, though, the health authority's work needs to be defined by the woman who can't get timely access to addiction treatment, or the addict who's a thousand miles from home and is discharged from hospital without a place to go, or the guy with non-traditional mental illness in an SRO who isn't getting medical treatment for that condition. When decision-makers aren't located where the problem is, despite their best efforts, it's too easy for the people being served to become theoretical, and for the most challenging patients to become somebody else's problem.

“You need to come together around a vision, a goal, a cause … something.”

Working groups

As the health authority tries to create greater connectivity, and considers strengthening the role of working groups in areas of common interest, many people observed that it must keep one principle in mind. There needs to be a reason to meet. Throughout this consultation process, people said they need to come to the table feeling that they will have influence in a decision, or that money is on the table, or that the interests of their clients will be served. “You need to come together around a vision, a goal, a cause … something.” With the Inner City Planning Team — a VCH manager team — there’s a case conference every second meeting. Mechanisms that put patients at the forefront are good ones.

Agendas need to be goal-driven and meetings need to be effectively chaired with that in mind. What hazards would a low-barrier methadone clinic create and how can they be mitigated? How can we better provide improved housing for the mentally ill who are not homeless? What are the most effective ways to improve continuity in addiction treatment? How can the system be simplified to benefit clients? VCH also needs to report on the actions it takes as a result.

Internal staff who spoke to the issue agreed with the idea that VCH should explore innovative administrative models for delivering complex social services, such as the “collective impact” model advocated by St. James Community Service Society’s executive director Jonathan Oldman. No one who spoke to the issue disputed Oldman’s view that systemic innovation in how groups work together gets very little attention, when in fact it’s a key to success.

Communication

For Vancouver Coastal Health, open communication with both partners and the public is complicated. Partners and staff are frustrated, and the public has little sense of the health authority’s activities or strategy. “Before I could go to internal stakeholders I have to go to [senior] managers,” one middle manager said of internal communication protocol. “Then I have to communicate to the Ministry of Health.” Only then can information go out to various external stakeholders.

When it comes to communicating with the public, old-school media approaches (an op-ed in the daily broadsheet, a media release) are increasingly ineffective. Blog-style posts by VCH leadership on its website may seem innovative, but they don’t appear to draw much traffic. Right now, there is little on the VCH website that relates to DTES services, save for the report card promising 88 per cent follow up with those discharged from hospital with addiction or mental health issues within 30 days, which as a measure of success with these patients is itself some pretty weak tea.

Is VCH effectively using contemporary media tools to communicate with people in the Downtown Eastside? Can social media be effectively used to bring together the wide range of people interested in Downtown Eastside healthcare? Is VCH too old-fashioned in its approach to getting its message out? Many people I spoke to are frustrated that VCH does not effectively communicate information about its programs in ways that engage both those who shape and deliver services and those who receive them, though none is particularly expert in the options.

Many large organizations that need to push key messages create their own media. The American health provider Advocate Health Care launched a website structured like a media outlet, ***Health eNews*** [http://www.ahchealthenews.com]. The communications firm that spearheaded the initiative tells the story here: [http://bit.ly/1905iPq]. This stuff is doubtless old hat for communications staff at VCH, but the question remains whether tools such as these can be better employed to create a greater sense of openness and mission in the Downtown Eastside.

Whatever route VCH chooses to take, many staff feel the health authority must better communicate its DTES policies and goals not just to its own staff and partners but to the community at large.

Contract reform

Both partner agencies and internal staff welcome contract reform. In none of the interviews I've conducted did anyone argue against sweeping reform in how services are contracted out.

However, as program managers move away from annual contracting with checkbox obligations to longer terms that prioritize flexibility to achieve better health outcomes, overextended managers will need more time. One senior manager estimated that 30 per cent of their time could be taken up by new obligations. Program managers feel VCH must follow through with organizational changes that will allow them the time to do this work effectively.

Whatever route VCH chooses to take, many staff feel the health authority must better communicate its DTES policies and goals not just to its own staff and partners but to the community at large.

Both partner agencies and internal staff welcome contract reform.

