Community Action Initiative

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Towards a Community Driven, Collaborative Continuum of Substance Use Care in British Columbia

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Land Acknowledgement

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Disclaimer

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Executive Summary

Nearly half a decade ago, the Provincial Health Officer of British Columbia (BC) declared a public health emergency in reaction to alarmingly high numbers of fatal drug overdoses in BC. In mid-2021, the crisis has yet to be abated. With today's dual syndemics of the COVID-19 pandemic and the overdose crisis, a spotlight has been placed on the vast ***systemic*** and ***structural inequities*** of BC's mental health care system. In 2017, the BC government released its decade long vision for mental health and substance use (MHSU) care, outlined in the report, *A Pathway to Hope.* This roadmap outlines the importance of transforming BC's MHSU system away from its crisis-response approach, towards a system based on "wellness promotion, prevention and early intervention" (Government of British Columbia, 2019, para. 5). One of the priority actions of the Ministry, is to create of a new adult substance use framework, with the goal of connecting British Columbians to evidence-based and trauma-informed treatment and recovery services and supports (Ministry of Mental Health and Addictions, 2019). The purpose of this report is to articulate a vision for a community driven, collaborative MHSU system of care that exists on a continuum which begins in community, extends into health care, and ultimately leads back to community.

This report considered the following question: What does a community-led ecosystem approach to prevention, treatment and recovery for mental health and substance use issues look like in BC, while prioritizing an upstream focus on social and structural determinants of health? It consisted of two literature reviews which looked at the concept of what "recovery" in substance use means as well as what a recovery-oriented and community-led substance use system of care needs to include. Additionally, two focus groups were conducted, which involved people with lived/living experience (PWLLE) as well as "system allies" from community-based organizations, health care providers such as nurses, professors, policy analysts and researchers.

Key themes that emerged from this report are that mental health and substance use should be addressed concurrently, and that understanding the concept of what recovery means is surprisingly not straight forward nor self-explanatory, which alludes to how there has been confusion around how this policy problem has been represented. Additionally, promoting mental wellness and addressing substance use/mental health at a community level requires a multi-scalar and multi-pronged approach which includes:

- addressing issues of legislation and sustainable funding and evaluation models at the macro level;
- addressing issues with information sharing, housing, expanding and co-locating treatment services, building capacity of community workers and providers, paying special attention to specific populations at the meso level;

- addressing opportunities for family and peer support, skill building, fostering leadership, education and employment, addressing shame, stigma, and trauma and valuing personal choice at the micro level.

This report outlines ways in which the current system of care excludes those most marginalized by the system in reform and planning efforts in addition to placing little emphasis on the role that the community sector plays in achieving equitable health care. However, a community-based MHSU that supports the work of PWLLE via authentic partnership and inclusion can help address broader social determinants of mental health and promote the ultimate goal of mental wellbeing.

Introduction

British Columbia’s Overdose Emergency and Why this Work is Important

Nearly half a decade ago, the Provincial Health Officer of British Columbia (BC) declared a public health emergency in reaction to alarmingly high numbers of fatal drug overdoses in BC. In mid-2021, the crisis has yet to be abated. With today’s dual syndemics of the COVID-19 pandemic and the overdose crisis, a spotlight has been placed on the vast ***systemic*** and ***structural inequities*** of BC’s mental health care system. Since the declaration of the overdose public health emergency in 2016, approximately 6,000 British Columbians have unnecessarily died from drug overdose (BC Coroners Service, 2021) and in 2020 alone, nearly five people died of an overdose per day (BC Center for Disease Control, 2021). Recent statistics from the BC Coroners Service show that with on average 170 drug toxicity deaths per month between January and May of this year, BC is on trend for the highest average drug toxicity deaths per month, ever (BC Coroners Service, 2021).

Many scholars agree that recovering from a substance use disorder (SUD) is a “continuous, lifelong process” (Sheedy & Whitter, 2013, p. 242). Additionally, various harms have been reported by those who use substances, which span a number of determinants of mental health including negative impacts on housing, economic entrenchment, and loss of social relationships (Government of Canada, 2019; Daley, 2013). These harms are structurally “produced” by a system that disenfranchises marginalized people and includes financial issues from unemployment or underemployment, grief and loss, housing instability, and higher rates of medical sequalae such as HIV and hepatitis C (Daley, 2013). The culminating effect of such harms are a reduced quality of life (Ministry of Mental Health and Addictions, 2021).

However, these facts cannot be sterilely examined given the disproportionate spatial and temporal patterns of substance use amongst communities who have been systemically marginalized, minoritized and excluded from society due to discrimination. Indigenous British Columbians continue to be unjustly overrepresented in overdose deaths, “accounting for 16 percent of all overdose deaths in the first half of 2020 despite representing 3.3 percent of the population (First Nations Health Authority, 2021). Additionally, First Nations women “died from overdose at nearly 9 times the rate of other women in BC in 2019” (First Nations Health Authority, 2021, para. 4). Therefore, given the high prevalence and harms associated with SUD, multi-scalar and multi-prolonged approaches are required to tackle this public health issue, with equity and community-focused approaches at the center.

A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia.

In 2017, the BC government released its decade long vision for mental health and substance use (MHSU) care, outlined in the report, *A Pathway to Hope.* This roadmap outlines the importance of transforming BC's MHSU system away from its crisis-response approach, towards a system based on "wellness promotion, prevention and early intervention" (Government of British Columbia, 2019, para. 5). Core pillars noted in this report include: wellness promotion and prevention; seamless and integrated care; equitable access to safe and effective care; and Indigenous health and wellness. Through this roadmap, the provincial government committed to a number 3-year priority actions, including a focus on improving care and saving lives with regards to substance use (Ministry of Mental Health and Addictions, 2019).

One of the priority actions is the creation of a new adult substance use framework, with the goal of connecting British Columbians to evidence-based and trauma-informed treatment and recovery services and supports (Ministry of Mental Health and Addictions, 2019). The Ministry committed to working with partners to define and determine key elements needed to ensure a coordinated, integrated and interdisciplinary system of addiction prevention and care, which works for everyone. The framework is intended to address issues of service fragmentation, inconsistency in service models, confusing navigation, and lack of access and collaboration.

About the Community Action Initiative

CAI plays a fundamental role in BC's mental health and substance use system because they foster diverse, cross-sectoral initiatives that promote mental health and wellness using a "whole community" approach. With an initial $10M endowment, and subsequent investments from the Provincial Government totaling $15M between 2015-2020, CAI provides grant funding and capacity building opportunities to community-based organizations (CBO's) across BC to develop and implement innovative service projects in alignment with provincial priorities for mental health and wellness. CAI works alongside BC's community-based mental health and substance use sector which is understood as non-government organizations including not-for-profit, charitable, and Indigenous-led organizations providing MHSU services and supports outside a hospital setting. CAI plays a unique role in BC, bridging provincial government priorities and community needs. We partner with communities to identify and articulate local priorities and co-create solutions that complement provincial health and wellbeing goals. For ten years, CAI has consistently taken a road that begins in and leads back to community (Community Action Initiative, 2021). CAI was invited as a stakeholder in the development of the new adult substance framework by the MMHA to help design an evidence-informed framework for a community driven mental health and substance use continuum of care.

The Purpose of This Report: Advocating for Integrated and Collaborative Mental Health and Substance Use Care

Substance use services and supports are conceptualized by the formal system, as existing on a “continuum” of care ranging from preventative efforts (e.g: anti-stigma campaigns) to specialist care such as harm reduction services and bed-based treatment. **The policy problem under consideration examines how the current system of care excludes those most marginalized by the system in reform and planning efforts in addition to placing little emphasis on the role that the community sector plays in achieving equitable health care**. An individual’s recovery is directly impacted by their experience of community life; therefore, entire communities must be engaged with the goal of improving mental health.

Additionally, there is a financial imperative inherent in the need to transform the system of substance use care in BC. Mental health and substance use problems are estimated to cost the province over $6.6 billion annually (Canadian Center of Substance Use and Addiction, n.d). Additionally, the “total health costs of opioid use in B.C. are estimated to exceed $90 million annually and the economic costs of lost productivity associated with opioid use are close to $1 billion annually” (Ministry of Mental Health and Addictions, 2021, p. 8). Yet, there is also an ethical need to transform the system into one which is in alignment with Canadian values of fairness and egalitarianism.

Engaging whole communities to improve mental health will be more powerful than any single program or intervention. It is time to redirect momentum to build a transformative, comprehensive, and equitable system of mental health and substance use care, starting with a framework that is co-created and driven by community. Recovery from SUD is impacted by aspects of community life are impacted by all aspects of community life and engaging whole communities to improve mental health will be more powerful than any single program or intervention. Therefore, it is time to redirect momentum to build a transformative, comprehensive, and equitable system of mental health and substance use (MHSU) care, starting with a framework that is community driven and co-created.

Unfortunately, the community sector is often seen by policy and decisionmakers as a sort of peripheral appendage to the “real” MHSU system of care. In reality, many community organizations are under-recognized for the significant role they play in maintaining and promoting community mental wellness and providing essential infrastructure at a community level. **The purpose of this document is to articulate a vision for a community driven, collaborative MHSU system of care that exists on a continuum which begins in community, extends into health care, and ultimately leads back to community**. In the United States, the WellBeing Trust created the Healing Nation report (Miller et. al, 2020), which proposes a similar framework. This report highlights opportunities for the new substance use framework be multi-sectoral, includes concrete and meaningful links to community, and integration with mental health care at the micro, meso and macro level.

Research Context and Methods

This section of the report will outline the research question, key terms, research approach and method of analysis used for this project.

Research Questions

What does a community-led ecosystem approach to prevention, treatment and recovery for mental health and substance use issues look like in BC, while prioritizing an upstream focus on social and structural determinants of health?

Sub-questions:

1. **What does "recovery" in substance use mean**?
    - The focus of this area of inquiry was to examine the experiences of substance use recovery and wellness amongst people with lived and living experience (PWLLE). Additionally, specific attention was given those who have been systematically marginalized from society such as Indigenous people, women, people who identify as LGBTQIA2S+, people who have been formally incarcerated, people experiencing homelessness and people who live in rural settings.

2. **What does a recovery-oriented and community-led substance use system of care need to include?**
    - This question focuses on understanding conceptualizations of what integration between the community sector and formal healthcare sector could look like, by exploring avenues whereby communities have built capacity, enhanced community-change leadership and promoted health.

Key Terms

The key terms used to frame the research questions are presented in Appendix A.

Research Approach

The research undertaken in this project is heavily shaped by the author's ontological and epistemological proclivities as an African immigrant, a black woman and mental health and public health nurse. The research questions were analyzed using the lenses of intersectionality and equity as well as more "mainstream" frameworks of the social-ecologic model and the social determinants of health. These lenses were used to promote critical dialogue and knowledge around how we conceptualize substance use and mental health care in BC.

Intersectionality and Equity

Historically rooted in black feminist scholarship, intersectionality is a theoretical lens that helps researchers deconstruct Eurocentric philosophical traditions which have dominated the field of mental health and substance use care research (Feralette et. al, 2019). Intersectionality was used in this analysis because it is aligned with a social justice approach and "has the potential to help realize the broader goals of reducing inequities and enhancing citizenship for people with mental illness" (Rossiter & Morrow, 2011, p. 315) by examining structural forces of oppression. An intersectional mental health approach is defined as "the social, political, and economic processes through which oppression and privilege are experienced by individuals who have the added stigma and discrimination associated with a mental illness diagnosis. That is, intersectionality "is not the intersection itself, but what the intersection reveals about power" (Rossiter & Morrow, 2011, p. 314).

This framing is important given that research within the field of mental health and addictions has been criticized for perpetuating the "racialization of health research" (Rossiter & Morrow, 2011, p. 313) as the field has historically treated variables (such as ethnicity and gender) as separate rather than intersecting and interlocking. As Lee & Hankivsky (2011) state, "the degree to which social models of recovery can gain traction is hindered by structural barriers such as the lack of community-based mental health resources, including housing, income security, and employment, as well as the ongoing dominance of the biomedical paradigm in mental health well as the ongoing dominance of the biomedical paradigm in mental health" (p. 320). This is why a "one-size-fits all" approach to policy – which lacks nuance and specificity – has negatively affected so many marginalized populations since one cannot simply "cherry-pick" one determinant over another. *Figure 1.* (Giorgadze et. al, 2015). Demonstrates the concept of intersectionality as a wheel diagram. The innermost circle reflects a person's unique circumstances of power, privilege and identity. The second circle following that reflects aspects of identity. The third circle reflects various types of discrimination that affect identity. And, the outermost circle reflects broader societal/structural forces of oppression (Giorgadze et. al, 2015).

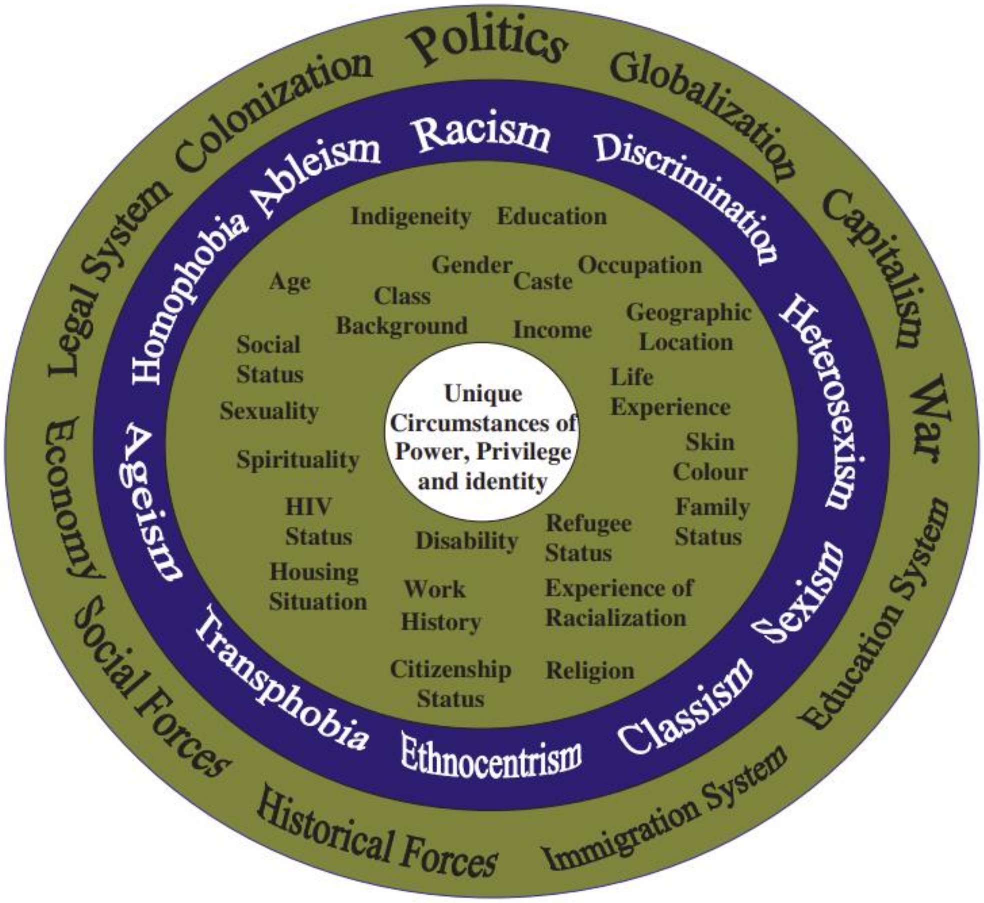


Figure 1. from Giorgadze et. al, 2015.

An example of how intersecting social identities can affect certain populations is evidenced by the number of Indigenous people in BC with a SUD who do not have equitable access to care. Indigenous people are affected by numerous structural and social determinants which have been largely unaddressed such as mental illness, homelessness, unemployment, abuse, stigma and discrimination in healthcare settings. As Goodman et. al (2017) state in their paper, "*They treated me like crap and I know it was because I was Native*", mainstream "medical services relying on western medicine and conventional public health approaches, tend not to address the social and economic determinants that greatly affect individual health, and rarely do services accommodate for cultural differences. Without understanding the social and historical contexts of the current health status of Aboriginal peoples, racialized stereotypes (e.g., 'drunken Indian') prevail" (Goodman et. al, 2017, p. 88).

Social-Ecologic Model and the Social Determinants of Health

The second framing used to guide this study is the social-ecological model and the social determinants (SDoH) of mental health. Using ecological systems theory, the social-ecological model contextualizes behaviours based on individual, interpersonal, institutional and policy contexts (Ashford et. al, 2020; Jalali et. al, 2020). Similar to intersectionality, this framework recognizes that the "complexity of the [overdose] crisis is represented by the multiple spheres of influence […] indicating the necessity of a broader and a more integrated approach that includes prevention, treatment and overdose rescue interventions" (Jalali et. al, 2020, p. 2). More specifically, this framework posits an 'eco-social' approach that can help us understand health inequities and the "social and political economy of health and the social production of disease" (Karban, 2017, p. 893).

Health inequalities are "linked to genetic, biological, social and other factors that result in differences in health status which may or may not be unfair, whereas health inequities refer to avoidable and unjust 'social processes underlying the unequal distribution of these factors between groups occupying unequal positions in society" Health inequities can be worsened by stigmatizing and discriminatory policies that result in exclusion from social structures such as social networks, social institutions and broader political and economic structures. Exclusionary processes often contribute to health inequities" (Belle-Isle, Benoit, & Pauly, 2014, p. 178). Therefore, to combat inequities, it is important to assertively link the content and structure of a person's microsystem (at the individual and interpersonal levels) to their corresponding dependent ecologies at the meso and macro level (at the institutional and policy contexts) (Ashford et. al, 2020).

In this model, at the individual level, factors that influence SUD include biological and sociodemographic factors such as whether or not someone has a mental health disorder or struggles with issues of self-stigma. On an interpersonal level, supports that someone with a SUD has access to – namely, family and friends – can influence whether or not someone uses drugs. For example, on side of the spectrum, "people who have a family member with opioid use disorder are 10 times more vulnerable to misuse and overdose on the drug themselves and youth witnesses of family member overdose are more prone to overdose themselves" (Jalali et. al, 2020, p. 3). But, on the other side of the spectrum, beneficial and healthy family and friend supports can greatly impact an individual's choice to seek help through emotional and motivational support (Jalali et. al, 2020).

At the community level, factors such as "geographic conditions, treatment accessibility, medication disposal services, workplace environment, […], community norms, and access to legal and illegal" (Jalali et. al, 2020, p. 4) substances can perpetuate SUDs. And finally, at the societal level, factors that affect SUD include "government regulations, economic conditions […], elements of the media, social stigma, discrimination and prejudice, advertising campaigns, educational campaigns, and law enforcement" (Jalali et. al, 2020, p. 5). In considering the individual, interpersonal, community and societal factors that affect SUDs, we can then understand how various determinants of mental health – such as low income, insecure housing, limited education, unemployment, precarious employment, child abuse, poor neighborhoods and low social support (Fisher & Baum, 2010) interact.

