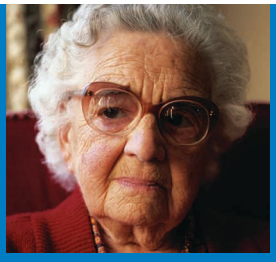

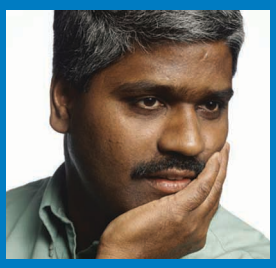

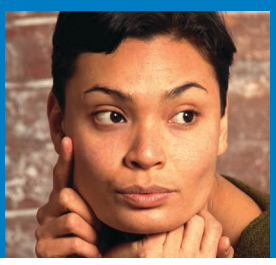

# EVERY DOOR IS THE RIGHT DOOR

## A British Columbia Planning Framework to Address Problematic Substance Use and Addiction

MAY 2004

BRITISH COLUMBIA
Ministry of Health Services

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**"Dedicated to individuals, families and stakeholders who have made it clear to us that every door must be the right door. Wherever people seek help they will be treated respectfully and supported to access the services they need."**

Honourable Susan Brice, Minister of State
for Mental Health and Addiction Services

# Ministry MESSAGE

We are pleased to present *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction.*

The planning framework will guide and support health authorities to ensure British Columbia has a comprehensive, compassionate, and effective response to addictions and problematic substance use within our current resources.

British Columbia recognizes addiction is a chronic health condition and is often linked to concurrent mental illness. Effective services help people develop the resources to recover, improve their wellness and manage their long-term health.

British Columbia is at the forefront of research and action on a number of aspects of addictions and problematic substance use in Canada. We must continue to develop and build on our partnerships with communities, health authorities, care providers, people living with addictions and problematic substance use and their families.

Together, we can identify the strategic investments that will provide the most effective, responsive services for British Columbians living with addictions and problematic substance use.

**Honourable Susan Brice**
**Minister of State for Mental Health and Addiction Services**

**Penny Ballem**
**Deputy Minister**
**Ministry of Health Services**

# Contents

# Executive SUMMARY

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The profound burden of disease and harm associated with problematic substance use in British Columbia (BC)—with consequent suffering, economic loss, disability and death—clearly warrants the most effective and evidence-based approach possible. Problematic substance use and related mental health problems directly or indirectly affect a large proportion of the province's population.

In response, the province of British Columbia is developing a comprehensive, integrated, evidence-based system of mental health and addictions services, one that focuses on promoting health, preventing harm, treating dependency, and supporting individual and family resiliency and self-care.

The Ministry of Health Services has developed this Planning Framework to support community and health authority efforts to address problematic substance use and associated mental health problems with integrated responses. The Framework helps service providers and community partners understand how problematic substance use and associated mental health problems may affect people at different stages of life. It examines critical differences in how problematic substance use can affect women and men. It points to the need for planning efforts that consider unique circumstances faced by vulnerable communities. Finally, it promotes the redesign and restructuring of services within the limited dollars that are available by supporting the re-organization of the current response based on the growing body of evidence about "what works" in addictions and mental health interventions.

The Framework proposes a comprehensive continuum of services built on four fundamental concepts: population health, health promotion, harm reduction and community capacity-building. While this Planning Framework approaches problematic substance use as a health issue, it also acknowledges that responding effectively to problematic substance use and associated mental health problems requires a collaborative, multi-system response. Accordingly, the Framework identifies critical factors for success and defines roles and responsibilities at the individual, community, health authority and government levels.

# Executive SUMMARY

BACK TO TOC

This Framework builds on work undertaken in 2003 by the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia. It gathers the best evidence from across jurisdictions, with a particular emphasis on research and evaluation efforts that focus on problematic substance use in British Columbia.

Problematic substance use represents a profound challenge to our services and our communities. This challenge can be met through an integrated, multi-faceted approach which balances prevention, treatment, self-management and harm reduction within a comprehensive response in which every door is the right door. This framework has been created to support this response.

**OVERWHELMINGLY, PEOPLE SAID: "LET'S GET ON WITH THE TASK" AND "LET'S DO IT BETTER THAN EVER BEFORE".**

Province-wide consultation

# Vision

BACK TO TOC

A client-centred and sustainable health system is one that supports people to stay healthy, get better, live with illness or disability, and cope with end of life issues. It enables people to have their care needs met seamlessly as they move through the health system, regardless of who has the administrative or management responsibility for health services.