Several other logistical problems and opportunities arose:

- The need for greater standardization of contracts, and particularly harmonization where contracts involve multiple agencies
- The benefit of separating funding for infrastructure, administration and programs
- The need for more streamlined reporting obligations
- The need for VCH to provide services to ensure that the burden of complex outcome assessment doesn't fall on the agencies
- Public disclosure of contracts to ensure greater transparency regarding the work of agencies working in the Downtown Eastside

Measuring outcomes

Reforming the contracting process is step one in building trust and partnership with DTES agencies and partners. Yet while no one argued against reformed contracting that focuses more on outcomes, there are sticking points. These revolve around who measures outcomes, how they measure them, and with what data.

Some DTES organizations are very reluctant to share individual patient information with Vancouver Coastal Health, citing the confidentiality of the clients they serve. They feel reporting is being imposed on them. The people they serve are sometimes paranoid, and the healthcare system that serves them can be patrician and controlling. There are other complicating issues. Some addicted clients exploit the system for medication, and have a habit of deceiving authority. Asking a client's permission to share information can become a significant barrier to providing the service that the client needs. As well, agencies know that reporting work can diminish their productivity.

Sharing information is also logistically complicated. In the Portland Hotel medical clinic, Ron Joe, medical manager of addictions, points with quiet bemusement at a desk occupied by two computers. "Portland is Mac, Vancouver Coastal Health is PC," he says.

It is an apt metaphor for the divergent culture of the two organizations, but it also highlights the challenges of adopting a single coherent client-centric electronic record from which to base clear clinical decisions at any given moment in time. Out of the concern expressed in 2010 by the Auditor General of BC about its potential for breaching confidentiality, VCH's PARIS software has evolved in an increasingly complex system and is at times frustrating for staff to navigate. A significant challenge moving ahead would be how VCH's systems would provide access to information while upholding current privacy legislation.

Data sharing is obviously a critical component in creating continuity in the system, measuring outcomes, and ensuring patients get appropriate treatment. Staff who spoke to this issue universally argue that a protocol to share patient information is necessary.

What does VCH know about an addict in treatment? One manager said the health authority has no idea whether a patient is moving from one program to another, and there is no long-term tracking of treatment outcomes. One doctor expressed deep frustration that when his patients receive care, such as detox at an independent agency, he is almost never notified. He argues that when agencies ask patients "Do you want anybody to know that you're here?" the client's answer is almost inevitably a barely considered no. "Circle of care agreements happen everywhere, except here."

Establishing in a collaborative, respectful way a protocol for sharing information is essential for VCH and the agencies it works with. However, the agencies want to ensure this doesn't become a big administrative burden, an invasion of privacy, or an undue intrusion or form of control. As such, the agencies and clients being asked to share information need to have a role in creating the protocol so that it respects their concerns as well as the health authority's and the clients' needs.

Data sharing is obviously a critical component in creating continuity in the system, measuring outcomes, and ensuring patients get appropriate treatment. Staff who spoke to this issue universally argue that a protocol to share patient information is necessary.

Finding leverage

HOW THE VANCOUVER COASTAL HEALTH AUTHORITY PLANS FOR CHANGES IN FUNDING OF DTES PROGRAMS IS A HUGE SOURCE OF FRUSTRATION, BOTH EXTERNALLY AND INTERNALLY.

Nowhere is this more evident than with pilot programs that are initially funded from sources outside of VCH, such as the federal government. “Every time there’s a need they dump money into new programs,” says one observer, adding that the approach only contributes to the profusion of silos. “There is absolutely no wrap-around or holistic approach.”

Funding silos skew the system

Many internal and external stakeholders acknowledge the difficulty in finding new operating funds to continue pilot programs. Whether it’s fair or not, the perception is that VCH does too much backing and filling at the last minute and needs to plan more effectively for such transitions.

No one would dispute that we need to do a better job of helping addicted women in the sex trade find a way out of their plight, or that we need more effective strategies to care for the hardest to house. For VCH, finding the money to continue such programs — from ACT Teams to the Rainier Women’s Treatment Centre — when pilot funding runs out has been distracting and ultimately damaging.

Many insist that the health authority needs better day-treatment addiction programs, and more outreach to those with non-traditional mental illness, and a low-barrier methadone clinic, but those priorities are often sidelined as managers look for money to extend other pilot programs. Senior governments arguing over who should provide ongoing funding is scant consolation.