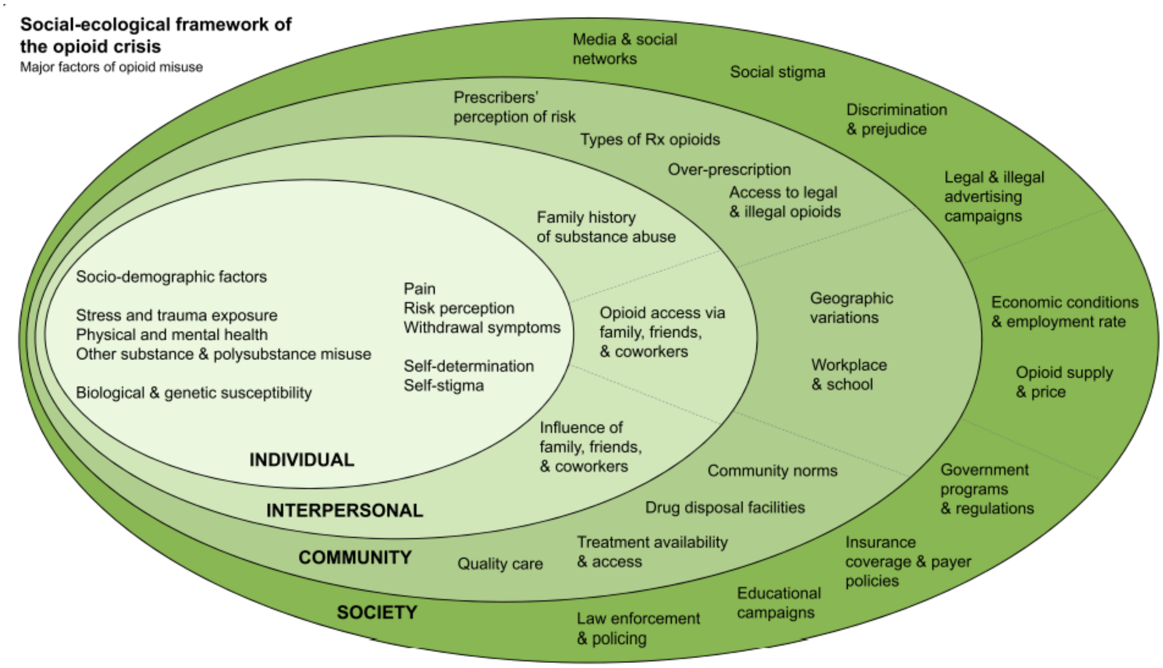


Figure 2. from Jalali et. al, 2020

Literature Review

Two literature reviews were conducted addressing the research questions of: "*What does "recovery" in substance use mean?"* and "*What does a recovery-oriented and community-led substance need to include?"*

The literature reviewed for this paper examined literatures from 2010 to 2021. Given time constraints of this project, this literature review not meant to be a systematic review. The scientific databases of CINAHL and PsycINFO were used to find peer-reviewed articles whereas Google Scholar and Google were used to find grey literature. Key terms used for the searches are included in Appendix B. Inclusion criteria for both reviews were limited to full-length, peer-reviewed journals or grey literature that focused on the adult population (defined as an individual older than 18 years of age). Retrieved documents had to be published within the last ten years. Exclusion criteria consisted of papers examining pediatric populations. Articles retrieved by the searches were first screened by title and abstract, followed by a full-length paper review. Reference lists of relevant articles and grey literature were further reviewed for final inclusion in the literature review.

Focus groups

Two semi-structured focus groups were conducted with key stakeholders that represented diverse voices from the realms of community health, mental health and addiction services. The first focus group (n = 10) was held on July 9th, 2021. This group consisted exclusively of PWLLE and explored subjective experiences of recovery, what recovery means and what might lead to recovery. The second focus group (n = 12) was held on July 16th, 2021 with one additional one-on-one interview being held on July 19th, 2021 for an individual who could not make the original focus group date. These focus groups consisted of "system allies" from community-based organizations, health care providers such as nurses, professors, policy analysts and researchers. The purpose of this focus group was to explore what integration of the formal and community sector within the field of substance use should include. The focus group schedule and questions developed in consultation with colleagues at CAI (refer to Appendices C and D). Recruitment was guided by purposive sampling strategies and involved emailing invitations to members of CAI's network of community-based organizations and informal community relationships. All interviews were audio-recorded on Zoom (a videoconferencing platform), and participants provided implied consent via e-mail. The interviews were approximately 90 minutes in duration. In line with equity-oriented and participatory based methods, a $50 CAD honorarium was provided to participants with lived/living experience.

Data Analysis

Notes were taken during the focus groups as well as when re-playing audio recordings. Audio recordings were re-played multiple times to get familiar with the data, and notes were taken to mark trends/potential themes. Following this, the author undertook a more theoretical approach to mapping the data by using the perspectives of intersectionality and the social-ecological framework. These frameworks were used to examine and interpret the connections between an individual's social location at the micro, meso and macro levels (i.e: individual, interpersonal, institutional and societal levels) and systems of power.

Findings

Brief Overview: A Vision for a Community-Driven and Collaborative MHSU Framework of Care

Figure 3. articulates elements of a community driven and collaborative MHSU framework of care, and is the culminating visual product of the literature reviews and focus groups. This figure visually articulates a population health approach to substance use care, which is **non-linear, and lies on a continuum which begins and ends in the community sector with three entry points of influence at the micro, meso and macro levels**. As opposed to the

concept of “recovery”, **the outcome of this framework is mental wellness** and the foundation of the model is built on a trauma-informed approaches.

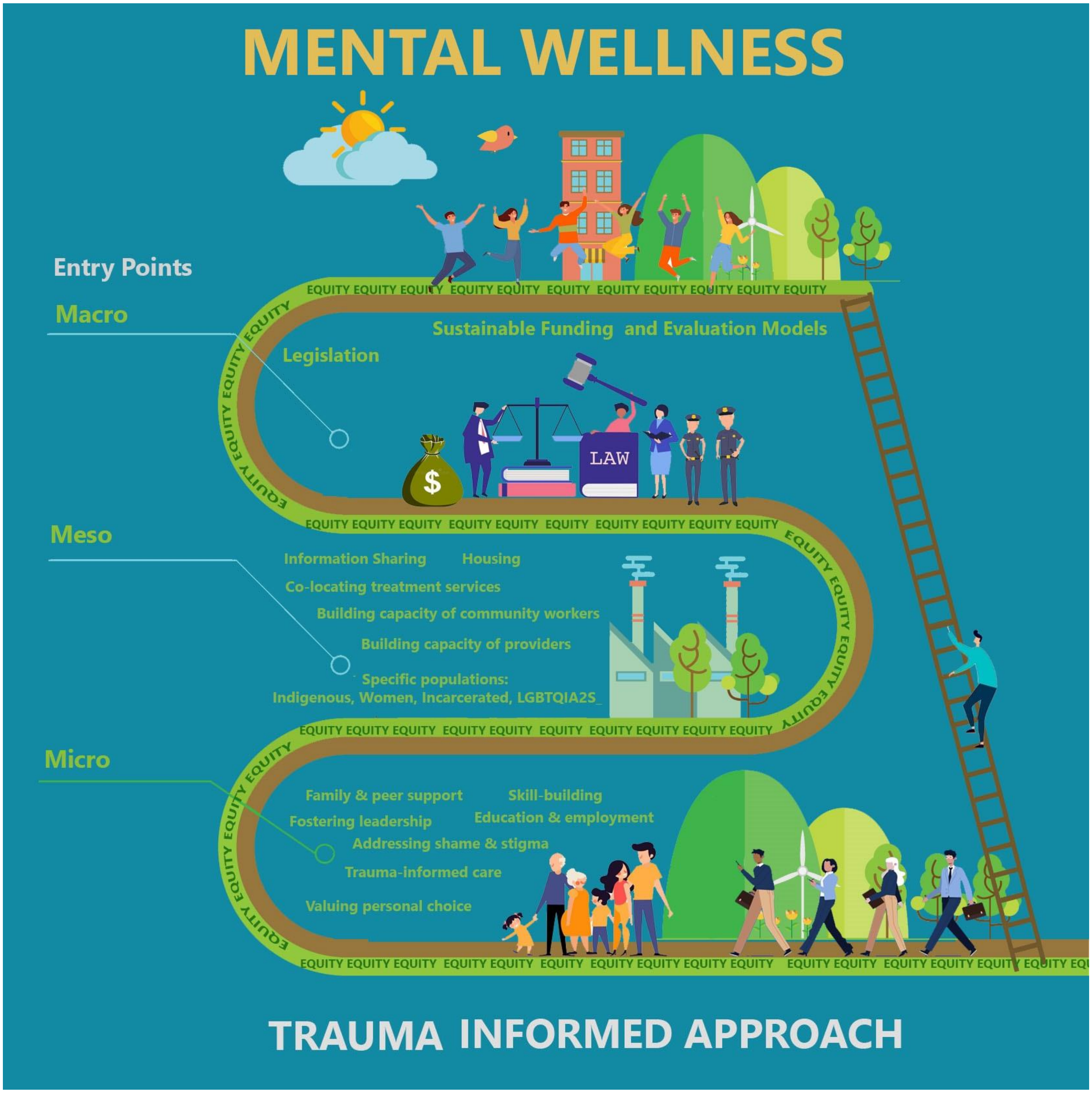


Figure 3. A Community Driven Approach to MHSU care

Principles Decoded:

- ***The Outcome of Mental Wellness*****:** The outcome of the framework is mental wellness for two reasons: 1) it is a strengths-based approach that moves past individualistic and oppressive framings of the term “recovery” and, 2) it incorporates a systems-level perspective that focuses on dismantling structural inequity and stigma. Structural stigma is defined as “the accumulated activities of organizations that deliberately or inadvertently create and maintain social inequalities for people with lived and living experience of mental health problems and illnesses and/or substance use [and] is located in the formal and informal rules and practices of social institutions […]” (Knaak et. al, 2020, p. 2). This part of the framework is the main focus of *Part 1: Lived Realities* where the concept of recovery from a SUD is further explored.

- ***At the foundation: A Trauma Informed Approach:*** At the foundation of this framework, is the recognition that the experience of trauma is highly associated with substance use and mental illness. In recognizing that most people who require substance use and/or mental health care have had at least one traumatic event in their life, this lens moves beyond the idea of individually treating trauma to also addressing issues that further exacerbate inequity and re-traumatize people including stigma, health care accessibility issues and discrimination.

- ***Addressing Structural (In)Equity and Non-linearity:*** This framework shows a “windy” road to mental wellness, travelling through three entry points at the micro, meso and macro levels. The path to mental wellness is often non-linear, and, as such, the SU framework should dynamic and flexible to support different life transitions throughout an individual’s healing journey. The concept of non-linearity reflects the chronicity of SUD, and how individuals with a SUD often have to explore various avenues and treatment options as well as a number of “attempts at” trying to maintain mental wellness before actually achieving it. Additionally, equity should be reflexively and actively embedded through the structures of the system of MHSU supports and services, inclusive of policies, governance and culture.

- ***Entry Points at the Micro, Meso and Macro Levels*****:** This framework recognizes the fact that people will have different entry points into the system, spanning micro, meso and macro levels, but that ultimately people begin their journey in community, potentially receive support and care from the formal health care system, and then end up in community. At the micro level, this needs to include opportunities for family and peer support; skill building; fostering leadership, education and employment; addressing shame, stigma and trauma; and valuing personal choice. At the meso level, this needs to include information sharing among agencies; supportive, affordable housing; co-locating and expanding community treatment services; building the capacity of community workers and health care providers; and paying special attention to specific populations (Indigenous people, women, those who have been/are incarcerated, those who identify as LGBTQIAS2+). At the macro level, this includes addressing issues of policy, legislation and sustainable funding and evaluation models. All of these points will be further expanded upon in *Part 2: Change the system*.

While the literature around recovery tends to focus on mental health and substance use problems separately, **this framework was created in such a way to help advance mental health and addiction care in a comprehensive manner by integrating and addressing both service areas simultaneously**. Important to note, however, the ongoing siloing of these issues, is reflected in “parallel visions of recovery in mental health services and drug and alcohol services” (Brekke et. al, 2017, p. 14). Consequently, “addiction treatment settings often lack the mental health personnel and resources to treat mental health conditions and substance use often causes barriers for [PWLLE] to access regular mental health services” (Wang et. al, 2016, p. 14). This makes very little logistical sense given that, there is a growing body of evidence that shows that SUD and mental health disorders have “a high degree of co-occurrence” (Brekke, 2017, p.13) and “can affect as many as 50% of those who develop a single disorder” (van Draanen, 2020, p. 1). Secondly, people with SUD have identified that managing mental illness and, going beyond that – to promoting mental wellness – in a co-occurring manner is a cornerstone for successful recovery (Timpson et. al, 2016). Therefore, this framework uses “a common language for both the mental health and addictions fields” (Sheedy & Whitter, 2013, p. 233).

Part 1: Lived Realities

KEY FINDINGS ON THE MEANING OF RECOVERY

- Understanding the concept of what recovery means is surprisingly not straight forward nor self-explanatory, which alludes to how there has been confusion around how this policy problem has been represented.
- There is no normative definition of "recovery" within the literature, but working definitions are orientated towards voluntary and sustained control over substance use that is individually focused, person-centered and addresses wider factors such as housing, employment and well-being
- The concept of recovery was espoused during the psychiatric survivor movement. The subsequent recovery movement started in Canada during the 1990s as a reaction to and resistance of "deinstitutionalization, critiques of psychiatrization, and the identification of sanism as a form of discrimination" (Reid et. al, 2020, p. 46).
- Recovery can be viewed as: 1) a clinical outcome, 2) a personal endeavor, 3) a social endeavor, or 4) none of these
- Viewing recovery as a personal endeavor is "a key construct in neoliberal forms of governance, underpinned by an emphasis on self-regulation, self-discipline, self-motivation, control and rationality" (Lancaster, Duke & Ritter, 2015, p. 620).
- The current policy responses to SUD care are emphasized within the acute care model of addiction treatment, where there is an opportunity for recovery initiation but not necessarily for the process of recovery maintenance (White, 2009).
- A community-based MHSU that supports the work of PWLLE via authentic partnership and inclusion can help address broader social determinants of mental health and promote the ultimate goal of mental wellbeing.

Recovery as a Concept

This section of the report explores findings from the research question: What does "recovery" in substance use mean? **Understanding the concept of what recovery means is surprisingly not straight forward nor self-explanatory, which alludes to how there has been confusion around how this policy problem has been represented**. For example, does recovery mean taking a harm reduction approach or an abstinence based one? As Timpson et. al (2016) state, "**there is no normative definition of "recovery"** within the literature, but working definitions are orientated towards voluntary and sustained control over substance use that is individually focused, person-centered and addresses wider factors such as housing, employment and well-being" (p. 30). Surprisingly, "relative to SUD onset and relapse, stable recovery is the least studied phenomenon in substance use research" (Pettersen et. al, 2019, p. 2). Significantly, the concept of "recovery" is viewed contentiously, as the concept is foundational in "making claims about what users of drug services want, what type of services should be provided and how treatment outcomes should be measured" (Klein & Dixon, 2020, p. 2). This can be seen in Canada historically, as the concept of recovery was espoused during the psychiatric survivor movement. The subsequent recovery movement started in Canada during the 1990s as a reaction to and resistance of "deinstitutionalization, critiques of psychiatrization, and the identification of sanism as a form of discrimination" (Reid et. al, 2020, p. 46). But, as Morrow & Weisser (2012) state, "while this movement has had empowerment and resistance to the dominance of psychiatry as its main goals, the concept of recovery has since shifted in recent years. This has led to vigorous discussion about the usefulness of the concept, and about its uses in the context of the increasing authority of biomedicalism and neoliberal policy regimes" (p. 28).

Given the historically oppressive roots that gave birth to the term "recovery", it is important to interrogate its current meanings in order to disrupt current forms of structural oppression. The author shares the similar view that substance use laws and "policies do not react to pre-existing problems which exist 'out there' waiting be solved, but rather create particular kinds of problems, where the notion of 'drug problems' is so embedded" (Lancaster, Duke & Ritter, 2015, p. 617). Additionally, "because policies by nature make proposals for change, every policy contains implicit representations of what may be considered 'problematic' and how these 'problems' ought to be thought about" (Lancaster, Duke & Ritter, 2015, p. 618). Therefore, the author maintains the position that it is important to remain skeptical of how the term recovery is utilized as a conceptual framework for system change (Morrow & Weisser, 2012). It is also important to recognize the political context in which the recovery has been viewed within addiction care given the dominance of the medical model and abstinence-based therapies and pharmacological treatments (Karban, 2017). As Reid et. al (2020) state, several "mental health policies have embraced recovery as a framework but have failed to fully integrate the social determinants of mental health. This has resulted in overlooking the ways in which social determinants of health intersect with mental illness to produce experiences of oppression and marginalization as well as a lack of knowledge about the lived realities of people with lived experience of mental illness. Consequently inconclusive, limited, and de-contextual understandings of recovery are perpetuated" (p. 46).

Reid et. al (2020) argue that "recovery is not one thing with multiple meanings. Rather, different practices bring different "enactments" of recovery into existence, and not all enactments of recovery are equal" (p. 48). Generally speaking, however, the concept of recovery both within the realms of substance use and mental health care has been generally understood as a personal/subjective journey/process involving friends, family and society as a whole and can be seen as either: 1) a clinical outcome, 2) a personal endeavor, 3) a social endeavor, or 4) none of these. All four of these domains will be further explored in this section of the report. Though all four conceptualizations of recovery have merit, achieving mental wellness requires a **community-based MHSU that supports the work of PWLLE via authentic partnership and inclusion can help address broader social determinants of mental health and promote the ultimate goal of mental wellbeing.**

The culmination of this section corresponds to the top of the framework, where the concept of mental wellness is proposed (see Figure 4.).

Figure 4. A Community Driven Approach to MHSU care

Recovery as a Clinical Outcome

The first view of recovery from a SUD is as a clinical outcome. Clinical recovery is the most reductionist – and perhaps most contentious – view of recovery in comparison to the other lenses. This view presents a symptom-focused version of recovery from a SUD, whereby alleviating symptoms is the primary goal. Many people with lived and/or living experience completely reject this medicalized view, given that recovery can be life-long and non-linear(Piat & Polvere, 2014). In fact, many people with a SUD "describe recovering from the mental health system, as opposed to recovering from a mental illness" (Piat & Polvere, 2014, p. 5). This is because, many people with a mental illness or SUD feel "routinely violated by a mental health system that oppresses, stigmatizes, and silences them, particularly in the context of involuntary treatment" (Piat & Polvere, 2014, p. 5). None of the peers or system allies interviewed in our focus groups referred to this definition of recovery.