In concert with health authorities, local governments and their partners, the province is developing an integrated mental health and addictions service system. This integration will result in improved health care services for the majority of clients with substance use problems who also have a mental illness.

The long-term outcomes for an integrated mental health and addictions service system in British Columbia are:

- Improved mental health of the population
- Reduced problematic substance use and mental disorders
- Reduced disability and other negative impacts from problematic substance use on individuals, families, and the community
- Reduced need for health services
- Reduced stigma and discrimination experienced by people with substance use disorders and mental disorders.

The purpose of *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (the Planning Framework or the Framework) is to assist health authorities and their partners to plan, implement and evaluate integrated and evidence-based responses to problematic substance use and mental disorders.

The Framework describes the scope of the challenge, fundamental concepts, a comprehensive continuum of services, a collaborative model of community and health system responses, roles and responsibilities of key partners, foundations for building system capacity, and critical factors for success (see model on page 5).

This Framework will serve as a tool for health authorities and their partners to use in developing regional plans and initiatives in health promotion, prevention of problematic substance use, harm reduction, and treatment for substance use disorders and mental disorders.

In particular, the Framework is intended to assist health authorities and communities to:

- Assess their strengths, challenges and priorities in responding to problematic substance use and mental disorders;
- Develop integrated health service delivery plans;
- Work with partners to implement plans;
- Monitor progress, evaluate and plan improvements in service delivery.

The Framework addresses problematic substance use, where substances are understood to include both legal and illegal psychoactive drugs or chemicals. Substances that are sometimes used for psychoactivity, such as solvents and glues, are within the scope of this Framework; however, drugs taken to enhance sports performance are not within its scope.

Tobacco, although psychoactive, is also not within the scope of this Framework. The unique historical, cultural and political legacy—and health and economic burdens of disease—associated with tobacco has made it the focus of other provincial and federal initiatives. British Columbia has a provincial tobacco reduction strategy and an Aboriginal tobacco strategy. However, it must be recognized that tobacco use and other substance use often overlap and effective responses may address these as concurrent problems.

Like almost everything related to problematic substance use, the issue of language is extremely complex. In British Columbia, the plural "addictions" is used to describe the field of health responses to problematic substance use. This document uses the phrase "problematic substance use" to encompass the concepts of potentially harmful substance use behaviours or patterns that are not clinical disorders (e.g. impaired driving or the use of substances during pregnancy) and "substance use disorders" (i.e. clinical conditions defined by the DSM-IV, including dependence or addiction).

The Framework is not intended to address forms of addictive behaviour that do not involve psychoactive substances, such as those associated with gambling, sex, eating, television watching, or Internet use. It is recognized that other types of addictions not involving the use of psychoactive substances may represent significant health risks and may warrant treatment. Problem gambling, for example, is an area of concern that is under the purview of the Gaming Policy and Enforcement Branch in the Ministry of Public Safety and Solicitor General.

See the glossary in Appendix V for further discussion of terminology.