The silos are hardly just a matter of money, however. Medical health officer John Carsley, who came to Vancouver from Montreal, says he was surprised by the lack of integration and collaboration at many levels, from the services being provided by the health authority to the work being done by contracted agencies. “An ‘A to Z’ review of programs is absolutely warranted.” But he argues that it’s labour-intensive to make that happen, it has to happen based on evidence, and Vancouver Coastal Health hasn’t had the resources to do it.

In the meantime, the health authority must still bring an open process and good judgment to build on what it's got. There aren't many observers who believe the health authority can do that without creating a little more financial elbow room.

New funding models need attention

Several people argued for new strategies to leverage, diversify and stabilize funding for DTES programs. These include drawing more effectively on the capacity of the The VGH and UBC Hospital Foundation, encouraging models such as the Streetohome Foundation, examining whether there is a place for social-impact bonds in funding DTES services, and breaking down funding silos to ensure VCH employs strategies that save money in the healthcare system overall. All of these approaches require that VCH have clear, well-articulated, tangible long-term goals.

The silos of funding problem is hardly just an internal one. It's federal and provincial, of course; the impact of federal pilot programs illustrates that well enough. VCH staff argued it's also a matter of in-house versus contracted services, and acute care versus community services. It's a matter of preventing addiction versus treating it. It's doctors versus nurse practitioners. In the case of methadone, it's prescription and dispensing fees versus capital costs for a low-barrier clinic.

Enormous frustration among managers arises from these obvious tensions. Pulling all this stuff apart and putting it back together again in a better way is not easy. Would savings in emergency room, ambulance and policing costs be sufficient to underwrite some form of effective urgent care in the DTES? What sort of interventions by the Ministry of Children, Families and Social Development would noticeably reduce the influx to the Downtown Eastside of young people at risk of addiction and mental illness? The further up the chain you go, the more complicated it gets.

Most people I spoke to about the issue were emphatic, however: within VCH and beyond it, money and effort is spent inefficiently because of funding silos. As such, many believe the health authority must identify some clear cases where there is social and financial benefit in spending new money to address key unmet needs, in the interest of saving money elsewhere, in both the near and distant future.

Collaborative fundraising

Most of the agencies working in the Downtown Eastside don't have the capacity to raise their own money from philanthropic sources. The impediments are many. They don't have the tax status, they don't have the right skills, they don't have the resources, or they don't have the sort of program that's attractive to donors who often prefer to support capital as opposed to operating needs, or support sick children instead of addicts.

Several people argued for new strategies to leverage, diversify and stabilize funding for DTES programs.

Yet those who wish to support better outcomes in the Downtown Eastside are numerous. The Streetohome Foundation has built on the widespread commitment to address homelessness with a range of partnerships that have created new investment. This has been accomplished by drawing people together around a clear and measurable goal. Would a clear, concise and coordinated plan to improve addiction treatment draw similar support?

How effective is Vancouver Coastal Health in leveraging its position to draw new initiative and funding for healthcare in the Downtown Eastside?

Context is helpful. The VGH and UBC Hospital Foundation's interim president and CEO, Barbara Grantham, says that only in the last three years has the foundation, which was created to support the hospital's work, had a mandate to raise money for community services. "There's no question that on the community health piece, in terms of philanthropy, we're on a learning curve and VCH is still on a learning curve."

However, Grantham, who was once the CEO of Streetohome, adds that the foundation has regularly collaborated with the BC Cancer Foundation, and notes the foundation has done work in the Downtown Eastside for VCH's Sheway program. In late 2012, Goldcorp gave $5 million through the St. Paul's Hospital Foundation and the VGH & UBC Hospital Foundation to fund both an addiction medicine education program and an ACT Team to assist those coping with addiction and mental health issues in the Downtown Eastside.

"We're open to working with the agencies, though our mandate is to raise money for VCH," Grantham says. She adds, however, that she would be happy to sit down with a group of agencies from the Downtown Eastside, VCH staff and Dick Vollet, another former head of Streetohome who is now the president and CEO of the St. Paul's Hospital Foundation, to examine ways in which "we can help Vancouver Coastal Health find new ways of working together with other partners. That would be a very useful conversation."

Vollet also welcomes the dialogue, but he says effective outcomes would depend on bringing the right people and agencies together and that VCH "has to put the issue in front of us as a priority." Again, for the health authority, articulating a clear vision for the Downtown Eastside is essential.