Recovery as a Personal Journey

The second view of recovery from a SUD is on the personal level, whereby people with SUD have described recovery as a "way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness" (Government of Australia, 2013, para. 16). In this sense, recovery is seen as something whereby people with a SUD are "central actors" (Brekke et. al, 2017, p. 14) or experts in their *personal* condition, and this approach recognizes their strengths (Karban, 2017). The assumption behind this view is that it "validate[s] consumer or survivor expertise over professional control in order to mitigate broader processes of exclusion and dominance of biomedical approaches to mental health" (Reid et. al, 2017, p. 47). Therefore, discourse relating to abstinence based versus harm reduction approaches is largely decided by the individual and the motivations to "seek help" or "recognizing the need to change" is an individual decision (Timpson et. al, 2016). What this actually "looks like" within the community sector can change from person to person, but generally speaking, involves activities that "improve cognitive abilities and health, or [involve] rediscovering skills" (Brekke et. al, 2017, p. 18). In this sense, recovery can be viewed as life-long, continual "health work", whereby people with SUD have to "work at" their recovery by making a "commitment to self-determination, taking responsibility, and having agency and control in their lives, and that maintaining the will to persevere […] in the context of living in poverty and facing other systemic and societal barriers" (Reid et. al, 2020, p. 53). For example, this might involve activities that help PWLLE create "a sense of purpose and belonging" (Timpson et. al, 2016, p. 32) and feeling "useful and accepted" (Brekke et. al, 2017, p. 15) such as gaining meaningful employment, furthering education and volunteering (Timpson et. al, 2016). In reality, what this means is that PWLLE often have to individually "negotiate healthcare, mental health, employment, and housing systems as well as societal stigma and feelings of exclusion" (Reid et. al, 2020, p. 53).

One criticism of this view of recovery is that it overly emphasizes *self-responsibility* in one's own "health work" which has the tendency to further marginalize PWLLE and drawing attention away from structural and social determinants of mental health (Reid et. al, 2020). For many people with a SUD, "recovery is about 'overcoming the effects of being a mental patient, including poverty, substandard housing, isolation, unemployment, loss of valued social roles and identity, loss of sense of self and purpose in life, and iatrogenic effects of involuntary treatment and hospitalization'" (Piat & Polvere, 2014, p. 4) **This is in alignment with what Lancaster et. al (2015) argue, which is that, this definition of recovery is "a key construct in neoliberal forms of governance, underpinned by an emphasis on self-regulation, self-discipline, self-motivation, control and rationality" (p. 620).** Therefore, barriers to this view of recovery involves structural stigma and "a lack of tailored help [to navigate] complex systems and uncoordinated services" (Brekke et. al, 2017, p. 14).

Recovery as a Socially Mediated Process

The third way in which recovery is conceptualized, is as a socially mediated process that involves the acquisition of recovery 'capital'. Recovery capital is defined as the "quantity and quality of internal and external assets that can be drawn upon to initiate and sustain recovery from severe [addiction] problems" (White, 2009, p. 150). Similar to the determinants of mental health, recovery capital spans four domains at the individual, interpersonal, communal and societal levels, which are defined as: human, social, physical and cultural (Sheedy & Whitter, 2013). Examples of each type of capital is presented in the Table 1. (Sheddy & Whitter, 2013). In this view, there is a recognition that "what is required to sustain recovery is qualitatively different than what is required to initiate recovery" (White, 2009, p. 151). The current policy responses to SUD care are emphasized within the acute care model of addiction treatment, where there is an opportunity for recovery initiation but not necessarily for the process of recovery maintenance This is because downstream approaches to recovery, such as repeated readmissions to hospitals as an example –fail citizens in making successful transitions to the community sector and are a form of institutional profiteering (White, 2009).

Human capital	Physical and mental well-being, skills, employment
Social Capital	Family, friends, support networks
Physical capital	Finances, safety
Cultural capital	Beliefs, identity

Table 1. Examples of human capital

This concept of recovery considers an intersectional and equity-based perspective, viewing recovery as a socially mediated process. Such a perspective highlights how recovery involves barriers or access to different forms of capital highlighted by the experience of peers, who have been disproportionately affected by social exclusion, stigma, and discrimination

(Reid et. al, 2020). For example, in considering human and physical capital, insecure housing and economic precarity are major obstacles to recovery (Brekke et. al, 2017). Given this perspective, acquiring capital in these areas might include finding meaningful employment, which has other effects such as "strengthening identity personal growth; structuring daily routine; establishing a sense of belonging and contribution, and achieving independence" (Jarman, Hancock & Scanlan, 2016, p. 660). Another example, within the realm of social capital includes fostering ongoing support, positive relationships (Pettersen et. al, 2019) and social reintegration (Timpson et. al, 2016). As Reid et. al (2020) state, "for some, accessing ongoing support [is] important in preventing relapse. For others, ongoing support provide[s] a safety net and a feeling that things would be alright if a relapse did occur" (Timpson et. al, 2016, p. 33). Building nurturing pro-recovery relationships with other peers, family or friends is incredibly important for PWLLE to reintegrate into society, maintain employment (Jarman, Hancock & Scanlan, 2016), decrease feelings of social isolation and increase feelings of confidence and self-esteem (Timpson et. al, 2016). Facilitators of recovery capital include genuine community participation such as services that act as a link into the community may facilitate genuine participation (Brekke et. al, 2017).

Findings from the Focus Groups: Introducing the Concept of Mental Wellness

The ideas of whether or not recovery is a clinical outcome, personal journey or a socially mediated process are all partial truths when viewed separately. In reality, the most accurate concept of recovery from a SUD or mental health disorder is perhaps somewhere in between all of these conceptualizations. However, what is most important to highlight is that **beyond these three camps of thought, there must be a recognition of the social and structural barriers which are "articulated and enacted through a number of dimensions of power such as biomedicalism, racialization, sanism, sexism, ageism, heterosexism"** (Morrow & Weisser, 2012, p. 28) **which impede recovery**. As Morrow & Weisser (2012) have argued, "biomedicalism and the pharmaceutical industry, which when coupled with the dramatic erosion of the social welfare system in Canada over the past 15 years, has led to a system that rations resources based on diagnosis and severity of symptoms, and responds primarily through medication and medication management over and above social supports and responses" (Morrow & Weisser, 2012, p. 30).

When asked about what keeps peers healthy and safe in our focus group, most of them listed the importance of addressing various intersecting structural inequities in promoting recovery including: addressing the housing crisis, fostering environments that nurture supportive relationships including peer-based supports, addressing income inequality, and addressing the need for community-based programs and access to specialists/clinicians. Unsurprisingly, none of the peers focused on individual or medical characteristics as the basis for recovery, nor did any of the peers necessarily "cherry-pick" one single thing that led to recovery. Instead, most peers listed numerous things at once. As one peer stated,

> *“I was chatting with a friend and ally today; we were talking about housing. For me, having a supportive partner with some extra income there and not being at risk of losing my housing in the last year. I mean, I probably would have been homeless and lost everything that I tried to build in my adult life. You know, if I didn't have some kind of assured support there. Basic needs are not necessarily fully assured throughout my adult life. So, you know, that's what I encourage a lot of services to focus on with people just giving them money and food and clothing, you know, free drugs and housing would be like the linchpin for me. The housing piece is…you know, I feel so fortunate that if I have some meltdown, I will not have everything fall apart”.*

Such comments illustrate the ongoing structural and systemic challenges wrought by BC, and Canada’s ongoing affordability and housing crises. This quote characterizes the need to conceptualize recovery as something which moves away from a strict biomedical framing of addiction, towards mental wellness, and more upstream, population-level health approaches, which shifts focus towards broader social processes and the power dynamics which shape them.

The Link between the Community Sector and Mental Wellness

People with SUD, PWLLE and peers are “experts in understanding which interventions are the best for them. As such, exclusion from decision-making processes related to the health care received [is] viewed as akin to an abuse of their basic human rights”(Hungerford & Fox, 2014, p. 211). One approach to help move from top-down framings of mental wellness to a bottom-up, systems-level perspective is to focus on the role of the community sector. **The community sector is important in fostering population-based recovery because it fosters authentic partnership and inclusion with PWLLE.** The community sector is well versed in bringing those who have been marginalized in society together “in their struggle against injustices, build local leadership and give people a greater sense of control over their lives” (Belle-Isle, Benoit & Pauly, 2014, p. 183). Power differences are the culmination of exclusionary practices and, as Piat & Polvere (2014) state, “individuals with psychiatric disabilities have been denied a voice in shaping policy agendas for mental health reform because their perspectives have been viewed as illegitimate and inferior to authoritative clinical perspectives” (p. 5). In working with the community sector, PWLLE can have “shared power and inclusion in decisions that affect their lives, community members gain a voice and opportunities to make decisions in their best interest and that of their communities” (Belle-Isle, Benoit & Pauly, 2014, p. 180).

Additionally, the community sector addresses gaps in the within the continuum of care, left by the formal health care system. The formal health care system is simply illsuited to meet all the needs of folks seeking mental health and substance use services and supports. As an example, the community sector is often first point-of-contact for folks seeking support for with substance use challenges. The folks and organizations making up the community sector, are experts in building and sustaining trust in relationships in communities, through the provision of programming such as low-barrier harm reduction, outreach and peer navigation (Wagner, 2021). For example, community soup kitchens tend to serve precariously housed individuals as well as PWLLE. Such organizations can serve as an access point for PWLLE where they can get the opportunity to connect with peers, build a community of safety and trust and discover resources that they find appealing for their mental wellness (Tiesmaki & McEwan, 2016). Other examples of the range services provided by the community sector in addressing the mental health and SUD needs of British Columbians is outlined in the Table 2. below, from the 2016 BC Community Mental Health & Substance Use Sector Survey (Tiesmaki & McEwan, 2016).

TABLE 4. SERVICE TYPE	
Education and information	77%
Referral	74%
Events and/or Public Awareness	62%
Outreach	57%
Crisis Intervention	55%
Counselling	55%
Self-Help	51%
Case Management	50%
Assessment and/or Screening	47%
Peer Support	42%
Family Support	37%
Early Intervention	36%
Housing	35%
Employment	30%
Harm Reduction	26%
Psychosocial Rehab	24%
Psychotherapy	23%
Traditional Healing and/or Cultural Support	22%
Temporary Shelter	20%
Residential Treatment	15%
Withdrawal Management	11%
Day Treatment	9%
Detoxification	7%
Other Services	20%

Table 2. From Tiesmaki & McEwan, 2016

Therefore, a community-based MHSU that supports the work of PWLLE via authentic partnership and inclusion can help address broader social determinants of mental health and promote the ultimate goal of mental wellbeing.

Part 2: Change the System

This part of the report discusses findings from the research question: What does a recovery-oriented and community-led substance use system of care need to include? In considering current policy responses to substance use and mental health care, radical transformation of the MHSU will require a community-driven public health approach that is multi-pronged and multi-scalar. **In understanding where and how can interventions be made to improve the problem**, one key theme that emerged from the system allies focus group was how the overemphasis on the biomedical perspective in addressing mental health and SUD in combination with a lack of intersectoral or inter-ministerial collaboration has resulted in a crisis-oriented system of care. As one system ally stated,

> *"The system is currently oriented towards partitioning out the role that health care is playing. And so, what that means is that it's not a particularly attractive place for folks to go. So, by the time service providers are seeing people, it is oriented towards putting out fires and that more could be done – just blanket health promotion kinds of functions that should be available and accessible to everyone aren't happening. The housing pieces, the child welfare pieces, like they're all so disconnected that all those things … we're not going to treat our way out of the situation that we're in right now in terms of health and equity for folks who use drugs and people who have mental health problems.* ***It's not something that the health care sector is going to be able to solve by itself****. And so, there are there is going to be a need for, you know, affordable day care, affordable housing, food security, all of those kinds of pieces to come together as well. And I know that falls outside of the scope of a lot of the work that that you're doing. And it's a challenging, complex thing to for us to be raising for you today. But I really do think it's important. That we have this conversation because it's that bigger public health approach that needs to happen for us to kind of move the needle here".*

A new approach that addresses micro, meso and macro level factors in the MHSU system is required. The factors can be conceptualized as both stratified levels and structures within the system. These three levels are used to help identify ways to scale up interventions for improved service delivery, empower communities and create a new dynamic system that is flexible enough for adaptive learning. Critical strategies for transformative change include:

- addressing issues of legislation and sustainable funding and evaluation models at the macro level;
- addressing issues with information sharing, housing, expanding and co-locating treatment services, building capacity of community workers and providers, paying special attention to specific populations at the meso level;

- addressing opportunities for family and peer support, skill building, fostering leadership, education and employment, addressing shame, stigma, and trauma and valuing personal choice at the micro level.

Each of these strategies are meant to address the social determinant needs of those with SUD and as well, highlight windows of opportunity to promote wellness and **reduce inequities** via integration between the community and formal sectors.

At the Macro Level: Community Engagement Models and Collaborative Mental Health Care

KEY FINDINGS AT THE MACRO LEVEL

- The health care sector is not going to be able to solve the mental health/SUD crisis by itself. It requires intersectoral collaboration
- **At the macro level:**
    - Many community-based organizations are chronically under-resourced. This translates to essential, preventative services not being publicly funded, which pushes people into crisis before they can get help.
    - Ideally, system outcome and evaluations measures should reflect mental wellness of both the individual and community using quality-of-life measures
    - The Mental Health Act requires considerable revision, particularly with regards to certification and involuntary status and treatment practices
    - Current policy windows exploring drug decriminalization and safe supply should be further explored as it greatly reduces social, structural or physical harm

At the macro level, there are many challenges that impede the development of a comprehensive model of continuum of care. Such challenges include: “funding, stigma, availability of addiction treatment, policies and legislation and staffing” (Leece et. al, 2019, p. 6). Two ways to implement an integrated and equity-oriented service model into government-led health service organizations and community-managed organizations include 1) legislative and policy change of the Mental Health Act and drug decriminalization and; 2) sustainable funding and evaluation measures.

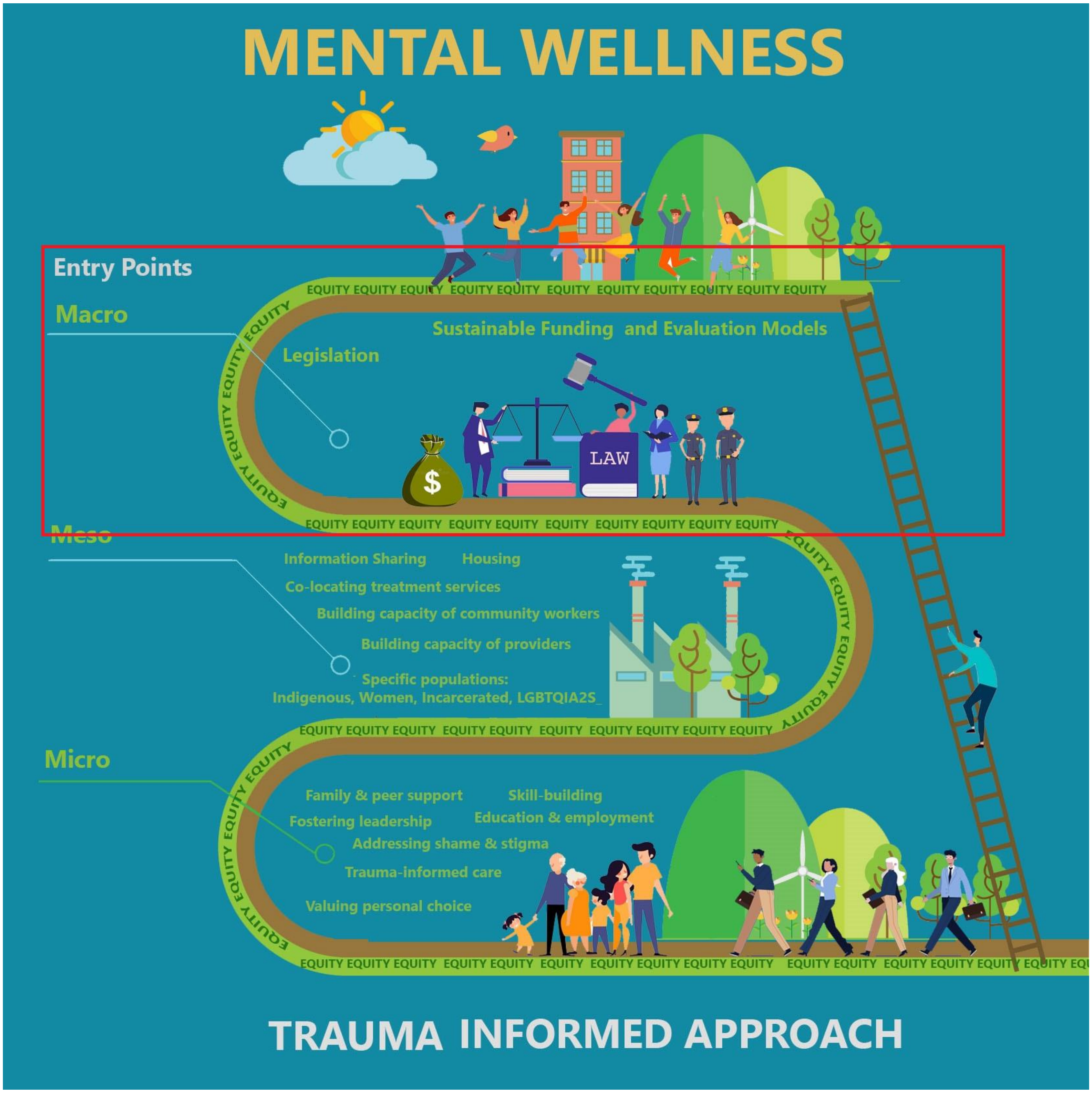


Figure 5. A Community Driven Approach to MHSU care

Sustainable Funding and Evaluation Measures

Community based organizations play a large role in the recovery process of SUD or mental illness such as “(a) offering a physical space (e.g. recovery community center) for recovery related activities and service delivery; (b) engaging in and organizing advocacy efforts at the local, state, and federal level meant to improve policy and increase availability of recovery resources and services; (c) offering recovery support services, often as peer recovery support services, meant to enhance the recovery process; and (d) educate the local community on SUDs and the recovery process” (Ashford et. al, 2020, p. 5). Ashford et. al (2019) state, “while the prevalence of the services and resources included within the community level should meet or exceed the population of individuals in the recovery process in any given community, at baseline the presence of at least one of each resource or service is beneficial to creating a health environment supportive of recovery” (p. 7). However, this reality is largely determined by the distributive policies which determine how economic resources are divvied up between the community and formal sectors (Sheedy & Whitter, 2013).