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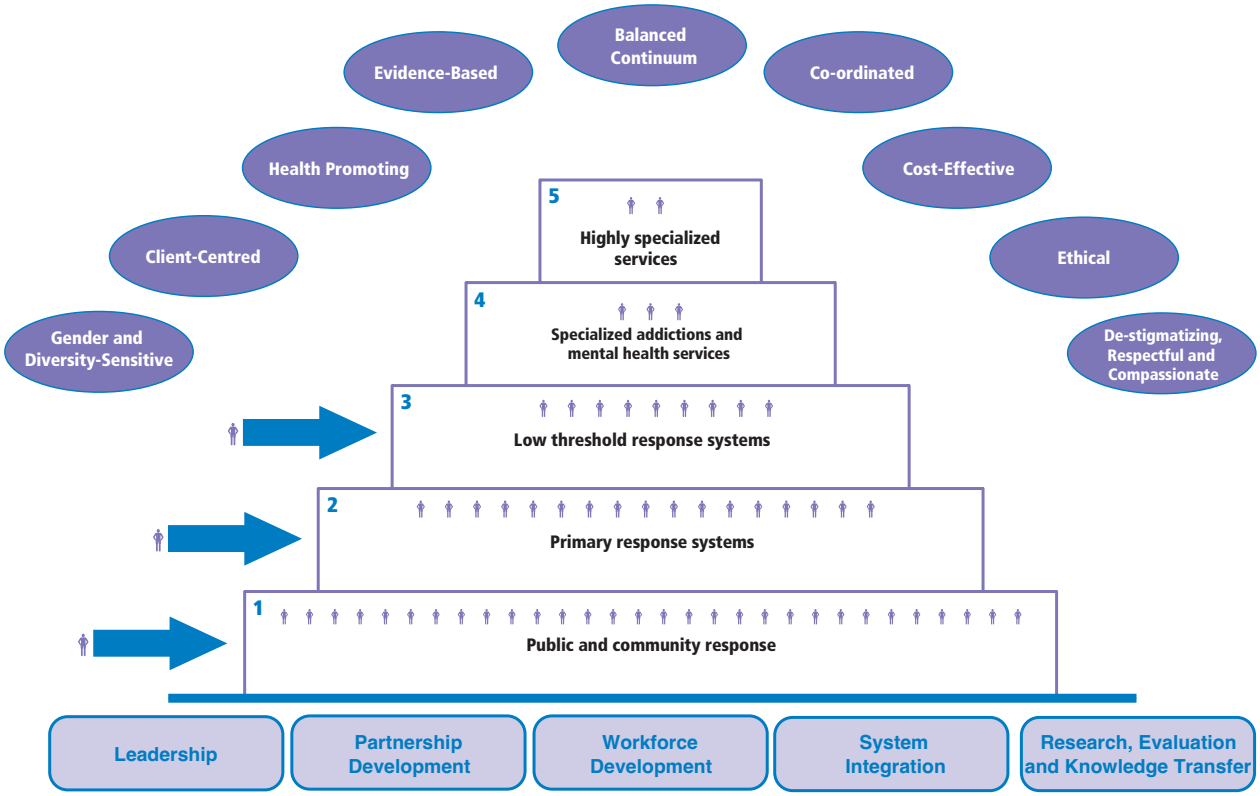
# COLLABORATIVE MODEL OF RESPONSE




**1 to 2 – Shared responsibility of health authorities and partners.**
**3 to 5 – Primarily health authority responsibility.**

# Scope OF THE CHALLENGE

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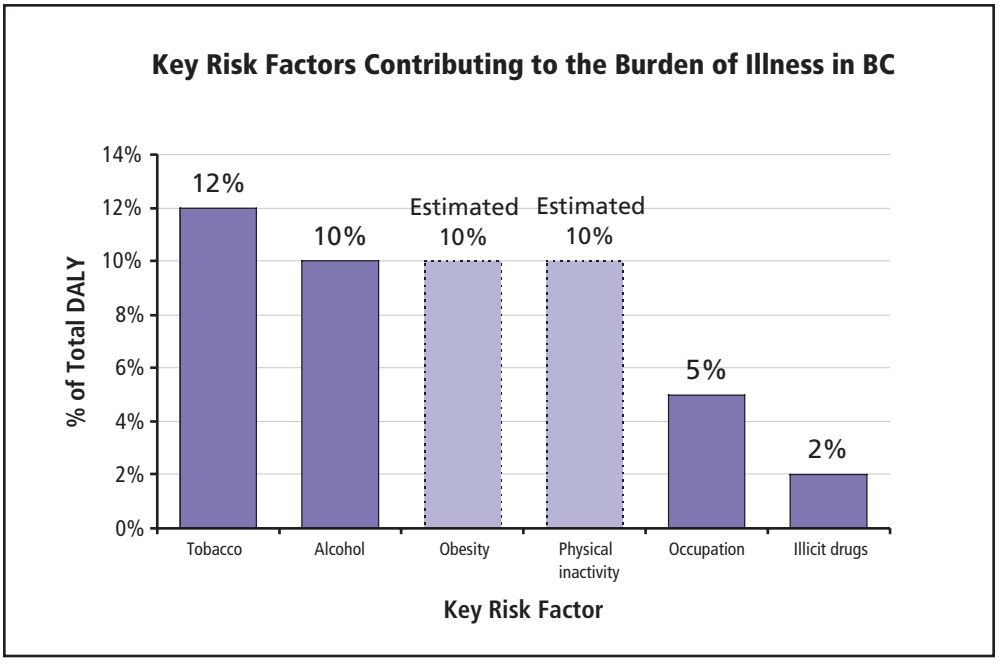
According to a recent Canadian epidemiological survey, approximately 120,000 British Columbians have a high probability of alcohol dependence and another 224,000 have some indications of dependence.[1] Within this group, estimates from other sources suggest that between 173,000 and 200,000 British Columbians are probably experiencing problems in some areas of their life, as a result of their consumption of alcohol.[2] There are fewer reliable estimates available about the prevalence of illicit drug use, but most recent epidemiological data suggest that approximately 33,000 British Columbians have a dependence upon illicit drugs.[3] Rates of illegal drug use, drug-related mortality, and drug-related pregnancy and childbirth complications are all higher in BC than in other provinces.[4] Illegal drugs seized in BC have the highest average potency in North America.[5]