Social impact bonds

It's the future of philanthropy. It's the new face of social enterprise. It's the flavour of the month. Social impact bonds represent a new form of underwriting programs intended to improve social outcomes for those at risk. In Britain and New York, prominent programs aim to reduce recidivism among those being released from jail. In Canada, the federal government's first call for proposals employing social impact bonds closed in February. The approach calls for projects to be funded privately, by business or philanthropic organizations, with clear and measurable goals, and governments commit to return the investment plus a small additional margin if the goals are successfully met.

It's the future of philanthropy. It's the new face of social enterprise. It's the flavour of the month. Social impact bonds represent a new form of underwriting programs intended to improve social outcomes for those at risk.

Proponents argue the tool gives social enterprise capitalists and philanthropic organizations a chance to work in the social services sphere in a goal-oriented way that brings new streams of funding and initiative to social programs. Opponents argue it's just another way for business to make a buck on the backs of the poor by doing work that is more properly the business of government.

Given the federal government's vocal commitment to this approach, and Vancouver Coastal Health's need to tap all the available sources of operating money, the health authority needs to watch this trend closely.

Proponents argue that social impact bonds can provide innovative approaches to problems that have proven to be intractable, as well as a greater degree of accountability on both costs and results. Ian Gill, who as president of Ecotrust Canada helped to broker a groundbreaking land-use partnership between resource industries, aboriginal communities and governments, argues social impact bonds can create new sources of long-term funding and incentives to collaborate. He argued social impact bonds will be funded by philanthropic organizations and community-minded capitalists who will roll any return on their investment into new projects. Gill believes the method focuses attention on achieving goals in a way that government-driven social programs often do not.

Gill has pitched the federal government on a social-impact bond project that would employ early childhood education in disadvantaged Manitoba communities to reduce future social service costs. His occasional collaborator, Eric Young, who is involved in a project to try and control escalating healthcare costs in Guelph, Ontario, argues that we need to create a greater culture of achievement in the social domain that reflects the focus on innovation found in the best businesses. "We need a new paradigm for tackling large-scale, seemingly intractable problems."

Innovation, Young argues, has to be able to come from anywhere. "We don't know what to do, we know we don't know what to do, but let's start working with the right people to find a solution," he says. "Let's invest in the conditions that enable the necessary breakthroughs to happen."

Gill acknowledges that social impact bonds are "only one tool among many" and are only effective in certain very specific contexts, but he believes they present a viable alternative for governments where they have struggled, despite their own financial investment, to achieve the social outcomes they desire. Both Young and Gill believe the Downtown Eastside needs the innovation and investment that new models can bring.

Capital projects

Some people believe Vancouver Coastal Health needs a robust health facility in the Downtown Eastside that could provide an arcade of services: this might include emergency health services, a clinic, group counselling, methadone maintenance, a sobering centre, and other services. The Buddhist temple site at Hastings and Gore has been cited as a promising location. The old Vancouver Police Station was once identified for this purpose, but is now slated to become a centre for technological and social innovation. Others, however, believe a central facility is not a priority.

Some argue there is a need to bring the clinics and mental health teams together. "How is it that in a 10-square-block area they aren't fully integrated?" Others suggest that putting them in the same building and expecting them to work together wouldn't necessarily mean they'd actually talk to each other. Some think renting space to service agencies in a shared facility would help them work together more effectively. Others believe those administrators are best off close to their services.

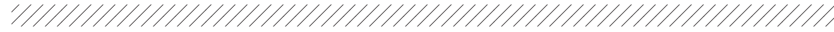
Some think that Vancouver Coastal Health needs to run its flag up a pole in the Downtown Eastside to say it truly cares for the community. "We need one place, one door. The symbolic value of having a nice new building — that has value in itself. Medically it may not be needed. It may be needed psychologically." Others think there's too much work to be done on the ground to allow a glossy capital project to distract from that need.

Some people believe the DTES needs a 24-hour urgent care facility to take pressure off police, ambulance services and hospital ERs. Others feel the health authority must simply make the St. Paul's emergency ward work better for DTES clients. Some argue the two VCH-run clinics need to extend their hours to meet a portion of this need.

If Vancouver Coastal Health chooses to create a robust, interdisciplinary facility in the Downtown Eastside, it will have to be very carefully planned in terms of cost, structure and effectiveness. However, few feel its an option that's been methodically and fully considered, and many feel the concept deserves that sort of examination. One manager observed that form must follow function, and VCH first needs to determine what its goals are.