Unfortunately, **many community-based organizations are chronically under-resourced** (Shera & Ramon, 2013). **This translates to essential, preventative services not being publicly funded, which pushes people into crisis before they can get help**. Several system allies in our focus group mentioned funding as a major barrier to the current system of care. For example, one ally talked about how service planning models structurally produce power imbalances between the formal sector and community sector, whereby decision-making power is often not within the control of the community sector:

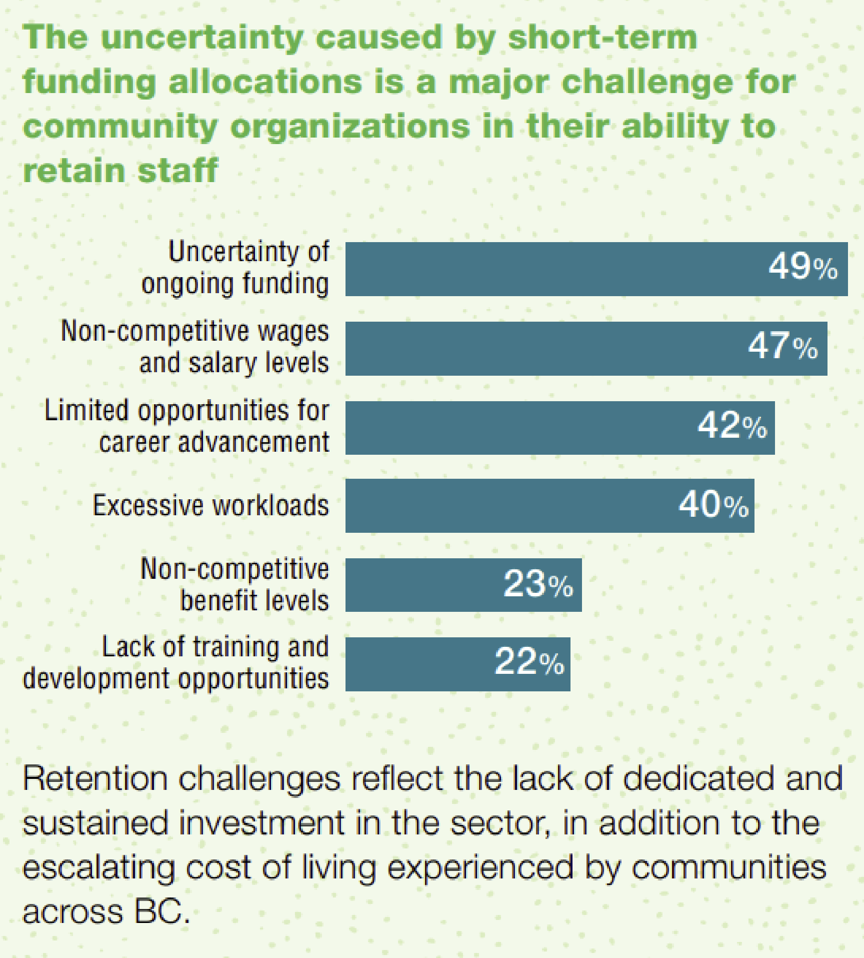
> *“One of the barriers that I see from my work and I've seen for many years is just the way our health system is structured. And the Ministry of Mental Health and Addictions, for example, can set policy that but they don't have the funding that goes to health services – that's the Ministry of Health. And then the Ministry of Health gives the funding to the health authorities.* ***And the health authorities have a lot of power to determine how those services are delivered and they are not necessarily reflective of community****. […] I know there’s great people that work in health authorities. And I'm talking much more about sort of just the structures of that and how as a community-based agency trying to work within that structure, it's super challenging to just to get services funded and then also to be able to have real meaningful input into how the health authorities roll out services”.*

Additionally, another system ally pointed out how chronic underfunding of the community sector is tied to how the current MHSU system conceptualizes the idea of health as something limited to physical well-being, which thus, undermines the importance of the community sector.

> *“I think that the funding structure and the kind of the breakdown of funds that goes to help kind of more broadly into mental health specifically is problematic because it doesn't really acknowledge the links between health and mental health. So, I was thinking a lot about how historically community based mental health programs are underfunded. And I know you mentioned that as well, that*

> *underfunding is key. So, it seems to me that some of it is about resource allocation".*

It is not uncommon for many community-based organizations to have uncertainties about future funding and unrealistic and/or high case load. For example, from the 2018 BC Community Mental Health and Substance Use Sector Survey, 49% of non-government organizations that provide mental health and substance use services in BC expressed uncertainty of ongoing funding while seeing a 14% decrease in earned income from 2016 to 2018 (Community Action Initiative, 2018). Additionally, research studies completed in the Downtown East Side of Vancouver – a neighborhood that has become the "face" of the overdose crisis in BC – suggest that "funding programs that bolster the current practices and preferences developed by [women who use drugs] (e.g. one-on-one peer witnessing programs in SRA rooms) is also critical to minimize overdose" (Collins et. al, 2020, p. 8).



The uncertainty caused by short-term funding allocations is a major challenge for community organizations in their ability to retain staff

Retention challenges reflect the lack of dedicated and sustained investment in the sector, in addition to the escalating cost of living experienced by communities across BC.

Figure 6. From Community Action Initiative, 2018

In times of fiscal austerity, policy decisions are often “influenced by the question of who pays” (Shera & Ramon, 2013, p. 20) as well as the rhetoric of “cost-effective evidence-based decisions”. As one system ally stated,

> *“I was shocked when I started working in the sector at how fragmented it is and how much the lack of resourcing has created, sort of a feeling of competition and territory amongst a bunch of community organizations that are all scrambling for funding. And in a way that not only are those organizations not able to advocate sort of in a way that brings all their voices together because they don't have the capacity to organize that and also might have engaged in relationships. It also means when organizations are advocating it feels like you're advocating for the survival of the organization and not for the broader sector or what folks need.”*

Ideally, wellness-oriented systems of care need to be adequately financed to enable access to a comprehensive continuum of services. Sheedy and Whitter (2013) suggested the use of pooled funding mechanisms to address issues with fragmented funding among systems actors. They state “pooled funding also may improve service coordination within and between different organizations and networks and may work to expand access to and provision of services” (Sheedy & Whitter, 2013, p. 252). However, there are two important points to consider. The first is that, it is not uncommon for community-based organizations to be skeptical of MHSU reform whereby “rather than working towards an integrated system delivering high-quality services at a reasonable cost, simply reducing the number of service providers [becomes the] prime objective” (Silburn & Lewis, 2020, p. 335). This is because reducing the number of service providers reduces the types of solutions and services available to people with a SUD/mental illness. This is inherently problematic in a complex system, where a variety of voices and perspectives are needed to solve a complement of issues and challenges. Therefore, **it is important that funding models are generated in a collaborative approach, where numerous stakeholders from various sectors can contribute their expertise** (Silburn & Lewis, 2020). Secondly, the MHSU framework should radically shift “the objectives of services away from the clinical model, which emphasizes treating patients, to the recovery model, which focuses on supporting individuals in realizing the goals that matter to them, regardless of whether or not symptoms are fully eliminated. [However], for many service delivery systems, even the conceptual shift away from the clinical model is a challenge because the traditional power dynamics between clinicians and service users are deeply ingrained (Piat & Polvere, 2014). As one system ally echoed in the focus group,

> *“For me, it really feels like the places to figure out how to fund community led organizations to do some of this work might not be necessarily health organizations or health specific organizations, because when you get into community service agencies or neighborhood houses, those organizations are already really skilled at seeing people as whole people. And if we can integrate and meet folks where they're feeling safe in that space, I think it's a different conversation”.*

Outcome Measures and Evaluation

Building on the previous point about “evidence-based policy decisions”, it is also important to recognize that outcome measures in support of wellness-oriented systems of care need to be developed in collaboration with PWLLE. **Ideally, system outcome measures should reflect mental wellness of both the individual and community using quality-of-life measures** (Sheedy & Whitter, 2013). However, “traditional evidence-based approaches do not take into account the practice knowledge of practitioners or the lived-experience knowledge of users” (Shera & Ramon, 2013, p. 24). As a result, evaluation related to the social determinants of mental health is limited. Additionally, many community-based organization may not necessarily have the capacity to evaluate their work given chronic underfunding and time constraints. As one system ally stated in the focus group,

> *“As systems researcher, I can demonstrate physician-based services that can I access data very easily to help them demonstrate the value of the work they do. And it's a real struggle to try to do that in community. […] It just seems like from my perspective over the past couple of decades, seeing this happen and seeing all these really good community organizations getting defunded…**it's almost like we've created this situation where they're not able to demonstrate the work that they do in the same way, which puts them at a disadvantage when the government is really focused on issues of accountability and public spending.** And I get it, there's a finite number of resources, but it just seems like there's a real inequity there that sets up the community sector to really not be competitive for funding in the way that the government is currently allocating it”.*

One solution may be to turn accountability requirements on their head and reduce inequities is by building in PWLLE determined evaluation mechanisms into planning and service delivery initiatives, so that those most impacted by the service have the ability to comment on the quality and relevance of services made available, ensuring a feedback loop which encourages continuous learning and quality improvement of the system. This is because PWLLE “play an important role by participating on evaluation teams to document the effectiveness of programs, including the programs they run as services or small businesses" (Shera & Ramon, 2013, p. 24).

Policy and Legislation

Policies and legislative factors often "impact the availability and capacity of resources and services within the institutional and community level" (Ashford et. al, 2020, p. 6). Two specific policy determinants that affect the implementation of a wellness-oriented MHSU in BC is related to the Mental Health Act and the decriminalization of drugs/safer supply. It is important to note that a lot of work is currently being done by advocacy groups or the government in these areas already, and so this section of the report is meant to be a brief overview of current issues.

The Mental Health Act

British Columbia's Mental Health Act (MHA) is a one of the main pieces of legislation that mandates involuntary care of people experiencing mental illness and/or a SUD who decline voluntarily treatment (Health Justice, n.d). Health Justice (n.d) has noted that:

> "BC now has substantially more involuntary than voluntary mental health admissions, meaning that our mental health system predominantly interacts with people in a coercive way. As a result of over-reliance on coercive care, people in BC often find they cannot access voluntary mental health and substance use services when they need them. Instead, their health may worsen until they are involuntarily admitted under the Mental Health Act, which is often a negative or traumatizing experience that may prevent them from getting therapeutic benefits from the services or alienate them from accessing services in the future" (para. 2).

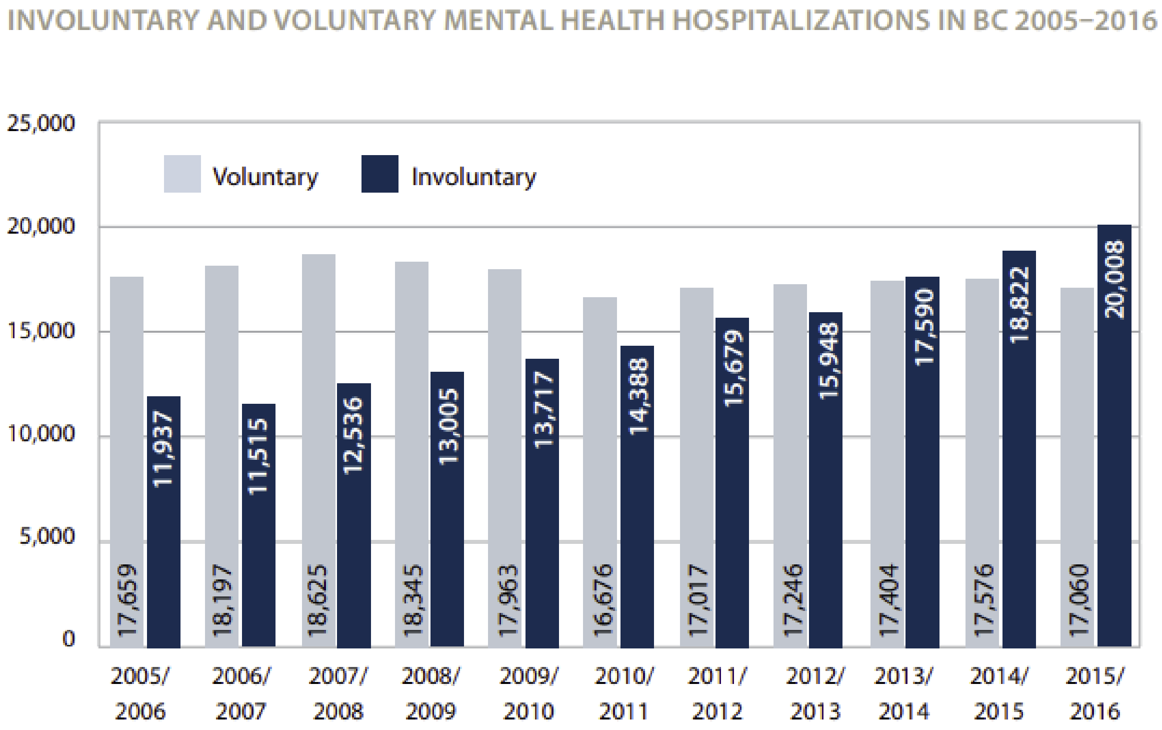


Figure 7. From Johnston, 2017, p. 24

BC's Mental Health Act has been criticized as failing to safeguard human rights (Health Justice, n.d) and for being "constructed within socio-historic discourses of biomedicalism, psychiatry, ableism, colonization, marginalization, and neoliberal orientations of governments" (Kolar, 2018, p. iii). This is especially true when considering the fact that the MHA disproportionately impacts individuals experiencing various forms of structural violence (Kolar, 2018). More specifically, the MHA has been criticized for creating more harm and trauma to individuals and relying "on harmful narratives and discourses based on deficit, vulnerability, dangerousness, and incapacity" (Kolar, 2018, p. iv).

For example, consultation with patients and their families within the MHA are either absent nor mandated for things such as the "consent processes, treatment planning, extended leave, and rights notification" (Kolar, 2018, p. 70). Many patients are completely unaware of their rights within the Charter of Rights and Freedoms, and in relation to the Mental Health Act. Statistics from 20 years ago showed that only 53% of patients knew their rights, 31% reported being notified of their rights by nurses or physicians upon admission, and the remaining 16% reported learning about their rights through sources such as advocates or lawyers (Kolar, 2018). It is no wonder, then, that BC's Mental Health Act was criticized in 2019 by the United Nations Special Rapporteur on the Rights of Persons with Disabilities as having "very broad criteria for involuntary admissions" (United Nation Human Rights Office of the High Commissioner, 2019, para. 40) and that there is a desperate need to transform “mental health systems to ensure a rights-based approach and well-funded community-based responses, ensuring that all health care interventions are provided on the basis of free and informed consent.” (United Nation Human Rights Office of the High Commissioner, 2019, para. 43). In taking an equity based and social determinants of health approach, it is important that the power granted to health care providers under the MHA and the lack of consent and patient engagement be challenged. **Therefore, one step in promoting population level mental wellness requires that the MHA be revised, particularly with regards to certification and involuntary status and treatment practices (Kolar, 2018)**. Additionally, some system allies from our focus group have advocated for the need for an independent mental health and substance use system advocate. As one system ally stated,

> *“What I would like to see is an advocacy system that can advocate at a high level for legislative changes and for policy changes, as well as individual level advocacy to help people who are in a very who are* ***disadvantaged by a power imbalance when they enter the mental health system****[..].The Mental Health Act is not only outdated, it's just it's just full of holes. And it's very, very problematic in so many different ways that it just needs a complete overhaul. The more I work with it, the more I notice how many gaps there are for certain populations and it doesn't accord with trauma-informed care or gender-informed care whatsoever.”*

Decriminalization and Safe Supply

One policy window that is currently being explored by the BC government is the decriminalization of drugs and access to safe supply. Decriminalizing drugs and gaining access to safe supply addresses SUD as a health issue rather than a criminal justice one. Simply put, the main tenant behind **drug decriminalization and safe supply is that it will reduce harm (whether it be social, structural or physical in nature)**. In July 2021, the MMHA and the Ministry of Health created a new policy titled, *Access to Prescribed Safer Supply in British Columbia: Policy Direction*. This policy supports the “provision of pharmaceutical grade alternatives to illicit drugs to people who are at risk of drug toxicity events and death” (Ministry of Mental Health and Addictions, 2021, p. 3). Additionally, in 2021, the BC government started to work on decriminalizing personal possession of illicit drugs. The author maintains the position that both of these steps are within the right direction, given that both decriminalization and safe supply not only reduce drug-related harms such as overdose, injury and death, but also, enhances people’s lives in a number of other ways. Some of the benefits include: **improved connections to health and social supports, decreased social and structural stigma, decreased encounters with and use of the police and eliminated criminal records which promotes opportunity for housing and employment (Greer, 2021)**. However, more work needs to be done to make decriminalization and safe supply a reality. As one system ally from the focus group stated, *“There is not a world in which we can destigmatize drug use without decriminalization. And decriminalization in and of itself is not far enough. But to criminalize behavior, no matter how many awareness raising campaigns you do, is never destigmatized. There is an inherent risk for folks to step forward. There are lasting ramifications from criminal records that truly undermine folks’ opportunities for the entirety of their lives. And for me, that is a macro level factor that ripples down and is just absolutely unavoidable in terms of addressing and moving forward. And just to say that decriminalization is great, I know that there are some moves in B.C., particularly thinking of Vancouver to move towards that. But decriminalization, there are very different models that can be pursued and a meaningful type of decriminalization in which, for example, possession limits arguably should not exist. If they do exist, they need to be meaningful amounts below which folks are actually using. There are so many ways in which decriminalization you can look towards other countries where it's on the books, but in practice it doesn't actually exist. So, when I say decriminalization, I mean a meaningful situation in which folks who use drugs are not criminalized and which therefore the stigma and also the access barriers to health services are meaningfully reduced”.*

At the Meso Level: Community-Change Leadership and Health Promotion

KEY FINDINGS AT THE MESO LEVEL

- Housing vulnerability greatly impacts people with SUD and introduces preventable harms to individuals such as increased risk of HIV and hepatitis transmission, and early mortality. BC continues to have substantial room for cross-collaboration between the community sector and formal sector in addressing the intersections of addiction, mental illness, poverty and homelessness/housing precarity.
- Co-locating and expanding community based mental health services can mitigate the inequities inherent in navigated a fragmented system of care, where intersecting issues such as stigma, lack of information, and lack of access to specialist care could all be simultaneously addressed
- Despite the need for more community-based treatment, it is important to have assertive linkages, such as recovery coaches that connect the community and formal sectors.
- Just as the community sector experiences funding deficits, and the impact of time-limited or project-based funding in comparison to the formal health care sector, the community sector also often lacks critical information and data held by the formal sector. Enhanced communication mechanisms will enable better support for individuals who are seeking help outside of an acute based system.
- There is a lack of understanding of the role community workers play in the recovery journey.
- Peers are well-versed in created culturally safe spaces for others. As people who have been through similar experiences, peers face numerous forms of oppression that someone in a position of power could never understand. Peers must be recognized for expertise they bring to the table and how they address various social determinants of health.
- While most care providers generally support the principles of recovery, many feel ill-equipped to implement it in day-to-day practice
- The community sector is adequately positioned to serve structurally marginalized populations (such as women and Indigenous people) who have been excluded from the formal care system

At the meso level, an asset-based approach to community building can be helpful in not only promoting mental wellness, but also integrating the formal and community sectors, by focusing on the strengths and assets of individuals (Collinson & Best, 2019). The goal of such an approach is to empower communities by enabling them to drive their own agendas (Collinson & Best, 2019). However, this would require collaboration across numerous sectors beyond the health care system to promote mental wellness in addition to adequate funding to gain access to adequate resources. More specifically, this can be achieved via: 1) mechanisms of information sharing and communication, 2) addressing housing, 3) addressing the capacity of community workers, 4) addressing the capacity of health care providers and 4) expanding and co-locating treatment services using assertive linkages – particularly amongst specific populations such as Indigenous people, women, those who identify as LGBTQIA2S+ and those who were involved in the penal system. An assertive linkage is defined as a mechanism to “connect people to community assets most appropriate to their interests, with a focus on the needs and subsequent engagement of marginalized groups” (Collinson & Best, 2019, p. 4). All of these approaches will be explored in the section below.