Problematic substance use consequently represents a significant public health challenge in British Columbia. It affects, directly and indirectly, a large proportion of the population. It also represents a substantial financial cost, estimated at 2.3 billion dollars in 1992.[6] Along with tobacco, alcohol contributes to a significant portion of the burden of disease for BC. Taken together, alcohol and illicit drugs match the influence of tobacco with respect to the number of disability-adjusted-life-years (DALYs) that they cost the British Columbia population.

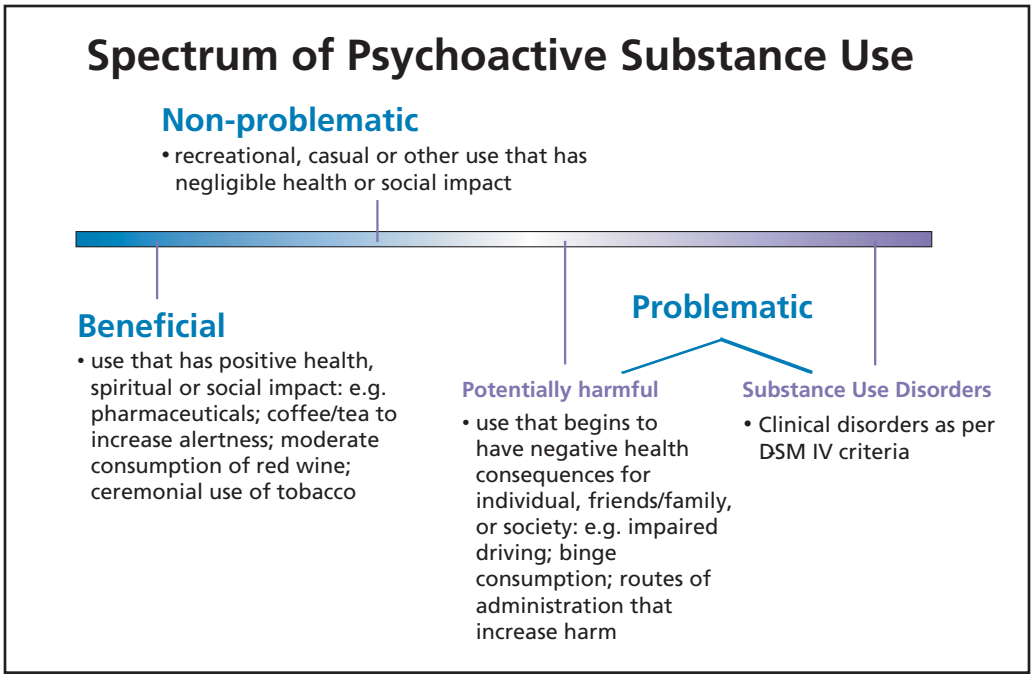



Source: Adapted from Evaluation of the Burden of Disease in British Columbia. Strategic Policy and Research Branch, B.C. Ministry of Health, January 2001.
Note: Obesity information is estimated. New information suggests obesity and physical inactivity are as high as 10% each.

# Scope of the Challenge

BACK TO TOC

The Framework recognizes that instances or patterns of substance use occur along a spectrum from beneficial use to non-problematic use to problematic use (including potentially harmful use and substance use disorders). Substance use disorders represent the extreme and most damaging end of the spectrum. Some people choose to abstain from using psychoactive substances while some people choose to use only certain substances. It is important to emphasize that abstinence is a healthy lifestyle option. Nevertheless, many people choose to use substances and some do not develop serious problems because of this use.[7,8,9] The following diagram illustrates the spectrum.




Substance use may begin at one point on the spectrum and remain stable, or move gradually or rapidly to another point. For some people, their use of one substance may be non-problematic or beneficial, while their use of other substances may be problematic. People who abstain from substance use or who use substances in a beneficial or non-problematic manner are not the focus of this Framework.

Those individuals or population groups that are vulnerable to problematic substance use, or use substances in ways that put themselves and/or others at risk, for either substance use disorders or other health-related problems, are the primary target of the Framework. An effective system of response focuses its resources on substance use at the problematic end of the spectrum.