"We don't know what to do, we know we don't know what to do, but let's start working with the right people to find a solution. "Let's invest in the conditions that enable the necessary breakthroughs to happen."

Addiction priorities



INTERNALLY, NO SINGLE PROGRAM ISSUE ELICITED MORE WIDESPREAD FRUSTRATION THAN THE DELAYS IN CREATING A LOW-BARRIER METHADONE CLINIC.

Methadone service delivery is not in good shape. In the Downtown Eastside, it's characterized by the proliferation of single-purpose pharmacies that offer "incentives" to clients to use their service, troublingly large costs for prescribing and dispensing the drug, and rather incomplete integration with other services.

Low-barrier methadone

"We need to have a Vancouver Coastal Health pharmacy that's accountable to Coastal Health," says one addictions program manager, noting potential savings in other health services would result from a low-barrier methadone clinic staffed by VCH nurses. "All those nurses seeing people in shared care could serve a lot more people with [low barrier] methadone."

The $1 million in new one-time funding needed to open the doors of a basic operation, which could be operated with Medical Services Plan and Pharmacare money already circulating in the system, is dwarfed by the money currently being spent on current methadone services — $12 million per year in dispensing fees alone for current and recent DTES residents receiving the drug.

The methadone system's problems have been thoroughly examined in two key 2010 documents: *Methadone Maintenance Treatment in British Columbia, 1996-2008: Analysis and Recommendations*, by Dan Reist, and the draft report *British Columbia Methadone Maintenance Treatment Program: A Qualitative Systems Review*, by Tessa Parkes. The issue has been on the table for quite a while.

Why is there no low-barrier clinic? "Everybody thinks it's a great idea but no one has come up with the money," says one manager. "I don't get why it hasn't been funded, quite frankly," says another. "The fact that nothing has happened indicates to me that addiction is not a priority," says yet another, reflecting a fairly widespread belief that VCH has not adequately supported addiction treatment.

Some wonder if VCH has even articulated its goals and done the necessary outreach to potential funders, and one notes that the City of Vancouver might see itself as a source of capital funding for such a project.

Garth McIver, a veteran of addiction treatment internationally, says the current retention rate at one year — considered a benchmark for benefit — is estimated at 33 per cent. Low-barrier methadone clinics can increase this rate to 80 per cent or more, based on experience in jurisdictions such as Toronto. (Late last year, New Brunswick's Saint John's Uptown Clinic boasted a retention rate of 95 per cent, at a cost of $5,000 per patient per year [http://www.cbc.ca/news/canada/new-brunswick/story/2012/10/29/nb-methadone-study.html].)

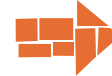
While Vancouver's NAOMI and SALOME trials explore the potential effectiveness of diacetylmorphine and hydromorphone in heroin addiction treatment — with a variety of scientific and regulatory hurdles in front of them — a generally effective and widely accepted methadone therapy is not being fully employed. There are many impediments, of course, including the College of Physicians and Surgeons' restrictive prescription criteria. Some internal staff wonder if they will be altered to allow psychiatrists and nurses to prescribe the medication, as happens in other jurisdictions.

VCH must reform its methadone programs well. Some argue it should be done in a partnership similar to Insite and Onsite. Others believe that VCH must take greater control of this service itself and create counselling, group support, connections to other addiction treatment programs, and potentially other health services around such a clinic in the manner of the long-discussed health services arcade. Whatever approach VCH takes, it needs to build it to succeed by collaborating with DTES agencies, with methadone users themselves, and with the community at large. Acting with dispatch in concert with the community to establish such a facility will go a long way to build confidence in the health authority's work.