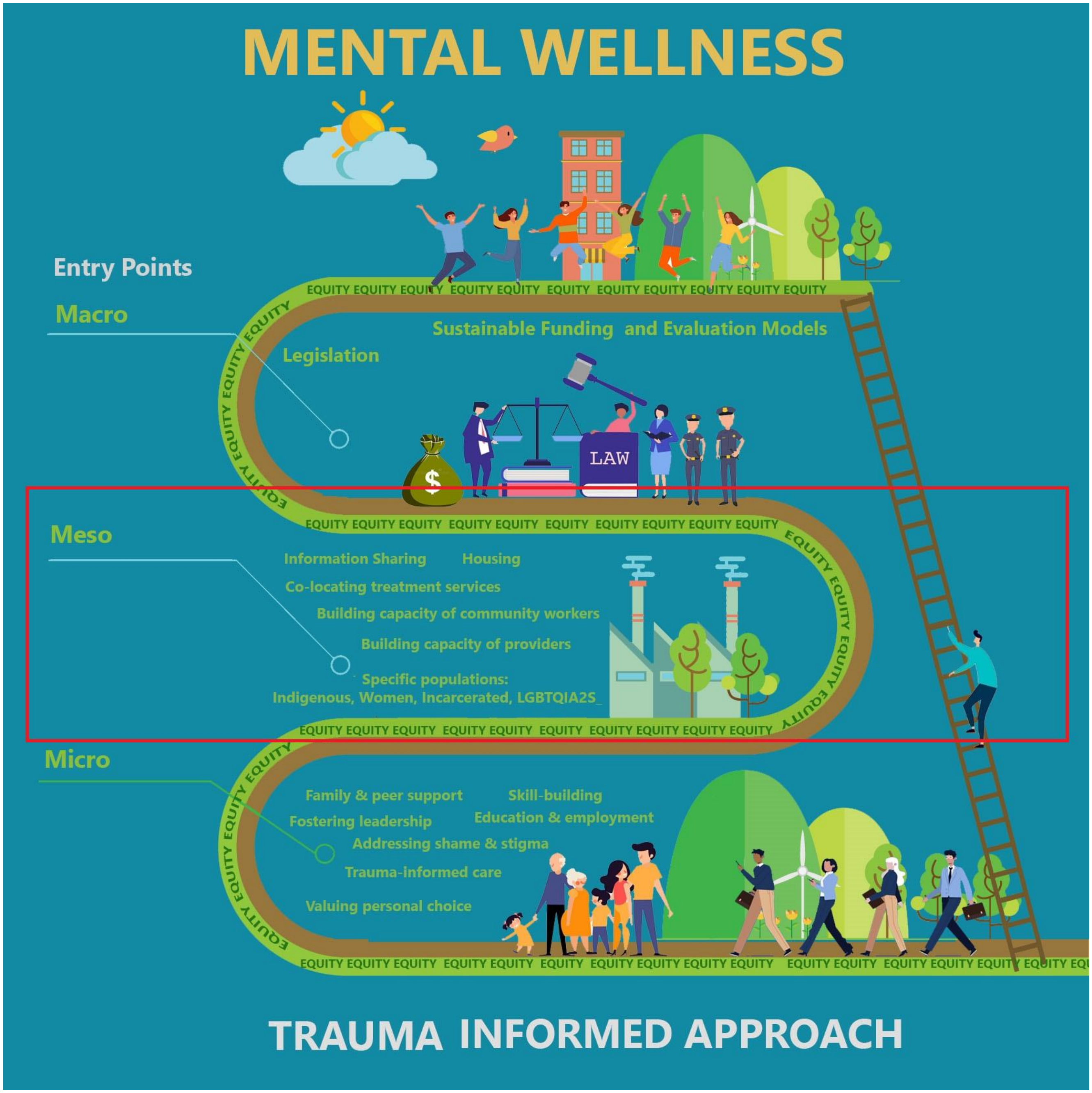


Figure 8. A Community Driven Approach to MHSU care

Housing

Housing vulnerability greatly impacts people with SUD and introduces preventable harms to individuals such as increased risk of HIV and hepatitis transmission, and early mortality (Fleming et. al, 2019). Findings from a study in 2011 noted that 41% of homeless individuals “considered alcohol and drug use as a contributing factor in their lack of housing” (Butler, Polovina & Goldner, 2017, p. 14). Additionally, studies from another study in 2016 “reported that among the homeless in Vancouver, 53% reported addictions and substance use problems, 42% indicated that they had a medical condition and 40% reported mental health challenges" (Butler, Polovina & Goldner, 2017, p. 14). Unfortunately, the cost of managing people experiencing homelessness in BC is high, costing public taxpayers over $50,000 per person experiencing homelessness yearly (Simon Fraser University, 2021).

Just like there is a continuum of care within the MHSU, there is a continuum of housing beginning "emergency shelter and housing for the homeless, transitional supportive and assisted living, independent social housing, rent assistance in the private market, support for first time homebuyers and consumer protections for buyers of new homes" (BC Housing, 2017, p. 6). **Despite evidence that housing is a cost-effective public health approach to tackling both mental illness/SUD and homelessness, there are a number of gaps within the realm of recovery housing in BC**. For example, "there are no empirically-sound standards in BC related to the assessment and placement of people who require supported housing […] There are no routinely collected indicators of when a person is homeless in BC. And there are no credible ongoing evaluations of outcomes from current spending" (Simon Fraser University, 2021, p. 8). Additionally, within the context of BC, research has demonstrated that people with a SUD are more likely to face eviction in low-income neighborhoods and that landlords are "motivated to fill housing units with tenants who are perceived as non-drug using" (Fleming et. al, 2019, p. 169). The most notable example of this is the neighborhood of the Downtown Eastside where single room occupancy (SRO) housing remains the main form of low-income housing. SROs are also known to have substandard conditions such as pest infestations and non-functioning washrooms (Fleming et. al, 2019). British Columbians with mental illness and/or a SUD face various socio-structural mechanisms that create housing vulnerability, such as prejudice, and an "**inability to assert power** in the face of abusive landlords and unsafe conditions" (Fleming et. al, 2019, p. 172). Also, "research shows that homeless people with concurrent disorders, in particular, who receive no additional supports have difficulty maintaining housing, which often results in cycling through shelters, the streets and emergency services" (Butler, Polovina & Goldner, 2017, p. 14).

There are many compelling examples of how safe, affordable housing can be an effective tool in tackling mental illness and SUD. Such housing provides a foundation enabling "subjective improvements in positive identity, experienced as a gradual process of shifting toward new social roles, networks, and routines" (Simon Fraser University, 2021, p. 16; Patterson et al., 2013, p. 5). Additionally, 70-90% of PWLLE want to work (Simon Fraser University, 2021). In general terms, people don't seek assistance for housing because they want to. People seek assistance for housing because they need it as it is a basic human need. Therefore, community can provide opportunities for PWLLE to build skills and secure employment without worrying about where to live.

A compelling example of the importance of housing is the Oxford House network in the United States, which houses more than 24,000 individuals recovering from a SUD and offers "mutual help-oriented, financially self-sustaining, self-governed, democratic communal-living environments where individuals in recovery can reside for as long as they choose after inpatient treatment or incarceration, during outpatient treatment or as an alternative to treatment" (Laudet, & Humphreys, 2013, p. 129). Some of the research on Oxford Houses is that it is "associated with greater rates of abstinence from substance use and with improvements in related functioning (e.g., higher employment rates)" (Laudet, & Humphreys, 2013, p. 129) and is cost-effective. Another example includes randomized controlled trials by Simon Fraser University that compared various housing options in BC. Results from the study demonstrated that "recovery-oriented housing caused a 71% reduction in crime, a 50% reduction in medical emergencies, and fundamentally improved client's quality of life and community wellbeing" (p. 10).

Expanding and refining current approaches of vulnerability assessments and coordinated access into the housing system in communities requires collaboration between the formal and community sector (BC Housing Coalition, 2017). An example of what this could look like includes the Sea to Sky Community Action Team (CAT) with CAI. The Sea to Sky Community Action Team serves Whistler, Squamish and Pemberton. Between 2017-2021, an innovative modular housing project was created called The Bridge. Like the rest of BC, Squamish has become a very difficult place to rent with vacancy rates at 1% or below (Community Action Initiative, n.d; Under One Roof, 2021). The Bridge was assembled out of approximately 50 "trailers into a single structure with one long hallway running down the middle, and single-occupancy rooms on either side" (Community Action Initiative, n.d, para. 5). The Bridge not only provided improved supports for social services but also had a peer-witnessing program, whereby peers have responded to overdoses (Community Action Initiative, n.d; Under One Roof, 2021). What makes Squamish unique is how the CAT simultaneously supported the process of improving social service connection and overdose prevention.

Therefore, though some improvements have been made, **BC continues to have substantial room for cross-collaboration between the community sector and formal sector in addressing the intersections of addiction, mental illness, poverty and homelessness/housing precarity.**

Expansion and Co-location of Treatment Services in the Community

The cost, length and stigma of SUD treatment are known barriers to help-seeking behaviors among individuals in need (Ashford et. al, 2020). Delivering services in natural, non-stigmatizing and low-barrier settings such as neighborhood centers, one's own home or community health clinics is an important aspect of wrap-around, community-based service delivery models of MHSU care (Ashford et. al, 2020). Additionally, other benefits to community-based care models in which medical services and SUD treatment services are integrated within the community include improved SUD outcomes and ameliorated medical conditions (Laudet & Humphreys, 2013). Yet, such community-focused integration is not yet a reality, as the system is fragmented and wait-times for services such as methadone maintenance treatment, drug checking services, home based withdrawal management, outpatient counseling, day treatment and specialist treatment remain quite high. For example, in a 2011 study published in the Canadian Journal of Psychiatry showed that only six psychiatrists out of 230 were willing to see a new patient on short notice and scheduled an appointment (Golder, Jones & Fang, 2011). Additionally, **there is a current need to move from episodic care to approaches that recognize the chronicity of substance use disorders** (Butler, Polovina & Goldner, 2017). Adding more acute/residential treatment beds is one thing, but actually addressing the issues that cause the *need* for more treatment beds is another. Two ways to address SUD and mental health disorders in a concurrent manner is to co-locate and expand community-based treatment and to have recovery coaches.

Co-location of treatment refers to treatment and wrap-around services that are located in the same physical space and are fully integrated with one another. This provides an avenue where people who have a SUD can get access to different care providers – whether they be counsellors, psychiatrists, or a general practitioner – in a “one stop shop” manner. The advantage of this is that it can prevent and treat SUD and mental health conditions as well as medical conditions such as diabetes and asthma. The other advantage is that it also improves communication and collaboration. As a result, this moves from a “one problem at a time” approach to SUD treatment, which is often too complex to be treated in this manner.

Additionally, it is important to recognize that many community-based organizations already do high service intensity work in the community that would not necessarily require more acute-based treatment. Currently, the BC Ministry of Health uses a five tier Mental Health and Substance Use Framework to inform service planning for substance use care. This model outlines “different functions that correspond to the continuum of problem severity in the population served and increasing levels of specialization in the functions provided. Individuals may access services and supports within different tiers based on need simultaneously or at different points in their recovery” (Butler, Polovina & Goldner, 2017, p. 10).

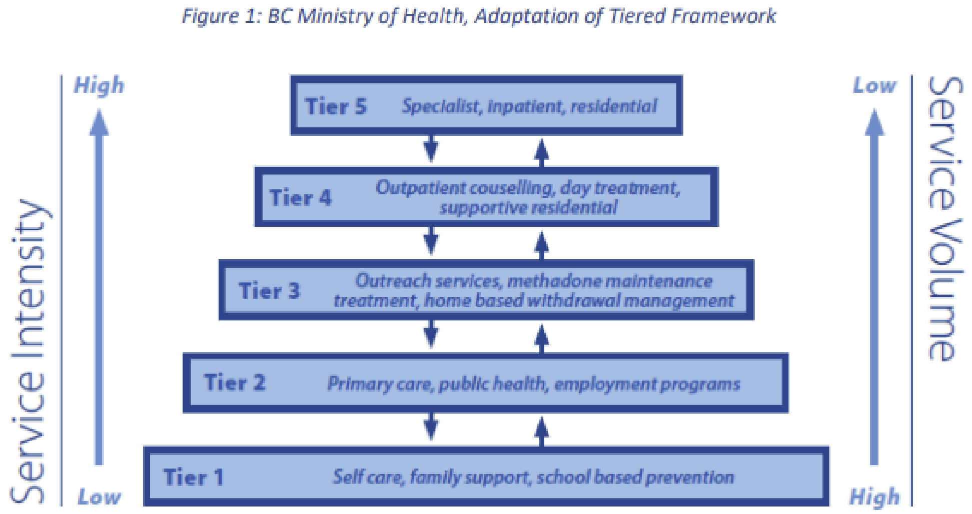


Figure 9. From Butler, Polovina & Goldner

Results from the 2016 BC Community Mental Health & Substance Use Sector Survey show that many organizations within the community sector provide services across all five tiers, “with a majority reporting provision of Tier 3 services for clients with identified mental health and substance use challenges (42%) Services within this tier focus on providing timely and appropriate community-based care to clients, and reduce the need for more intensive services, including emergency or hospital services” (Tiesmaki & McEwan, 2016, p. 22).

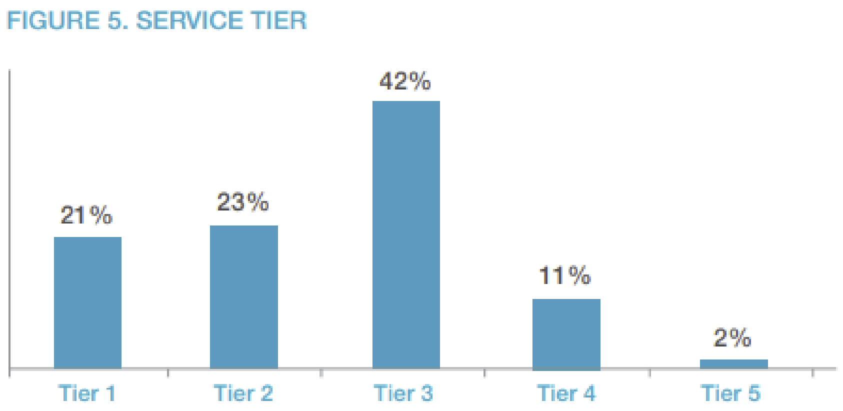


Figure 10. From Tiesmaki & McEwan

These results from the survey demonstrate that some community sector organizations are adequately “positioned to deliver low-to-medium intensity mental health and substance use services. In addition to providing community-based prevention and early intervention services, a large share of community NGOs perform assessment and general treatment functions that may be able to complement or supplement services delivered by the formal system” (Tiesmaki & McEwan, 2016, p. 14). Also, as Butler et. al (2017) state, “it is difficult to determine system needs by looking at residential services alone (tiers 4 and 5) because the optimal number of residential service beds is contingent upon there being adequate services and supports at lower tiers of the tiered framework to support affected individuals at all levels of severity. Earlier and lower-intensity interventions may help prevent or delay the progression to more severe and complex conditions that require more intensive treatments in residential settings" (p. 39).

Additionally, one theme that emerged from the peer focus groups was that **having low-barrier, community-based services could mitigate the inequities inherent in navigated a fragmented system of care, where intersecting issues such as stigma, lack of information, and lack of access to specialist care could all be simultaneously addressed**. For example, as one peer stated,

> *"I have a very good primary care clinic that's in my neighborhood. I live in the Downtown Eastside and I was very lucky to get in with the primary care clinic that was just sort of new in the neighborhood, because before that it was impossible. And I had doctors that were all scattered all over the place and they weren't they weren't cohesive. Right. So, whenever there's any sort of gaps like that, that's where people get lost. So, I mean, sort of like a wraparound kind of service. I can get my blood work done there. There's a psychiatrist there that I see. There's a psychologist I can talk to if I want to. There was a really great social worker there. She left. But, you know, I haven't met many like very, very good social workers. And I just, you know, and when you meet one, it's like you just changed my life in terms of the support. So, yeah, like somebody would do the paperwork, because I find that a lot of services, service providers like housing, for example, is very difficult. And it's almost like nobody wants to work on it with you, you know? And so, I found a social worker that actually was game to take it on. And that's really rare. And it's such a difficult system. It requires a lot of organizational skills I found in order to find my own housing, which I did eventually. But it was a lot of work and she made it easier."*

Despite the need for more community-based treatment, one note of caution is that it is important to have assertive linkages, such as recovery coaches that connect the community and formal sectors. Embedded within the primary care system, recovery coaches are "PWLLE who are in recovery from SUD who are employed to assist and provide guidance to patients in various stages of recovery" (Jack et. al, 2018, p. 307) and play "a variety of roles, including supporting people in recovery within community organizations; serving as one-on-one or small group supporters for private addiction patients; and delivering brief interventions in emergency departments” (Jack et. al, 2018, p. 307). Recovery coaches are often involved in care after a primary care physician make a clinical diagnosis of SUD and have “on-site clinical supervision from a social worker or physician and weekly supervision sessions with a physician and psychologist to discuss coach well-being and shared clinical or systems challenges, such as difficulty accessing resources for a patient” (Jack et. al, 2018, p. 308). Recovery coaches help address the social determinants of health as they help individuals with system navigation, supporting behavior change, harm reduction initiatives and relationship building (Jack et. al, 2018). They are particularly useful in helping individuals co-produce wellness plans and following clients when they are discharged from the hospital and into the community. Some promising data shows that recovery coaches who have been used to help individuals transition from the formal sector to the community sector has resulted in reduced admissions on hospital works, reduced hospital length of stay and reduced numbers of substance use related harm presentations at emergency rooms (Best et. al, 2021).