# Who IS AFFECTED?

BACK TO TOC

Problematic substance use is a complex issue that affects individuals of all ages and from all social groups. The scope of problematic substance use in BC is best understood by taking population-based approaches.

A life-stage approach looks at problematic substance use among the general population at different ages and stages of life development. A gendered approach looks at how problematic substance use is different for boys, girls, men and women. A multiple-diagnosis approach looks at people who suffer from two or more health problems simultaneously, including substance use disorders, mental disorders or other health problems. And a vulnerable populations approach looks more closely at some sub-populations and attempts to understand how some individuals from certain groups are vulnerable to problematic substance use and mental disorders.

These perspectives emphasize the need for co-ordinated responses that involve planning and integration across sectors. Different groups may need tailored care to better address specific needs and improve quality of life. The old adage applies: "one size does not fit all" in dealing with problematic substance use.

## Life-Stage Development

### Childhood

The use of alcohol and drugs prior to puberty is relatively rare, but this is a critical period of development for risk factors that can predispose individuals to problematic substance use and mental health problems later in life. The role of early childhood development in determining future health is well documented.[10] It is during this period, for example, that critical attitudes and coping skills are formed. This stage of the life-cycle is an important period for health promotion and prevention interventions that increase resilience and reduce the likelihood of future problematic substance use.[11]

Of particular importance are interventions that reach children whose caregiver(s) engage in problematic substance use and/or have mental disorders.[12] This work can begin with withdrawal management programs for pregnant women and substance-using mothers and their newborns, and with early identification of

Fetal Alcohol Spectrum Disorder. It extends throughout childhood with support for children living with a caregiver who may use substances problematically and/or have a mental disorder.

### Adolescence

This is the primary period of initiation of substance use and represents the period of the highest rate of use within the population. The majority of adolescents will end or curtail use as they move into adulthood. In recent years, trends have been relatively positive within this group (with a few exceptions noted below): overall rates of use in the general BC high-school student population have decreased over the past five years.[13] There is a relatively low rate of mortality from overdoses among adolescents, although higher rates of drug-related incidents of crime are reported. Injuries from motor vehicle crashes, violence or boating incidents associated with alcohol use are a primary concern within this age group.

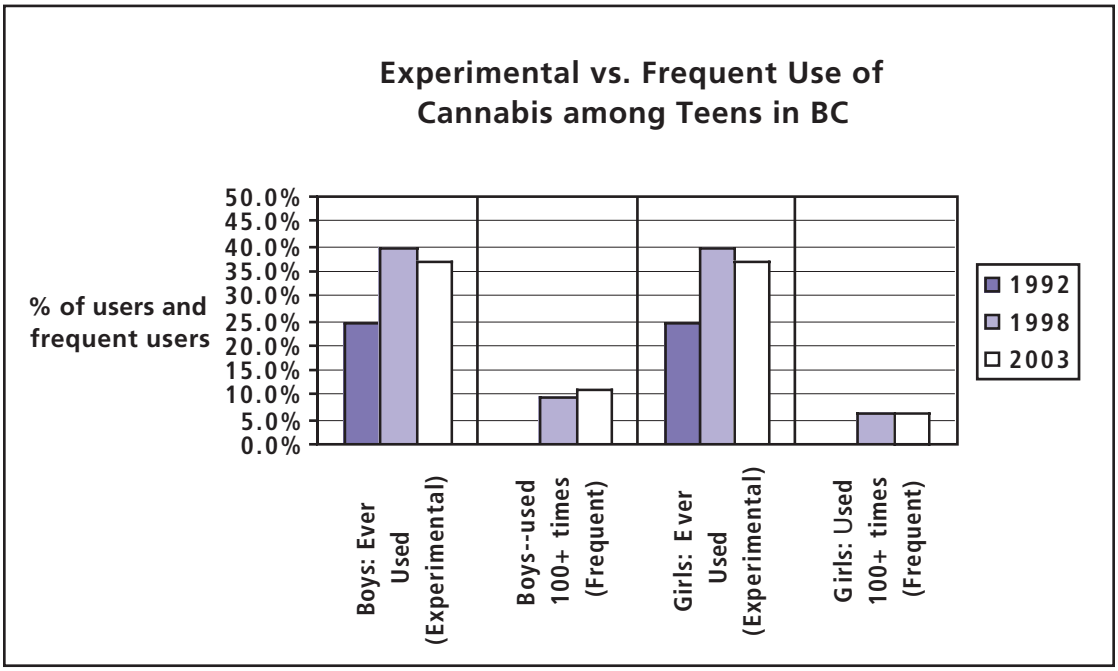
**Lifetime Substance Use Among BC Youth (% who report having tried at least once)**