Addiction treatment

Again and again, inside the health authority and out, people cite the disincentives that exist for an addict to commit to treatment, and the difficulty in gaining access when they do. Internally, many people talk about working toward a "continuum of care." Criticism of the system neglects the best efforts of many doctors, counsellors, case managers and those that work in both day- and residential-treatment programs. Yet the widely cited impediments to effective treatment are both numerous and discouraging:

- People who've struggled to find stable housing risk losing it if they go into residential treatment
- Day treatment options are limited and sometimes nonexistent, and there are no services for the working poor



- Treatment for women is not adequate, suitable options are less accessible than they are for men, and there are very limited women-only options for women who feel unsafe
- Programs specific to aboriginals do not adequately connect with the need
- People repeatedly use the Vancouver detox, sometimes as a shelter, in a way that can be harmful to their health
- Knowledge of the range and role of local detox and addiction programs among ambulance attendants, police and others assisting those in need is incomplete
- Interventions for youth at risk of addiction are inadequate
- Systems are developed without input at the outset from the grassroots
- Participation in methadone programs results in deductions from recipients' welfare cheques
- Existing methadone programs can impair a person's ability to normalize their lives because the waits for service along with the waits in food lineups can consume many hours per day
- People cannot access treatment, particularly residential treatment, in a timely manner when they decide they need it

Many people say the incentives are frequently backwards — that clients need to be rewarded for improvement instead of punished for failure. One doctor argues rent supplements should be used as a carrot for those who undertake the recovery process. "We need to make treatment as attractive as using, and we haven't." He cites an addict reluctant to go into treatment just before Christmas because he'd lose his welfare cheque and thus the ability to pay some debts and buy a few modest presents.

Reform comes in increments, of course. The health authority is currently trying to create greater accountability for VCH-funded residential treatment beds, because it believes some agencies have been filling those beds with people from other sources, which provide a payment or co-payment. Ironically, one observer told me that accountability existed in the past but was eliminated as a cost-saving measure. It's not the only such story, and for experienced middle managers, such history is demoralizing.

The lack of continuity in addiction treatment also extends to measurement of outcomes. "Implement a monitoring and quality assurance process, and let competition be based on quality," says one manager, arguing that in addiction treatment the relationship with best practices is poor. As such, VCH's move in early 2013 to develop better mechanisms to track treatment outcomes more carefully is welcome.

Drawing mental health and addictions management together, while accepted by many, is itself a source of apprehension. Some feel addictions is the poor cousin in this arrangement, and that as a key source of innovation in treatment for communities like the Downtown Eastside, people in the addictions field should play more of a leadership role.

Building a strong narrative, however, begins with simple, clearly articulated goals.

The greatest concern, though, is the need for a clear plan to improve the quality, availability and connectivity of addictions services. Work is being done to improve addictions training for doctors through the St. Paul's Hospital Goldcorp Fellowship in Addiction Medicine, but that's a long-term strategy.

The key ambition of many observers is more effective and connected case management. Several people would like to see the health authority create mini-ACT Teams that draw disparate service providers together to manage a set of clients. Some caution that they would lack fidelity to the ACT Team model. Others argue they don't have to be called ACT Teams, they simply have to create better-connected and more effective services. They maintain that healthcare in what is essentially a small community depends substantially on relationships, and that drawing people together in this way puts the focus on the client.

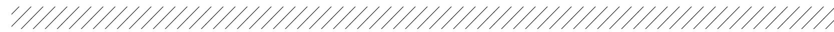
Once you've got that focus, though, you still require the service that will meet the person's needs. "You need to meet the need they have right at that very minute," says one addictions veteran, echoing a widespread refrain. In a system where it's increasingly difficult to compel people into some form of care and treatment — notwithstanding the Downtown Community Court's notable success in this regard — capitalizing on an addict's moment of clarity is important. Instead, the system almost always asks them to wait. "We have an incredibly hard time getting people into addiction and mental health services," says one manager. "Where the hell do they go when they finish detox?" says yet another.

Regarding residential treatment for chronic addicts, addictions services manager Reg Daggitt holds in high regard the non-profit Central City Concern in Portland, Oregon, that controls 1,500 units of housing, half of which are drug- and alcohol-free. With an annual budget of $41 million, it runs integrated treatment, employment, and life-skills programs. "They have a very high success rate," he says, based on a continuous system that cares for people for two or three years.

Selling better treatment for addicts is not an easy job, however. HIV/AIDS was a powerful tool for selling harm reduction, but the focus on disease transmission shaped what we've treated. "A lot of people equate harm reduction with facilitating ongoing use," one manager observed. "Harm reduction is a continuum of care."