A proposed example of how recovery coaches could potentially be useful is with helping correctional populations transition from the formal sector to the community sector. In 2019, “two-thirds B.C. residents who died of an illegal drug overdose over a 19-month period had recent contact with the criminal justice system” (Canadian Broadcasting Corporation, 2019, para. 1) and “between January 2016 and the end of July 2017, 333 people died within their first month of release from a correctional facility” (Canadian Broadcasting Corporation, 2019, para. 2). “Recidivism is reduced through reentry support services, and when these are delivered in collaboration with recovery support services, the reduction in criminal activity and recurrence of substance misuse often has a net-benefit on society and the individual in the recovery process” (Ashford et. al, 2020, p. 5).

Therefore, co-locating substance use disorder treatment in combination with recovery coaches where there is a focus on things like completion of aftercare services can help improve recovery outcomes (Sheedy & Whitter, 2013).

Mechanisms of information sharing and communication

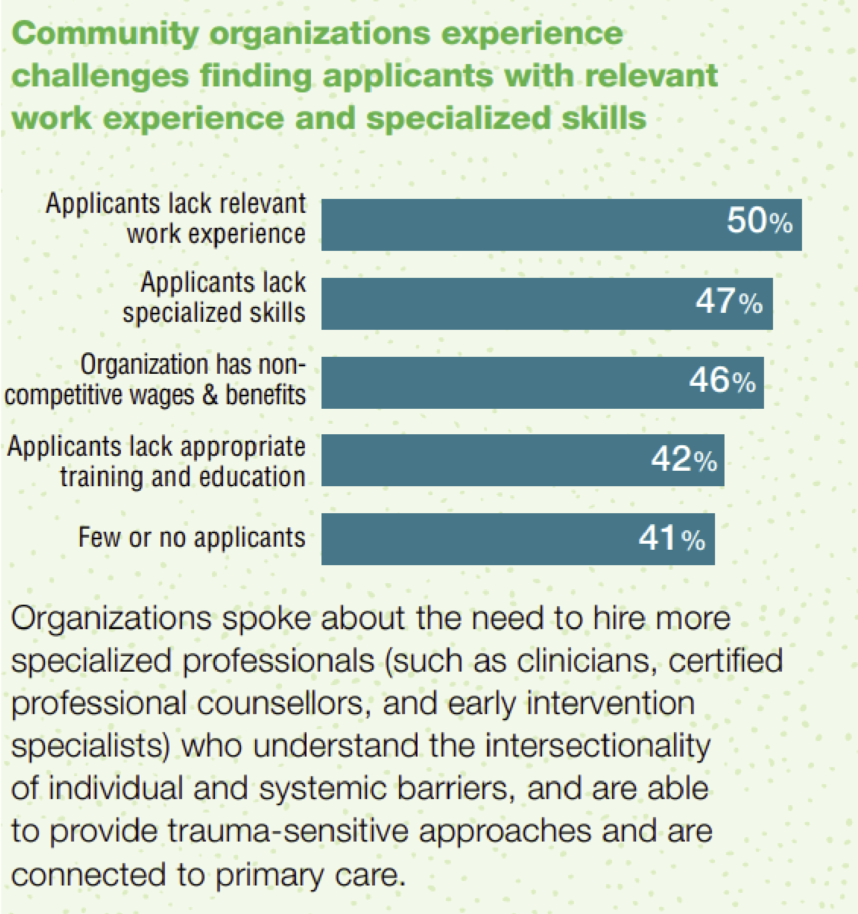
A frequently cited issue of tension between the community and formal sector is the lack of information shared between the two sectors. This is especially true during transitional phases of the recovery process. For example, when clients are discharged from hospitals they are often “handed over with little or no sharing of information – apart from the instruction to contact the clinician only if there [is] a problem” (Hungerford et. al, 2016, p. 354). **Just as the community sector experiences funding deficits, and the impact of time-limited or project-based funding in comparison to the formal health care sector, the community sector also often lacks critical information and data held by the formal sector.** Many community workers operate under short-term contractual work which means that many clinicians do not engage enough with them to understand their role in the process of maintaining mental wellness. As a result, community workers are often not seen as needing to be as involved with care or needing to know information. Consequently, many community workers often have to "constantly explain and justify their place in the continuum of care" (Hungerford et. al, 2016, p. 358). Though this system ally was not speaking to this issue directly, they mentioned a very interesting comment in the focus group which speaks to the broader issue of a lack of integration between the formal and community sector in general, which is that:

> *"The community connections with acute care are often broken very quickly, and there's just not a lot of part of it, I think, too, is a lack of understanding of how the community resources can really bolster the support and things that are happening in an acute care environment. And acute care is not by any means, has its challenges, but it's one of the components of the continuum of care. And if there were stronger relationships and a better understanding within the workforce, about services, how to manage various types of issues that are related to one another, where to refer people, how to kind of coordinate care that would better serve individuals rather than serve the system, because right now we very much serve the system and not the actual individuals who are accessing those services".*

Therefore, enhanced communication mechanisms will enable better support for individuals who are seeking help outside of an acute based system.

Building the capacity of community workers

Many community workers are wrongfully stereotyped by clinicians as nothing "more than a taxi-service, always available to drive consumers to appointments with medical practitioners or case workers" (Hungerford et. al, 2016, p. 358). Community workers such as peer workers, have an intimate understanding of their clients and are an invaluable part of the recovery process. Yet, in many cases they are not meaningfully connected to primary care, or treatment services. One possible explanation is an apparent lack of "tertiary qualifications held by the community workers – with this situation perceived as creating a hierarchical divide between community workers and clinicians" (Hungerford et. al, 2016, p. 352). For example, from the 2018 BC Community Mental Health and Substance Use Sector Survey, community organizations "experience challenges finding applicants with relevant work experience and specialized skills" (Community Action Initiative, 2018, p. 2) with 50% of applicants lacking relevant work experience.



Community organizations experience challenges finding applicants with relevant work experience and specialized skills

Organizations spoke about the need to hire more specialized professionals (such as clinicians, certified professional counsellors, and early intervention specialists) who understand the intersectionality of individual and systemic barriers, and are able to provide trauma-sensitive approaches and are connected to primary care.

Figure 11. From Community Action Initiative, 2018

In addition, there's a lack of understanding of the role community workers play in the recovery journey. An example of a community-led project in BC that supports PWLLE led interventions for peer workers in overdose response settings is the Peer 2 Peer Project. One study, titled *Running myself ragged: Stressors Faced by Peer Workers in Overdose Response Settings*, looked at the experiences of PWLLE in in creating safe spaces for people who use drugs (PWUD). One of the findings of the study showed that "several peers felt that they were not taken seriously or given due respect by their work colleagues and by other professionals they encounter in their work. This dynamic has many facets, including being identified via the potentially-stigmatizing term "peer", lack of basic work resources, lack of job clarity and relegation to menial labour, and disrespect from other professionals like police and paramedics" (Zahra Mamdani et. al, 2021, p. 1). However, it is important to recognize that the experience that peers bring to the table is a reminder to others as a symbol of hope and inspiration. In another study on Peer 2 Peer, titled '*It's an Emotional Roller Coaster… But Sometimes It's Fucking Awesome': Meaning and motivation of work for peers in overdose response environments in British Columbia*, a peer stated, "We're role models 'cause [PWUD] can look at us and say, 'I knew that person on the street when they were […] living in a tent and just sticking needles in their arm every day. And look at this person now. I mean, they still do dope but, you know what, they're doing okay'" (Bernie et. al, 2021, p. 1).

One consistent theme throughout the peer focus group discussion was the importance of leveraging the work of peers who are **well-versed in created culturally safe spaces for others. As people who have been through similar experiences, peers face numerous forms of oppression that someone in a position of power – such as a nurse or doctor – could never understand**.

For example, one peer talked about the discrepancy between how nurses and physicians are privileged by a system that renumerates them highly and formally recognizes their educational background, despite peers who might have a more intimate understanding of SUD and culturally sensitive approaches to treatment:

> *"Nowadays, all the doctors and nurses are trying to say that they're like inserting harm reduction into their services and that they are doing services in a harm reduction manner. But yet, I don't see the harm reduction community being in a leadership role as early adopters who do it fairly well. The whole like not offending people as they come in, just looking for basic things and asking questions about what is not obvious. So that discrepancy between, you know, harm reduction is on the rise, but that's just extra funds for doctors and nurses. That's not like actual actions. You know, that doesn't actually mean that the philosophies and well-developed body of knowledge of harm reduction, like… around vein care, around injection technique, like, you know,* ***I can explain it better than your average phlebotomists, probably because I have the cultural skills to use the right words with people****. So how do we resource the components of a community driven system? How about like empowering the people who are already doing it and trying to do that, saying…what do you need to bolster that front line first and foremost?"*

Other peers echoed similar feelings of oppression and being treated "not as professionals", despite having the adequate knowledge to help those with a SUD/mental illness:

> *"We need to bring someone with lived experience with certain terminal illness into hospitals to talk to someone because they can talk to that person better than any of the nurses or doctors that are there. These are like really extreme situations, but I don't think that doctors are really taking us seriously. And until we show them in these experiences, show them what we can truly do in*

> *a more powerful way, then they're not going to listen to us anyway, and especially in a culturally safe way".*

> *"We should all get basically the lived experience type of accredited badge for our experience – we know a lot. We are professionals at what we do and we should be treated that way. And we should be treated this way in all aspects. Also, even in planning, for example, what I do at is basically I'm also involved in hiring decisions and a whole bunch of stuff. So, this needs to be done all over."*

Therefore, one way to build capacity among peer workers is to **recognize the expertise they bring to the table and how they address various social determinants of health by providing formal avenues to recognize their roles and promote their leadership**.

Building the capacity of health care professionals

One of the most difficult issues in achieving a wellness-oriented MSHU system is convincing health care professionals to make significant changes to their practice orientation (Shera & Ramon, 2013). **While most professionals support the principles of recovery, many feel ill-equipped to implement it in practice** (Shera & Ramon, 2013). Building the capacity of health care professionals through education was a core theme brought up in both focus groups. As one peer stated,

> *"We also need way more help with social resources. Absolutely need a lot more social resources. When I'm talking about education, I am talking about like we need to start training nurses and health care workers to want to get into mental health and substance use. Because E.R. staff are meant to be in ER. Mental health care workers are meant to be in mental health care. There's very limited actual education done even in schooling. So, yeah, a little bit more extra time and really allowing people to come and follow us…"*

Systems allies also stated similar sentiments. For example:

> *"I was just going to add that I think it's one small piece of the puzzle, but there's like a gross lack of capacity within the health care workforce in terms of treating substance use in particular and a discomfort among many providers to deliver care for substance use. So, in our acute mental health settings, often, as people have mentioned, there is this idea that the mental health issue has to be dealt with before a substance use issue will be addressed. And the people who work in those units often have very, very minimal training in managing substance use. So, I think there needs to be*

> *much more emphasis for the workforce in terms of preparing them to deliver evidence-based care."*

One reason for this is that most health care professions are trained within a biomedical model, "which continues to dominate health systems and structures across the Western world" (Hungerford & Fox, 2014, p. 213). As one system ally echoed in the focus group:

> *"Another significant challenge that we often see is an uncomfortable or hesitancy to manage conditions outside of your specialty area of practice. So many physicians are trained and sub specialized to only offer treatment for a single disease model that they've spent the last 10 years working to kind of become very refined in. And so, when you are seeing the population here coming in with a number of other comorbidities, multi morbidities, a number of other challenges that you're just not set up or trained to manage, it becomes very easy to refer those issues to the subspecialist, who's more well trained."*

One way to increase the capacity of health care professionals and to promote the implementation of recovery-orientated practices is to build "communities of practice" (CoPs). CoPs are groups that consist of members such as clinicians, managers, PWLLE, caregivers, and researchers (Piat et. al, 2016). The goals of CoPs vary but can include focusing on "knowledge translation and sharing local recovery practices" (Piat et. al, 2016, p. 11). For example, CoPs can address issues such as "risk management and shared risk taking; quality of services and recovery measures; role of peers in clinical and organizational decisions; shared decision making; and hiring peers" (Piat et. al, 2016, p. 11). An example of established CoP is in Quebec, where in 2012, there was a focus on addressing recovery of people with mental illness. The goal of the CoP was to develop sustainable recovery implementation strategies and "create a common neutral space to share and transfer knowledge; support diverse practices, strategies, and solutions; develop a culture of collaboration; mobilize opportunities for quality improvement; and influence decision-making bodies" (Piat et. al, 2016, p. 11).

Another example of a community of practice in BC which addresses SUD care is the BC ECHO on Substance Use program, which was mentioned by a system ally in a focus group as an important tool in improving care in rural and remote communities. Based on the model of Project ECHO (which stands for Extension for Community Healthcare Outcomes), this project uses a recognized and evidence-based telementoring intervention that is used to improve patient outcomes for numerous health conditions, such as hepatitis C, autism and COVID-19 (University of New Mexico, 2021a; University of New Mexico, 2021b; The University of New Mexico, 2021c). The BC ECHO on Substance Use program is designed to increase competencies of health care providers within primary care to treat and manage substance use disorders without the need for intensive supervision, high cost of in-person training or travel (The BC Center on Substance Use, 2021; Stanford Medicine, 2021). Using videoconference technology, brief didactic presentations on alcohol or opioid use disorder are presented by an expert in addiction medicine followed by case- based learning which fosters an “all learn, all teach” approach (The BC Center on Substance Use, 2021; Stanford Medicine, 2021). Therefore, providing avenues for the creation of CoPs might provide a formal opportunity for people from both the formal and community sector to engage in crucial dialogue and create equity-based approaches to substance use and mental health care.

Specific Populations of Focus

Given that certain groups face disproportionate amounts of intersecting forms of oppression, it important that they are given special policy considerations. Additionally, “diverse populations are accessing community-based mental health and substance use services in BC, including groups that have been historically underserved by mainstream healthcare services” (Tiesmaki & McEwan, 2016, p. 22). Therefore, equity-based initiatives should be considered for: women, Indigenous people, people who identify as LGBTQIAS+ and those involved in the penal system (which was already discussed in the section above).

Women

Structurally vulnerable women (cisgender and transgender inclusive) with a SUD are greatly impacted by political, medical, and social discourses that are “situated in relation to larger, hegemonic gender roles and racialized dynamics that [shape] their practices within the drug scene” (Collins et. al, 2020, p. 3). For example, in British Columbia, women “have accounted for approximately 20% of fatal overdoses in BC with Indigenous women experiencing eight times as many non-fatal overdose events and five times as many fatal overdoses as white women” (Collins et. al, 2020, p. 2). A study that examined the experiences of women who use drugs in the Downtown Eastside showed that “while women were more at risk of violence in privately-operated SRAs, common spaces in non-profit-operated buildings were also gendered, with men regularly observed as being the primary occupiers of these spaces” (Collins et. al, 2020, p. 4). Additionally, women who use drugs are more likely to be evicted from their homes “not only on the basis of their drug use, but also for experiences of domestic violence, and police involvement” (Fleming et. al, 2019, p. 170). Therefore, there is a need to explore the intersections between gender, racism, colonialism, and gendered violence as this increases one’s vulnerability to overdose (Collins et. al, 2020).

Indigenous People

The Government’s inability to address the Truth and Reconciliation Commission, is clearly seen amongst the disproportionate deaths of BC’s Indigenous population in the overdose crisis (Lavalley et. al, 2018). Unfortunately, Indigenous people who use drugs have a mortality rate that is 5 times higher than other British Columbians. Indigenous British Columbians account for 10% of overdose deaths, despite the fact that they represent a 3% of the province's population (Lavalley et. al, 2018). Structural factors that increase vulnerability to overdose amongst this population include the "historical and ongoing traumas related to colonization, including the residential school experience, poverty and child apprehension and involvement in the child welfare system, […] inadequate access to education, health services and social supports", racialized violence and over-policing – which has led to disproportionately high rates of incarceration (Lavalley et. al, 2018). As outlined in the In Plain Sight report (Turpel-Lafond, 2020), the BC health care system is ill-equipped to address the impact of colonization and ongoing racism, which has resulted in poorer and unjust health outcomes for Indigenous people. Cultural racism in BC's MHSU system continues to have negative consequences for Indigenous people, such as: "missed opportunities for screening, difficulties resulting from differing responses to medication, lack of clinician knowledge about alternative and traditional remedies, diagnostic errors resulting from miscommunication, and disruptions in services" (Sheedy & Whitter, 2013, p. 247). Therefore, moving forward, the MHSU system needs to be grounded in cultural safety, which "necessitates a paradigm shift towards critically acknowledging and addressing power relationships on an ongoing basis to work towards achieving health equity" (Venugopal et. al, 2021, p. 10). One way this can be addressed is by increasing the visibility of Indigenous people in leadership positions within the MHSU system, as this can challenge "social and historical contexts [that] have resulted in health inequities and addresses power, privilege, racism, and discrimination in healthcare settings by promoting […] literal spaces and care that are free of judgement and discrimination" (Venugopal et. al, 2021, p. 10). Additionally, there is a continued need for "community-based mental wellness initiatives among rural and remote Indigenous communities, with cultural teachings, cultural activities, appropriate use of culture, land-based programming and knowledge sharing integrated into community programming" (Venugopal et. al, 2021, p. 2). An example of what this could look like in real-life is by the Portland Hotel Society, which is a community-based organization that provides housing, healthcare, harm reduction and health promotion for some of the most vulnerable and under-served people in Vancouver's Downtown Eastside (DTES) and Victoria. One of their initiatives called, *Culture Saves Lives*, is a program that addresses the social determinants of health of Indigenous people in the DTES by combining culture and harm reduction with healing circles, smudging, drumming, singing, traditional dances, feasts, sweat lodge ceremonies, drum-making workshops, honouring ceremonies and memorials. Additionally, they have the Hub, a cultural meeting place, where they provide coffee and sandwiches to those who were hungry due to the closure of neighbourhood food services (Portland Hotel Society, 2021).