| | 1993 | 1998 | 2003 |
|---|---|---|---|
| Alcohol | 65 | 63 | 57 |
| Marijuana | 25 | 40 | 37 |
| Mushrooms | n/a | 16 | 13 |
| Hallucinogens | n/a | 11 | 7 |
| Prescription Pills (without doctor's consent) | n/a | 10 | 9 |
| Cocaine | 5 | 7 | 5 |
| Inhalants | n/a | 6 | 4 |
| Amphetamines | n/a | 5 | 4 |
| Heroin | n/a | 2 | 1 |
| Steroids | n/a | 2 | 1 |
| Injected an illegal drug | n/a | 1 | 1 |

Source: McCreary Centre Society, 2004.

The proportion of people who rate their mental health as "excellent" is slightly higher in this age group than among adults. This is primarily due to higher reported rates among males. There are higher rates of reported "depressive episodes" among adolescents than among adults, due to higher rates among adolescent girls.[14]

A number of risk factors have been identified which predispose some people to the development of problematic substance use. These risk factors include: physical, sexual or emotional abuse; growing up with a parent who is mentally ill, suicidal, in prison, addicted, or absent; having a concurrent mental illness; and/or having limited or no social supports or a social group which is typified by substance use.[15,16] People with one or more of these risk factors are less likely to successfully manage their substance use and are, consequently, in need of additional supports and interventions, even during the early stages of their substance use. This is particularly true of people with concurrent disorders or multiple diagnoses, such as substance use disorders, mental illness and/or HIV and hepatitis C. They are more likely to develop problematic substance use and are less likely to benefit from stand-alone addictions services once problems have developed.[17]




Source: McCreary Centre Society, 2004.

## Who is Affected?

BACK TO TOC

Within the general population of adolescents, there are a few subgroups or special aspects of harm that need to be considered:

- The percentage of high school students who use alcohol heavily (who have used alcohol on more than 100 days of their life) — This has remained unchanged between 1998 and 2003 at ten percent, despite reduced levels of overall use among adolescents;[18]
- The percentage of high school students who report frequent marijuana use (more than 100 days of their life) — This has increased since 1998, particularly among boys;[19]
- The use of methamphetamine by youth — A 2001 Vancouver study found that seventy percent of street youth in that city had used crystal methamphetamine at some time in their life;[20]
- The links to violence by and against youth — Substance use can both decrease inhibition for violence, and increase vulnerability to exposure to violence. For example the exposure of girls to alcohol and other drugs used in "date rape" (e.g. GHB [gamma hydroxybutyric acid], Rohypnol [flunitrazepam], Ketamine [ketamine hydrochloride]) can leave them more vulnerable to sexual assault;
- Vulnerability to the physical health impacts of substance use by girls —The physical health impacts, pathways to use and course of problem development differ for adolescent girls.[21]

In a 2004 British Columbia study on people who inject drugs, almost 40 per cent of drug-injecting youth overall and 60 per cent of female drug-injecting youth began injecting at age 16 or younger.[22] Early initiates had distinct risk profiles. This has implications for the target age for injection prevention programs and reinforces the need to consider gender specific vulnerabilities among youth.

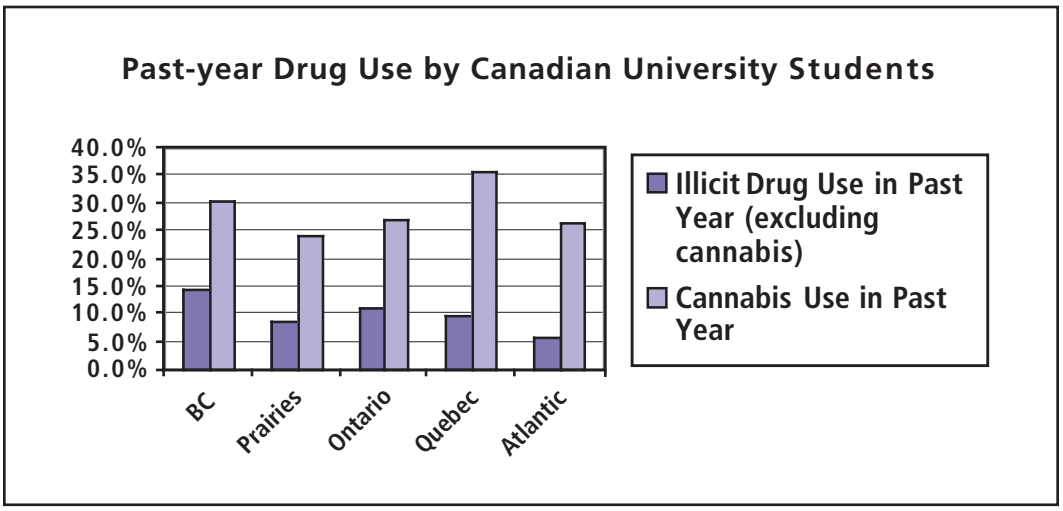
Adolescence represents a critical period for interventions because of high rates of substance use among Canadian youth during this stage of life. This implies a need for a variety of initiatives:

- Prevention initiatives providing adolescents with an opportunity to participate in meaningful and age-appropriate activities that reflect their interests, develop their skills and promote resilience and problem-solving;[23]
- Early intervention and treatment initiatives for people who use heavily and who have risk factors that increase the probability of developing patterns of problematic substance use, including mental illnesses such as depression;

- Harm reduction initiatives directed at injury prevention, health promotion, reducing overdoses and preventing sexual abuse or exploitation of people who use substances;
- Enforcement initiatives to reduce access to substances for minors.

### Young Adulthood (20-30)

During young adulthood, the overall rate of use declines compared to teens.[24] However, a survey of substance use on Canadian campuses found B.C. post-secondary students have among the highest rates of past-year use for both cannabis and other drugs.[25] Data from the United States suggest that twelve to thirteen percent of people who use alcohol, eight percent of people who use marijuana, and fifteen to sixteen percent of people who use cocaine will experience dependency within ten years of initiating use. The development of cocaine dependency occurs more rapidly than dependency on alcohol or marijuana.[26]

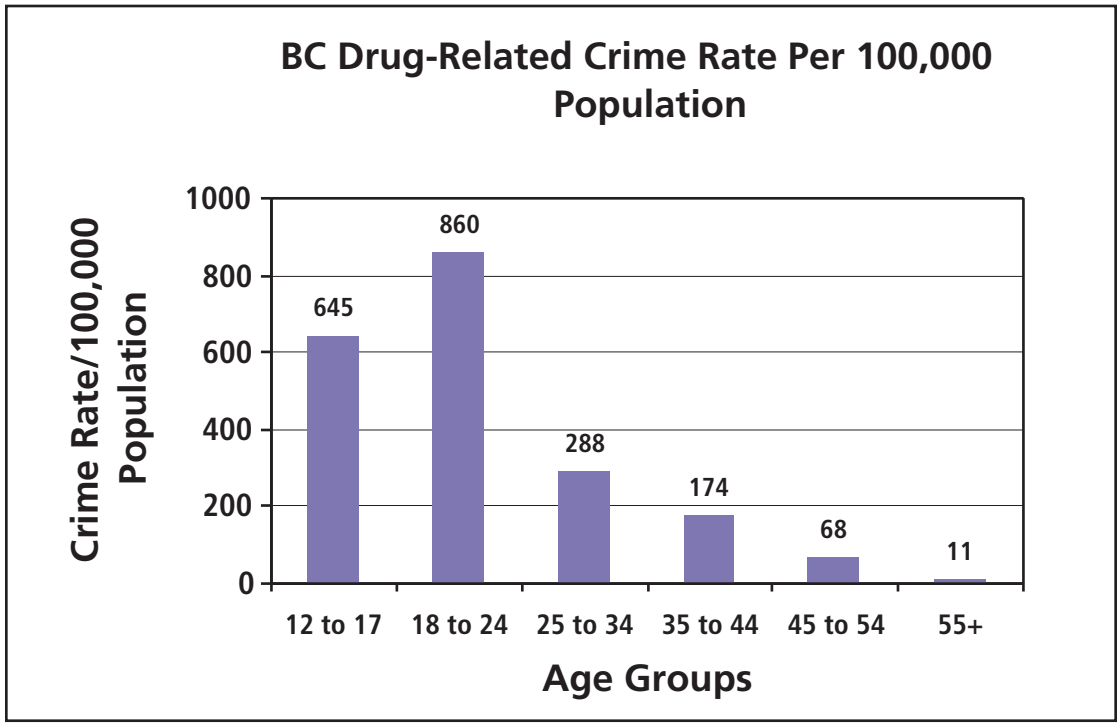



Source: Canadian Campus Survey, 1998.