Framing the public conversation effectively and creating a strong narrative to drive reform is part of what's required to create a real shift. "Don't give it an addictions spin," says one person, "Give it a public health spin." Another says the conversation needs to be brought back to homelessness, which he argues is a symptom of an underlying problem. Homelessness, he says emphatically, "is a mental health and addiction issue." Yet most people I spoke to argued we do not prioritize addiction and mental illness in the same way that we've prioritized issues such as AIDS and homelessness. They believe that has to change, both within Vancouver Coastal Health and in our public conversation about these issues. Building a strong narrative, however, begins with simple, clearly articulated goals.

Mental health priorities



"WE ARE MISSING PEOPLE, AND IT'S BEEN VOICED FOR SO LONG, AND IT DOESN'T CHANGE. MANAGERS MOVE ON, PROGRAMS MOVE ON, AND IT DOESN'T CHANGE."

Variations of that message are pervasive among those who work for Vancouver Coastal Health in the Downtown Eastside.

Unmet need among those with non-traditional mental illness

Years ago, we missed addicts and we missed the mentally ill. Now the two are often inextricably intertwined. Definitions of mental illness have broadened. In the Downtown Eastside today, the biggest area of concern involves access to treatment for those with non-traditional mental illness resulting from the complex cocktail of personality disorder, trauma, brain injury, and drug-induced psychosis.

How many people fall into this group? Are existing resources out of touch with the problem? Is outreach sufficient? What treatment is appropriate?

For psychiatrist Bill MacEwan, the answers are deeply concerning. "Vancouver Coastal Health is trying to get it covered, but they haven't," he says. "Down a hallway of 10 rooms, every single one of them has a serious problem within it." Based on a paper he's written that's awaiting publication, he rattles off the statistics for the 2,000 to 2,500 SRO residents he sees as critically in need: 95 per cent substance dependent, 74 per cent with psychiatric illness, 47 per cent with psychosis, 70 per cent with hepatitis C, 18 per cent with HIV, 65 per cent with a history of a head injury.

He said St. Paul's emergency ward saw 7,345 mentally ill / substance abusing patients last year, adding that the number increased 43 per cent in less than three years ending in late 2012. "I'm not saying things haven't been done. But the wave is curling over all the things that are happening."

MacEwan is a big personality who works hard to serve this group, knocking on doors as an outreach psychiatrist. MacEwan, who is among those advocating for small teams that draw on the ACT model, is the only psychiatrist working with Vancouver Coastal Health's Clinical Housing Team. He argues that the Strathcona Mental Health Team is trying to reach these people but isn't. Others claim that people with non-traditional mental illness are denied treatment at Strathcona and elsewhere because they don't meet old-fashioned criteria.

In the Downtown Eastside today, the biggest area of concern involves access to treatment for those with non-traditional mental illness resulting from the complex cocktail of personality disorder, trauma, brain injury, and drug-induced psychosis.

That said, there is widespread praise for many mental health resources, including the Strathcona Mental Health Team. "We have some wonderful resources. The populations they serve, they serve very well," insists one mental health insider.

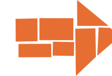
Strathcona Mental Health Team manager Gerry Bradley makes a good case for the Strathcona team's outreach efforts, noting that most staff spend as much time seeing patients outside of the office than as in it. He offers a nuanced description of the range of mental illness, and insists that no one is turned away because they don't fit old criteria. Bradley acknowledges that his team isn't adequately meeting the growing needs of this increasingly important constituency. However, he says the Strathcona team, which serves about 1,400 people, can't jump ship on its existing clients to aggressively pursue those with complex concurrent disorders who are not being reached.

What should the health authority do? For MacEwan, it begins with working harder to treat the psychosis, which is evident in the DTES streets but equally concerning when it's largely invisible in lonely rooms that addicts are often disinclined to leave.

But compelling them to take anti-psychotic drugs is difficult at best because of a failure to fully use the B.C. Mental Health Act, and he believes there needs to be a conversation with those working on civil liberties issues in the Downtown Eastside about how to proceed. And while he's at it, he'd also like to get people a little more worked up about drug dealers. "Who's marching about the drug dealers? They are the ones who are stabbing my patients."

One manager observes that specific training is lacking to deal with people whose needs can be draining. "We don't train social workers who will work with this population. We don't train nurses who will work with this population."

"We have unmet need," says Soma Ganesan, of those with non-traditional mental illness. "Let's talk about that unmet need, and work together."