LGBTQIA2S+

People who identify as Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual and Two-Spirit (LGBTQIA2S+) are also disproportionately affected by the overdose crisis due to a number of factors. For example, members of the LGBTQIA2S+ community are more likely to complete suicide or have a mental illness and experience a number of social barriers such as violence, bullying, and rejection from family and friends. Additionally, LGBTQIA2S+ members face structural inequities such as poverty, homophobia, transphobia, and stigma (Moazen-Zadeh et. al, 2019). LGBTQIA2S+ people “are often less likely to adhere to treatment for substance misuse, partly because of negative interactions with health-care services that are not well equipped to address the needs of LGBTQ people” (Moazen-Zadeh et. al, 2019, p. 725). Emerging research suggests that one way to address the oppression of LGBTQIA2S+ to foster “the provision of tailored addiction-treatment services for LGBTQ people [which] is feasible and can improve treatment uptake and adherence” (Moazen-Zadeh et. al, 2019, p. 725).

The Importance of the Community Sector in Helping Specific Marginalized Populations

The connection between structurally vulnerable groups and the community sector is that the community sector often serves such marginalized populations who have been excluded from the formal care system. For example, results from the 2016 BC Community Mental Health & Substance Use Sector Survey, show that the community sector serves various populations such as Aboriginal, First Nations and Métis people (51%), families and caregivers (50%), homeless people (48%), individuals with criminal justice involvement (44%), immigrants and refugees (23%), and women (63%) (Tiesmaki & McEwan, 2016)

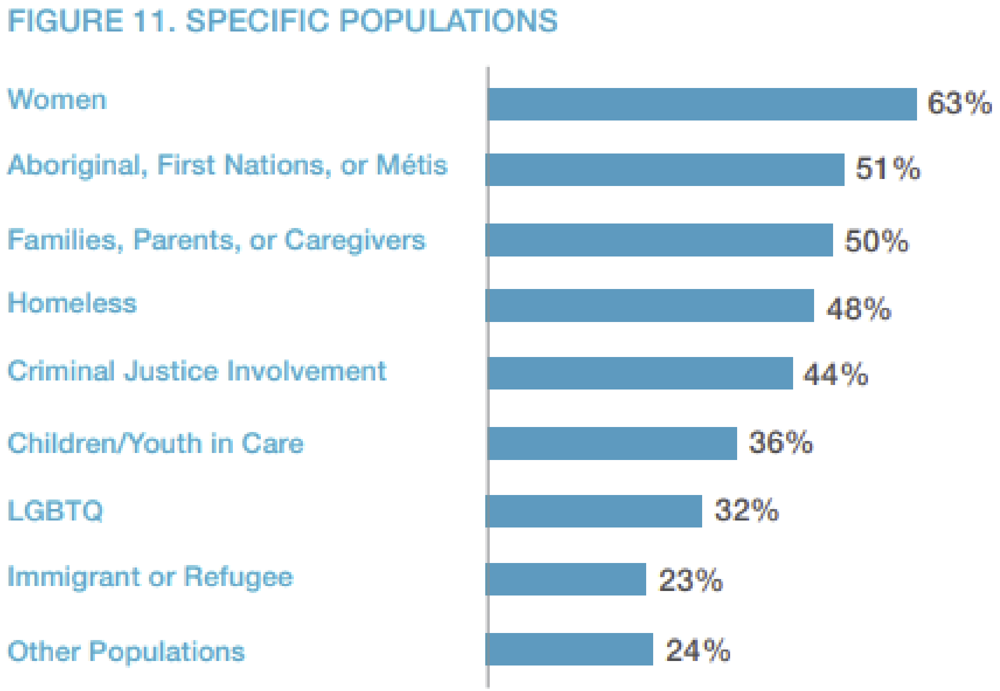


Figure 12. From Tiesmaki & McEwan, 2016

Therefore, community organizations are well positioned to respond to the specific needs of marginalized client groups and “reflect the higher need for mental health and substance use services among specific populations in BC” (Tiesmaki & McEwan, 2016, p. 23).

Micro Level: Capacity-building and Community Engagement

KEY FINDINGS AT THE MICRO LEVEL

- Building connections, fostering trust in the community and giving back is an important part of peers’ healing journey as it pulls people out of isolation and helps them work through shame. Peer-based networks sheltered PWLLE from experiences of discrimination, racism, unequal power dynamics, and stigma
- One important way to promote wellness amongst individuals with mental illness or a SUD is to promote the acquisition of “life skills”. Building life skills can help promote independence and improve one’s self-concept
- Peers have been systematically marginalized and oppressed by the MHSU system of care and their perspectives on social injustice have been overlooked by those in positions of authority/power. It is important to recognize their expertise and create formal educational or mentoring opportunities
- Given that unemployment and economic exclusion are associated with SUD, finding and sustaining employment is considered one benchmark within recovery. However, initiatives need to take a health equity approach where the aim is to decrease socioeconomic marginalization more so than just finding employment.
- Stigma commonly affects PWLLE, and is frequently associated with feelings of not wanting to engage with the formal system and feelings of exclusion. Addressing stigma and discrimination is essential component of creating transformative policy change and addressing structural discrimination
- The importance of personal choice should be considered in promoting wellness-oriented MHSU system of care. Systems should adapt to the needs of individuals, rather than requiring individuals to adapt to them.

At the micro level, emphasis should be placed on interpersonal processes such as building social support systems as well as taking a strengths-based approach to building intrapersonal characteristics. At this level of engagement, the following areas are important to address in order to promote mental wellness: the importance of families and peer support, skill building, fostering leadership, education and employment, addressing shame, stigma and trauma, and valuing personal choice.

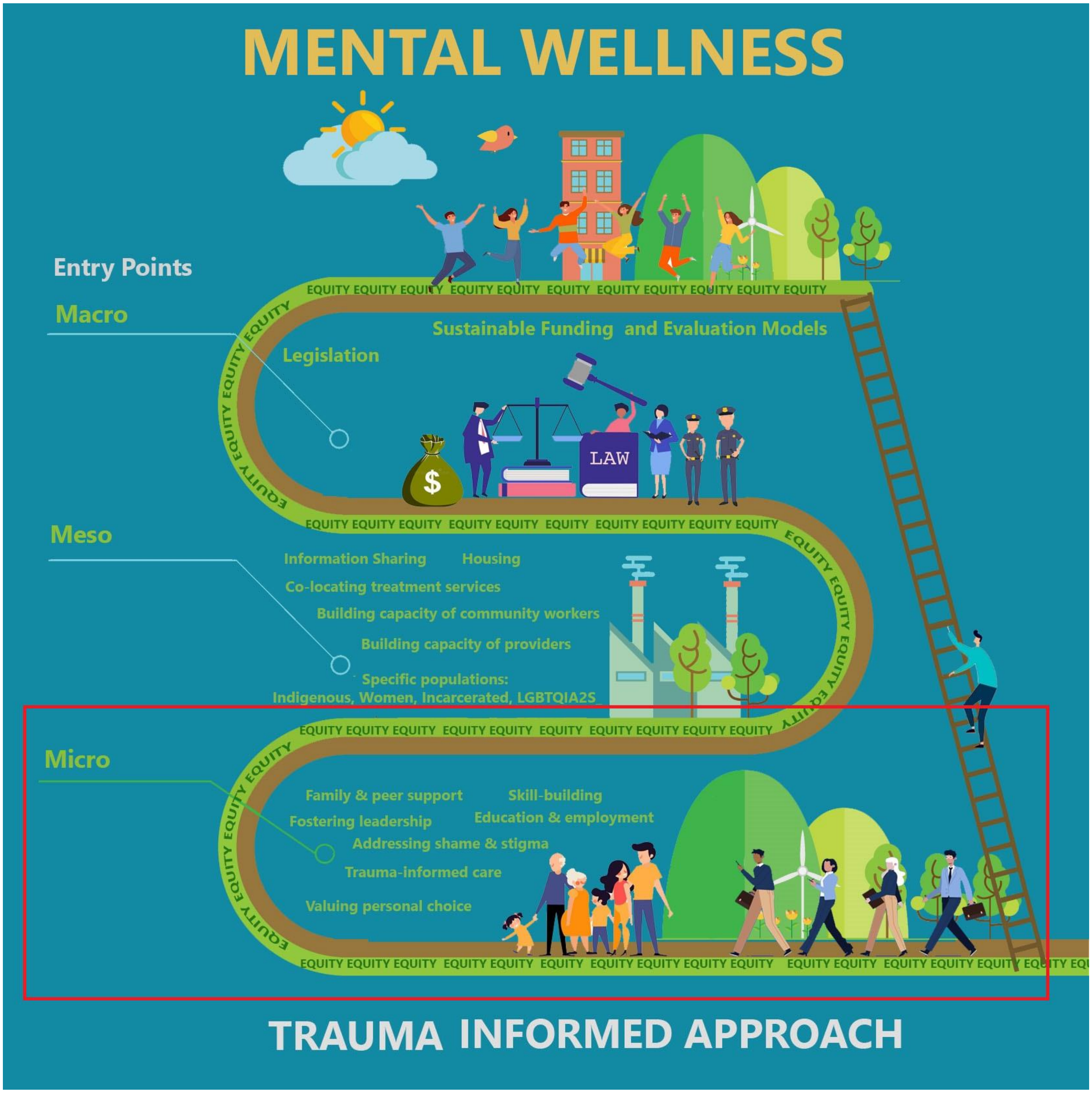


Figure 13. A Community Driven Approach to MHSU care

Families and Peer Support

Families, peers, and communities can be “considered in need of treatment and recovery when the health and performance of its members and the system as a whole have been severely impaired by alcohol- and other drug-related problems” (White, 2009, p. 147). The ways to capitalize on the social capital of families and peers is to: 1) extend the reach of treatment services into the community and by 2) integrating community services into formal institutions (White, 2009, p. 147). This can be done using peer-based recovery support services, which can be delivered in a variety of community-based venues such as community centers, faith-based institutions, jails and prisons (Laudet & Humphries, 2013). **Peer-based services use a "whole person" wellness approach by addressing barriers to accessing support caused by social isolation and by building people's recovery capital** (Best et. al, 2021). It "gives people the opportunity to connect with others, practice empathy, and learn self-value, including a more positive outlook on life and self, and promotes improvements in mental and physical health. **Building connections, fostering trust in the community and giving back is an important part of peers' healing journey as it pulls people out of isolation and helps them work through shame**" (Billinton et. al, 2020, p. 5). An example of this includes the *Our Park* project, which is a Vancouver-based community arts and peer support outreach initiative funded by CAI. This project consists of a coalition that includes: the Vancouver Park Board, the Western Aboriginal Harm Reduction Society, Vancouver Coastal Health and the City of Vancouver. The initiative works with cultural and peer support organizations in the Andy Livingstone area, in addition to park neighbors who use drugs and are precariously housed (Community Action Initiative, 2020).

Peer-based services have shown to improve SUD outcomes. For example, "among persons dually-diagnosed (SUD and mental health), a randomized clinical trial using a prospective design with repeated measurements documented the effectiveness of adding a peer-based component to clinical treatment in reducing substance use and peers have also proven effective at designing and disseminating mutual help related public service announcements to increase involvement in mutual aid/self-help groups for a range of chronic problems, including SUD" (Laudet & Humphreys, 2013, p. 6). The importance of peer-based services was a common theme in the peer focus group. For example, **peers mentioned how peer-based networks sheltered them experiences of discrimination, racism, unequal power dynamics, and stigma**. Some statements from peers include:

> *"For me, basically, I think it has a lot to do with networks and peer networks, with substance use and a lot of the work that I've done[…] which kind of helps me because* ***as a person of color, I'm not a fan of going to health centers or dealing with clinicians and doctors****. I rather do work with them. What you're doing right now for scientists, they're educators and such, but I always try to shy away from them."*

> *"One thing I would like to see that I don't see that I know would help me is some sort of accessible community that cares about me. You know, how do we do that? And also, a community that's not afraid to talk about, to name the issues and wants to figure out, OK, how do we work on conflict? Because I've been in so many sort of groups and communities and I find that overwhelmingly nobody wants to talk about the elephants. And that doesn't*

> *work for me. It's like, how do we how do we do this? How do we how do we do this in a different way, in a constructive way, in a supportive, loving way? That's really what I think could really change the game for me".*

Additionally, in a survey completed by CAI, 93% of community-based organizations agree or strongly agree that their organization is a key entry point for MHSU services and 96% of organizations agree or strongly agree that their organization is a key place to connect people to other local health and social service providers (Community Action Initiative, 2020b). Lastly, another example is from CAI's Overdose Prevention and Education Network (OPEN) initiative, which is a project that focuses on connecting "hard-to-reach people who use substances with supports, harm reduction supplies, and life-saving naloxone through peer workers, while also supporting the healing journeys of those same peer workers" (Billinton et. all, 2020, p. 5). Close to 43% of respondents in an evaluation completed on the OPEN project stated that sharing their personal stories and connecting with others was effective in shifting perspectives about people who use substances in communities (Billinton et. al, 2020). Despite the limited funding provided for each community group in the OPEN project, this statistic really speaks to the fact that the community sector is well equipped to create sustainable opportunities for peers to be a part of active civic engagement.

Skill Building

One important way to promote wellness amongst individuals with mental illness or a SUD is to promote the acquisition of "life skills". Building life skills can help promote independence and improve one's self-concept. For example, one way to promote building life skills is through peer-based supports that use a hub and spoke method. For instance, in England, the hub and spoke service model is used and people with a SUD "are expected to engage in a fully structured program that not only includes the 12 Step Recovery program but also involves activities of daily living, budgeting and regular exercise. Later on in the program, they are encouraged to engage in voluntary work, training or education, and other activities or courses aimed at removing barriers to meaningful employment" (Best et. al, 2021, p. 9). The results of these types of service models are promising. For example, some of the peer based recovery organizations in England who use this model have reported that "79% [of their clients] stayed abstinent for over 3 months with just over half remaining clean for over 12 months[…]. The numbers improve depending on the period of time spent within the project and whether they complete the 12-Step program of recovery. Of those completing the program, 69% remain substance free" (Best et. al, 2021, p. 9). Additionally, by providing opportunities to build life skills, data shows that people feel more involved and connected to their community, have improved self-esteem, increased coping strategies, reduced isolation, "reductions in the experience of trauma symptoms and family ties are brokered through weekly family night events" (Best et. al, 2021, p. 16).

Leadership Skills

Peers have been systematically marginalized and oppressed by the MHSU system of care and their perspectives on social injustice have been overlooked by those in positions of authority/power. Some elements of the formal sector “continue to pay lip-service to the value of lived experience (LEx) leadership, evidenced by the growth of initiatives seeking to ‘give voice’ to LEx leaders, without fully understanding the unique leadership strengths, competencies and skills that LEx leaders bring to the formal sector” (Sandhu, 2019, p. 38). Therefore, **it is important that the new system embraces a “*Nothing About Us Without Us*” approach, where the firsthand insights of peers help us move beyond reform to transformative change** (Piat & Polvere, 2014). In other words, it is ideal for services to be co-designed and co-produced by PWLLE, given their insider knowledge, wisdom and unique critical perspectives. As one peer in the focus group stated,

> *“I think we need to invest in peers as **subject matter experts**. So and by invest, I mean like organizations, for example, like [sic] who are resisting their peers unionizing. Why is that happening? Right. So paying them for their time as subject matter experts, right? Peers need to be at the table as partners. And we need to be at the decision-making table and we need to also talk about, how are we going to work together as partners? How are we going to collaborate as partners?”*

Engaging LEx leaders can: “1) improve services and decisions, 2) help to gain legitimization and/or community compliance, and 3) to bring about social change with the redistribution” (Sheedy & Whitter, 2013, p. 249). An example of how to capitalize on LEx leadership is to **create formal educational or mentoring opportunities to PWLLE**. For example, LEx leaders are formally recognized in the United Kingdom and the United States. For instance, there is a Lived Experience Transformational Leadership Academy hosted by Yale University that strengthens the capacity of Lived Experience Leaders to create systems-level change (Yale School of Medicine, n.d; Sandhu, 2019). Another more localized example includes CAI’s Community Wellness and Harm Reduction Grant program, which was used “to support community partnerships on focused, action-oriented harm reduction projects or initiatives, tailored to meet local needs” (Wagner, 2021, p. 3). Some of the activities included providing appropriate financial and non-financial support for self-organized peer coalitions and drug user unions – such as the Substance Users Society Teaching Advocacy Instead of Neglect and the Society of Living Illicit Drug Users – who are engaged in advocacy and collective action to support people who use drugs in their local communities. However, it is important to remember that there are many barriers when involving PWLLE such as: “1) lack of information about policies and how to best provide input; 2) fear of retaliation; 3) lack of feedback on input; 4) lack of skills to communicate and participate; 5) lack of encouragement by service providers; 6) use of professional jargon; and 7) lack of financial support for the costs of participation" (Shera & Ramon, 2013, p. 23). Therefore, taking an approach that is citizen led and co-produced can help move past consultation by redressing power differentials through authentic partnership.

Education and Employment

Another important way to promote mental wellness is to increase opportunities to access education and employment. **Given that unemployment and economic exclusion are associated with SUD, finding and sustaining employment is considered one benchmark within recovery**. Exclusion from social and economic opportunities includes: "labour market exclusion; informal or prohibited income generation (e.g. theft, drug dealing, street-based work); material insecurity (e.g. housing or food insecurity); inadequate income; incarceration; social stigma or isolation; and low socioeconomic status or poverty" (van Draanen, 2020 p. 2). **One way to address this is to increase educational opportunity, which supports those in the recovery process by improving self-esteem, self-efficacy, and increasing long-term meaningful employment opportunities** (Ashford et. al, 2020). Therefore, part of a recovery oriented MHSU will require emphasis on employment support services, where the goal is to increase the vocational and technical skills of individuals. Such services should "help individuals craft resumes and cover letters, fill out job applications, practice interviewing skills, or secure interview attire, are all employment recovery support services" (Ashford et. al, 2020, p. 4). Employment opportunity was frequently cited by peers in the focus group not only as means to address income insecurity – **but also, a sense of community, belonging, self-esteem and identity**. For example, one peer stated,

> *"I just wanted to add that, like I said, the peer work, the community, the upswing in that in the last year like… that actually was grounding. It's the only thing I had to do at times is like once a week or twice a week kind of Zoom appointment. The income like twenty-five bucks an hour or even three, four, six times a month. Like that's a real help in my life where I've done like pilot projects after part time job after pilot project, like the income insecurity on the front line… the haves and have nots of health and social services. And you know, just us being able to cobble together some kind of support system…like outing myself as a past and present drug user has been the only way I've gotten any kind of like, influence in the last several years because it's managers that are doing all the important work. Right? And so, you know, going out and doing some, like urgent emergency kind of community work recently in the heat wave was so nurturing to me like to hanging out with the folks and to see, like, grit and horror and like, you know, I have PTSD. So that's something that's kind of not totally healthy. But there was something really soothing about being with people, you know,*

> *and people that I feel safe and secure with because we just like. […]. You know, I just hope for a full time or a big part time job someday where I get enough benefits and money."*

An example of how the community sector has helped address employment barriers is highlighted in CAI's Community Wellness and Harm Reduction Grant Program Interim Summary Report. As of November 2020, "231 paid positions had been created for people with lived/living experience of substance use, mental illness, and/or homelessness through 21 funded projects" (p. 15). However, close to 81% of these employment opportunities were casually based and "several teams noted the lack of stable and equitable employment opportunities for PWLLE beyond their project" (Wager, 2021, p. 16). **This speaks to the need to move past the pilot project syndrome that plagues MHSU funding schemes and limits community sector's ability to do equity-based work**. Additionally, it is important not to overly rely on employment as the *only* solution to poverty and SUD. This is because "social and economic components of marginalization, including access to the resources and conditions that affect drug-related harm such as neighborhood deprivation and income inequality are associated with overdose and drug-related death not just at the individual level, but also structurally through the control and distribution of socio-economic resources" (van Draanen et. al, 2020, p.2). Therefore, initiatives need to take a health equity approach where the aim is to decrease socioeconomic marginalization more so than just finding employment. These approaches are necessary strategies to overcome the overdose crisis (van Draanen et. al, 2020).

Addressing Shame, Stigma and Trauma

At the foundation of the framework, part of enhancing wellness is addressing stigma, shame and trauma. Stigma and discrimination are known barriers to an individual's ability to receive care and thus, reach wellbeing (Sheedy & Whitter, 2013). For example, some studies have suggested that when "recovering individuals are honest about their drug histories, they will be turned down for a job 75 percent of the time" (Sheedy & Whitter, 2013, p. 240). Another example is that studies from Vancouver's Downtown Eastside have shown that women commonly use drugs alone to "minimize being judged by peers or observed while using or intoxicated. Participants' anxieties of being judged suggests that they were aware of how their embodied practices were at odds with broader expectations of women's bodies" (Collins et. al, 2020, p. 7). **Stigma was a common theme in the peer focus group, and was frequently associated with feelings of not wanting to engage with the formal system and feelings of exclusion**. As one peer stated,

> *"Substance use is often a social behavior. We have social problems that make people have medical problems. For example, you know, the people at the brewpub down the street, while they may be engaging in alcoholism, they*

> *don't need an outreach nurse. They actually just need their house and space at a pub to drink, you know? It's safe there. And so, what people need is space. And until, you know, the medical practitioners catch up and get past the stigma, I would say we need segregated space, separate space where we can control that the haters aren't present. You know, we need social gathering space where trauma-informed practice and services can all happen. But yet the managers of the health authority, they'll be like,* ***"yes, we can totally, minimally fund that and then use it as an access point where our highly paid nurses can go around looking for people. We can utilize that and get data and stuff". What I'm talking about actually is gifting the humans actual stuff and space resources, you know, somewhere where people can get all their basic needs met and information and or just smoke their crack, you know?*** *And until there's quite a bit of strong reform, you know, I would advocate for non-mixed space and that all of this is social. You know, people need their social needs addressed and then lots of the health care needs could peter out on their own over the years".*

The link between trauma-related disorders and substance use disorders is a well-established phenomenon. In fact, over 50% of people experience a traumatic stressor in their lifetime (Wiechelt, & Straussner, 2015). Given that relational and equity-based work is at the heart of community-based projects, the community sector is well versed in being able to address social stigma and trauma. For example, in an evaluation of CAI's Overdose Prevention and Education Network, some peers who have engaged in peer work through the initiative have stated, "It's raised my self-esteem. It's helped me work through trauma and grief that I had no idea how to cope with. It's personally helped keep me … on a positive trajectory, due to the fact that I work in the thickest, heaviest part of addiction, and everything that that controls in your life. It helps keep me on track and still connected with people" (Billinton et. al 2020, p. 3). Another example of what this could look like, or what this means was highlighted by a system ally who stated:

> *"With community led approaches within First Nation communities, we have like land-based community programs and cultural programs that aren't held up to the same degree as, for example, a community member going to pharmacy and being prescribed pharmaceuticals. We don't have the same amount of supports for someone to access the land community program or aftercare in technical terms. So it's just not held to the same degree, even though within our own culture that's the strongest foundation for us to heal from. And when it's done in a way where it's a well thought out planned out continuum of care, it's not just from extremes. And I've personally seen people pass away from*

> *going to those extremes, from being all over the land to being warriors to defending against pipelines and resource extractions to passing away from overdose on the Downtown Eastside years later. And all of those steps in between were missed and that person passed away because they didn't have those supports in between those two extremes. And that that's how the current system is failing our people as an example. So if community led approaches such land based healing and cultural healing programs are held up in a meaningful way, the same way that clinical pharmacy is, then we see a difference, but we don't see that. But if once that changes, we'll probably see some more changes that are more community led, more nation driven, and have more of a meaningful impact, especially in rural and remote communities."*

Addressing stigma and discrimination is essential component of creating transformative policy change and addressing structural discrimination.

Valuing Personal Choice

Lastly, **the importance of personal choice should be considered in promoting wellness-oriented MHSU system of care. "Systems should adapt to the needs of individuals, rather than requiring individuals to adapt to them**"(Sheedy & Whitter, 2013, p. 243). More specifically, "recovery-oriented systems of care should be individualized, comprehensive, and flexible and move from an acute-based model to one that manages chronic disorders over a lifetime" (Sheedy & Whitter, 2013, p. 243). A number of studies have shown that individuals are more likely to stick with a particular course of treatment if they are given the choice between several alternatives rather being forced to select a particular option. In advocating for a system that can address intersecting forms of oppression, a one-size fits all approach will not work. As one peer from the focus group stated,

> *"I think generally they have to stop treating people like one size fits all. Addicts aren't like a garment, you know, in that sense, we're not one size fits all. Kind of as someone said earlier, I have to meet us where we're at, which is why it's really important that when somebody is ready for, say, rehab or ready for detox, that they can get in as quickly as possible because, you know, anything could happen within a couple of days. Within a couple of days, they could get their check or something and just go off the handle because they got money or somebody in their family could die and they could spiral further into addiction. So, when somebody is telling you they're ready and they're really ready, you know, and they don't need an intervention, they're coming to you. The system should be able to take them then and there. In come as you are sense."*

Therefore, for recovery to commence, individuals need: “a safe place to live that is free from threat, freedom to make choices and a clear sense of self determination, which requires both the provision of accurate information about what the options are and no limits placed on what is possible by professionals” (Best & Lubman, 2012, p. 595). At the end of the day, **achieving mental wellness should be about giving individuals opportunity and autonomy and this “may or may not be related to clinical indicators of recovery”** (Shera & Ramon, 2013, p. 17).

Calls to Action: Recommendations for a Community-Driven MHSU Framework of Care

In examining what a community-led ecosystem approach to prevention, treatment and recovery for mental health and substance use issues look like in BC, it is clear that the health care system is ill-equipped to solve the problem on its own. In order prioritize upstream social and structural determinants of health, it is important that there is better intersectoral collaboration beyond the formal health care system to also include the community sector. Additionally, it is clear that people with lived/living experience, and those who work in the community are underutilized and undervalued. Therefore, multi-scalar and multi-pronged approaches which emphasize the voices of those who are most marginalized should be at the forefront of system change efforts. The following recommendations are made:

At the macro level:

- Funding models should be generated in collaborative approach, where numerous stakeholders from various sectors (including PWLEE) can contribute their expertise
- System outcome and evaluation measures should reflect mental wellness of both the individual and community using quality-of-life measures. Building in PWLLE determined evaluation mechanisms into planning and service delivery initiatives, so that those most impacted by the service have the ability to comment on the quality and relevance of services made available, ensuring a feedback loop which encourages continuous learning and quality improvement of the system
- The Mental Health Act requires significant revision, particularly with regards to certification and involuntary status and treatment practices
- Drug decriminalization and safe supply should continue being at the forefront of health promotion agendas, as it reduces social, structural or physical harms.

Meso level:

- Expanding and refining current approaches of vulnerability assessments and coordinated access into the housing system in communities requires collaboration between the formal and community sector. BC has substantial room for cross-collaboration between the community sector and formal sector in addressing the intersections of addiction, mental illness, poverty and homelessness/housing precarity.
- Co-locating and expanding community-based health services can mitigate the inequities inherent in navigated a fragmented system of care, where intersecting issues such as stigma, lack of information, and lack of access to specialist care could all be simultaneously addressed. However, it is important to have assertive linkages between the community sector and formal sector such as having recovery coaches.
- Just as the community sector experiences funding deficits, and the impact of time-limited or project-based funding in comparison to the formal health care sector, the

community sector also often lacks critical information and data held by the formal sector. Therefore, enhanced communication mechanisms will enable better support for individuals who are seeking help outside of an acute based system.
- There is a lack of understanding of the role community workers play in the recovery journey. Peers are well-versed in created culturally safe spaces for others. It is important to formally recognize the expertise they bring to the table and how they address various social determinants of health by providing formal avenues to recognize their roles and promote their leadership.
- It is important to create opportunities for care professions to be more comfortable with principles of recovery, such as building communities of practice

At the micro level:

- Peer-based services use a “whole person” wellness approach by addressing barriers to accessing support caused by social isolation and by building people’s recovery capital. Creating opportunities for more peer-based networks can help address experiences of discrimination, racism, unequal power dynamics, and stigma
- One important way to promote wellness amongst individuals with mental illness or a SUD is to promote the acquisition of “life skills”. Building life skills can help promote independence and improve one’s self-concept
- Peers have been systematically marginalized and oppressed by the MHSU system of care and their perspectives on social injustice have been overlooked by those in positions of authority/power. It is important that the new system embraces a “*Nothing About Us Without Us*” approach, where the firsthand insights of peers help us move beyond reform to transformative change. One way to do this is create formal educational or mentoring opportunities to PWLLE leadership.
- Given that unemployment and economic exclusion are associated with SUD, finding and sustaining employment is considered one benchmark within recovery. Increasing educational opportunity and decreasing socioeconomic marginalization supports those in the recovery process by improving self-esteem, self-efficacy, and increasing long-term
- Stigma is frequently associated with feelings of not wanting to engage with the formal system and feelings of exclusion. Addressing stigma and discrimination is essential component of creating transformative policy change and addressing structural discrimination
- The importance of personal choice should be considered in promoting wellness-oriented MHSU system of care.

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Appendix A

Key Terms

Substance Use Disorder

The Diagnostic and Statistical Manual (DSM-5) (2013) defines substance use disorders as “cluster(s) of cognitive, behavioral, and psychological symptoms indicating that the individual continues using despite significant substance related problems” (American Psychiatric Association, p. 483). The spectrum of psychoactive substance use in Figure 14 (BC Ministry of Health, 2010) demonstrates that people can have a range of relationships with psychoactive substances outside of a SUD including abstinence, beneficial or non-problematic use and problematic use. Diagnosable criteria for a substance use disorder includes the recurrent use of drugs despite significant impairment, exacerbated health conditions and a decreased quality of life. Additionally, in keeping with a trauma-informed approach, it is important to use non-stigmatizing language when referring to substance use. Examples of stigmatizing language includes: substance “abuse/r”, substance “misuse”, “bad habit” or “addict”. People diagnosed with a SUD are currently referred to as a “person(s) with a substance use disorder(s)”.

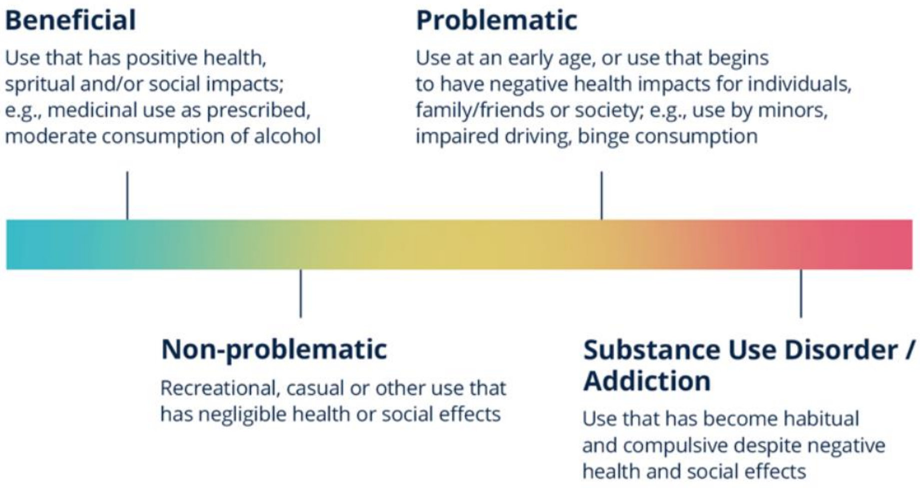

Figure 14. From BC Ministry of Health, 2010

Person(s) with Lived and/or Living Experience (PWLLE)

“Although widely used in social purpose work, there is no universal cross-sector understanding of what people mean by the term ‘lived experience’” (Sandhu, 2019, p. 12). A person with lived and/or living experience is defined as a someone who has had “direct, first-hand experience, past or present, of a social issue(s) and/or injustice(s)” (Sandhu, 2019, p. 3) with substance use. It is important to note that “everyone has lived, and everyone has experiences. But not everyone working in the social sector has direct, first-hand experience of the social issue, injustice or inequality they are tackling in their social purpose work. ‘All of us have lived experience. But the experiences that (we are referring to) here are those rooted in community and driven by the injustice and disadvantage (people have) experienced directly and personally” (Sandhu, 2019, p. 12). Additionally, lived experience is intersectional, and some people can experience numerous interlocking layers of oppression ((Sandhu, 2019).

The Community Sector

The community sector is defined as “social purpose organizations [that] inhabit the social sector. [It] is a broad term used to describe a set of values and structures and includes organizations working for the wider good of civic society. [It] includes individuals, funders, donors, investors, charities, not-for-profits, organizations, social enterprises, the voluntary or third sector, those parts of the public sector that have a primarily social purpose, and enterprises or businesses that trade like any other business but do so for the public good” (Sandhu, 2019, p. 3).

In BC, MHSU community sector, is conceived of as a sub-component of the broader not-for-profit social services sector, composed of organizations providing services and supports such as health promotion, illness prevention, harm reduction, treatment and recovery outside of the hospital setting. Services provided may also include treatment and crisis response, outreach, case management, counselling and related services such as housing and employment supports. In BC, the community-based MHSU sector is comprised of **well-established organizations**, providing services in more than one geographic location. Surveyed MHSU organizations in 2017 reported an organizational staffing complement of counsellors, educators, trainers and case managers providing MHSU services and supports focused on the most prevalent conditions including anxiety, depression, and medium to high risk alcohol consumption[1].

The Formal or Institutional Sector

The formal sector can be conceptualized as services provided by a healthcare or governmental institution such as a hospital or clinic. Typically, the formal sector uses public tax-generated resources for services and perform duties because of their mandate and/or power they confer on the government.

Appendix B
Search Terms

Review 1

For the first mini literature review examining recovery, key words used for the search included various combinations of: life experiences, experiences, perceptions, attitudes, views, feelings, "people with lived experience", "people with living experience", "lived experience", community-based organization", communit*, non-profit communit*, "community health center", addiction, "substance use", "mental illness", "mental health", recovery, "recovery-oriented", advocacy, leadership, partnership and engagement, consumer participation, "community engagement", "social capital", participat*, "peer led", coresearch*, co-research*, co-produc*, co-design*, codesign*, "community led", "service user", PWUD, PWID, "substance use", addict*, "drug use", "drug abuse", "substance user", non-profit, not-for-profit, coalition and integrat*. Key terms were matched to the controlled vocabulary (MeSH terms or Subject headings) for the databases of CINAHL and PsycINFO and mapped to each concept in the research question. Subject headings and MeSH terms revolved around the concepts of: 1) life experiences, 2) community role, 2) substance use disorders, 4) primary health care, 5) mental disorders and 6) recovery. Key terms for both literature reviews were combined with their matched MeSH term or Subject heading by using the Boolean operator of OR to create a search string. Following this, each search string was combined using the Boolean operator AND. Google scholar and Google searches were completed only using key term searches.

Review 2

For the second literature review, the key words for the search included various combinations of: collaborative mental health care, mental health care, mental health, substance use, capacity-building, community, leadership, leader*, equity, health promotion, intersectionality, social justice, community based organization, community engagement model, strategy, framework, model, coresearch*, co-research*, co-produc*, co-design*, substance abuse, substance use, drug abuse, drug addiction, drug use, "peer led", "lived exp", "service user", "community led", "shared decision" and participatory. Key terms were matched to the controlled vocabulary (MeSH terms or Subject headings) for the databases of CINAHL and PsycINFO and mapped to each concept in the research question. Subject headings and MeSH terms revolved around the concepts of: 1) integrated health care, 2) social determinants of health, 3) equity, 4) continuum of care, 5) framework/ conceptual framework and 6) community mental health services and community mental health. Key terms for both literature reviews were combined with their matched MeSH term or Subject heading by using the Boolean operator of OR to create a search string. Following this, each search string was combined using the Boolean operator AND. Google scholar and Google searches were completed only using key term searches.

Appendix C

INTERVIEW GUIDE FOR PEERS WITH LIVED/LIVING EXPERIENCE

1. When you think about your own mental health and substance use, what has been most helpful in keeping you healthy and safe?

2. How do we resource the components of a community-driven system to move away from crisis-oriented care?

3. The system is currently unbalanced in that many decisions are made by government or health authority staff. How do we change power dynamics within the MHSU system so that peer leadership is prioritized?

4. From the following list, which are the most important to address so that the new mental health and substance use system is equity based and trauma-informed. Please choose your top two: Gender and sexual orientation; Culture Race / Racism Colonization; Income and status Employment and working conditions; Education and literacy; Childhood experiences; Physical environments including housing; Social supports; Healthy behaviours and coping skills; Access to health services

5. In our current system of care, recovery from mental health and substance use problems are siloed. What are your thoughts on this – and should there be integration of both services?

6. Within the mental health care system, there is confusion about the way people have spoken about treatment for people with substance use disorders. For example, some people have focused heavily on recovery while others have focus more on harm-reduction, abstinence, wellbeing, liberation, or community-based initiatives. In your opinion, what do you think the building blocks of the system should be?

Appendix D

INTERVIEW GUIDE FOR SYSTEM ALLIES

1. The current mental health system has been criticized for taking a crisis-oriented approach. Where should the MHSU system resource micro, meso and macro level components so that the new system takes a preventative, intersectional and community-driven approach?

2. How do we capitalize on addressing the structural and social determinants of health so that the new mental health system is equity-based and trauma-informed?

3. What legislative changes would you like to see in the new MMHA system of care framework?

4. In our current system of care, mental health and substance use continue to be siloed. What are some barriers to integration? Why do they exist to begin with? How might they be overcome / removed?

5. The community sector is chronically under resourced and undervalued. How do we advocate for the value contribution for the community sector in terms of its ability to leverage the voices of those who are most marginalized and change power dynamics?