Housing, in and out of the DTES

Staff share the widespread concern of DTES agencies regarding inadequate supportive residential mental healthcare, which often results in people defaulting to the Downtown Eastside. Changes in the system, from the closure of Riverview's mental health facilities in Coquitlam to the challenges in establishing the Burnaby Centre for Mental Health and Addiction, have been rough on the people it serves. Most agree the Burnaby centre, now eight years old, is finding its equilibrium. However, several people were critical of the closure of the Brookside and Leeside facilities at Riverview, which were run by Coast Mental Health to provide transitional residential care for people, some previously homeless, with concurrent disorders.

On manager cited the $50 million allocated for housing as part of a $250 million provincial mental health strategy, and said, "With that $50 million, we still don't know, clearly, what we are doing." VCH, he believes, needs to work with its partners to create more clarity and accountability.

While the 14 residential facilities being created by the City of Vancouver and the province are intended to serve both the homeless and those with mental health issues transitioning to the community from other care, health agencies and governments have argued over who gets priority. A new 28-bed Sumac Place mental health rehabilitation facility in Gibsons, which opened last year, is welcome. Are those beds enough? "We don't know," says Ganesan. "If we need more than that in a year, we'll see what we can do."

Then there is the issue of mental health beds specifically for youth. One manager says VCH is the only B.C. health authority that has none of its own, and that it relies entirely on beds provided by the Provincial Health Services Authority.

While the Joseph and Rosalie Segal Family Health Centre, slated for completion in 2017 at Vancouver General Hospital, will address some of these issues, of course, the demolition of the existing mental health facilities on the site will again put transitions at the forefront.

For nearly 20 years as we've sought to modernize mental health care and bring people closer to home, we have managed the transitions badly and failed to provide the necessary capacity. People continue to default to the Downtown Eastside, and those in the Downtown Eastside who would choose to be elsewhere continue to have limited opportunity. Once again, there is a call for a clear plan to deal with unmet need.

Choice

TOO OFTEN, THE DEBATE ABOUT HOW VANCOUVER COASTAL HEALTH SHOULD DELIVER SERVICES IN THE DOWNTOWN EASTSIDE LOSES TRACK OF THE PEOPLE BEING SERVED.

Leaders and agencies jockey for territory, or funding, or high moral ground. Deep and sometimes unacknowledged philosophical disagreements aggravate entrenched positions.

Are we failing to hold out the promise of recovery for addicts, or are we pretending we can help people who will never recover? Are we putting patients' rights ahead of their health, or notions of public order ahead of the patient? Does the system favour addicts and the mentally ill at the expense of others who live in the community, or are the judgments of those others impairing the needs of those most damaged in our society? In serving this community, do we provide the same level of quality, access, dignity and respect that we do in communities better able to protect their interests?

Differing views can be passionately and honestly held, but the people being served must always remain at the centre of the conversation. Sometimes we lose track of the one central issue in the Downtown Eastside: we need to do a better job of caring for the addicted and the mentally ill, of giving them the opportunity — the choice — to normalize their lives as much as is possible for them.

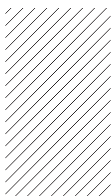
It's an issue for everyone, for leadership and for frontline employees. "Sometimes you just stop seeing the people," says one person who's worked in the trenches. Another laments paternalistic resistance to the idea that a client could speak for themselves as caregivers discussed their circumstances. "There was pushback from our own staff — we couldn't have a client in a case conference."

"We've got to keep the residents of the Downtown Eastside in the centre of this whole thing," says Gerry Bradley. When we do that, when the community is engaged, good things can happen. Peer testing as part of the Stop HIV/AIDS initiative, for example, was a result of people listening to the clients themselves. Vancouver Coastal Health, with its partners, needs to create opportunity for community residents to make their own decisions, to shape the system that serves them, and to help each other. The Downtown Eastside agencies made that clear, and those closest to the frontlines within Vancouver Coastal Health reiterated the message.

"If we are going to address the issue we need to move outside of our own silo," says Soma Ganesan. "We need to truly listen to the population. We need to go down to the grassroots instead of talking to the broker. Good ideas don't come from one person."

Any power we have over our own health begins with our ability to choose. Vancouver Coastal Health needs to give the citizens of the Downtown Eastside the opportunity to choose a course that will contribute to their health and the health of our community. It's not an easy task, but it's a clear one, and in the idea of choice perhaps there is the seed of a powerful healing narrative.

Notes



Vancouver
Coastal Health