The rate of drug-related crime peaks among young adults and overdose-related deaths increase slightly.[27]

Alcohol-related disease mortality remains low, relative to older adults. It is during young adulthood that most people establish their careers, begin families and mature out of problematic substance use. However, this is when the potential harms associated with continued substance use can begin to impact on a broader range of roles. Early intervention is critical, prior to the deterioration of family and career roles, because treatment outcomes are enhanced by stability in family life and employment.[28,29] Employee assistance programs, school programs, family counseling programs and family supports play a critical role in maintaining stability in these important areas. Many people will "self-manage" problematic substance use. This process can be facilitated by a variety of interventions, such as self-management training and brief motivational therapies.[30]

A large proportion of young people who use more heavily will not develop patterns of long-term chronic use.[31] The implementation of harm-reduction strategies for this group is of critical importance in supporting their efforts at self-management and mitigating the negative effects of substance use.

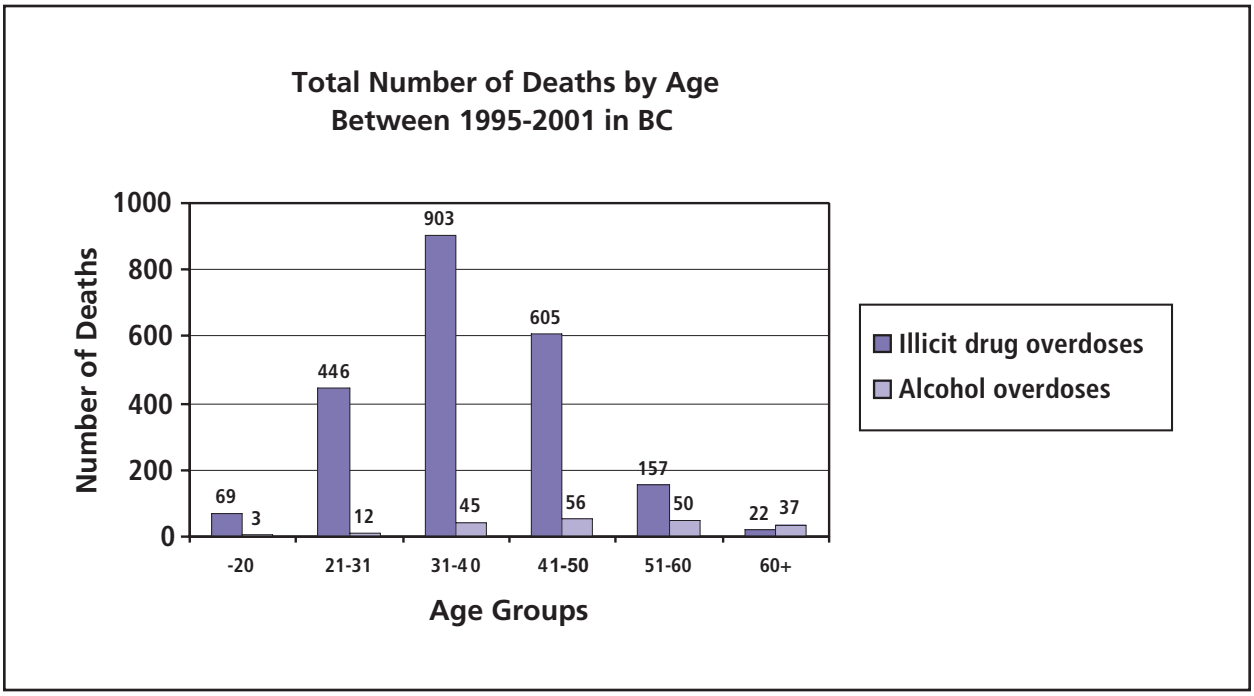



Source: Statistics Canada Uniform Crime Reporting Survey, 2004.

## Adulthood (30-64)

The rate of use of psychoactive substances continues to decline as people move into their thirties and forties, primarily through self-management. Figures from the United States suggest that the average duration of dependent drug use is approximately ten years, with approximately twenty to thirty percent of young adults who use heavily developing chronic long-term problems.[32]

Among the twenty to thirty percent of older adults who develop longer-term problems, significant health effects can begin to emerge. Longer-term substance use can lead to changes in brain functioning which, in turn, can be associated with an increased risk of relapse.[33] There is a high rate of dependence among people who use heavily in this group. Although the rate of drug-related crime falls, mortality from drug and alcohol overdoses peaks among thirty and forty year olds. Mortality from drug-related diseases increases substantially after age forty-five. Health consequences tend to be more severe for women.[34]




Source: BC Coroners Service, 2003.

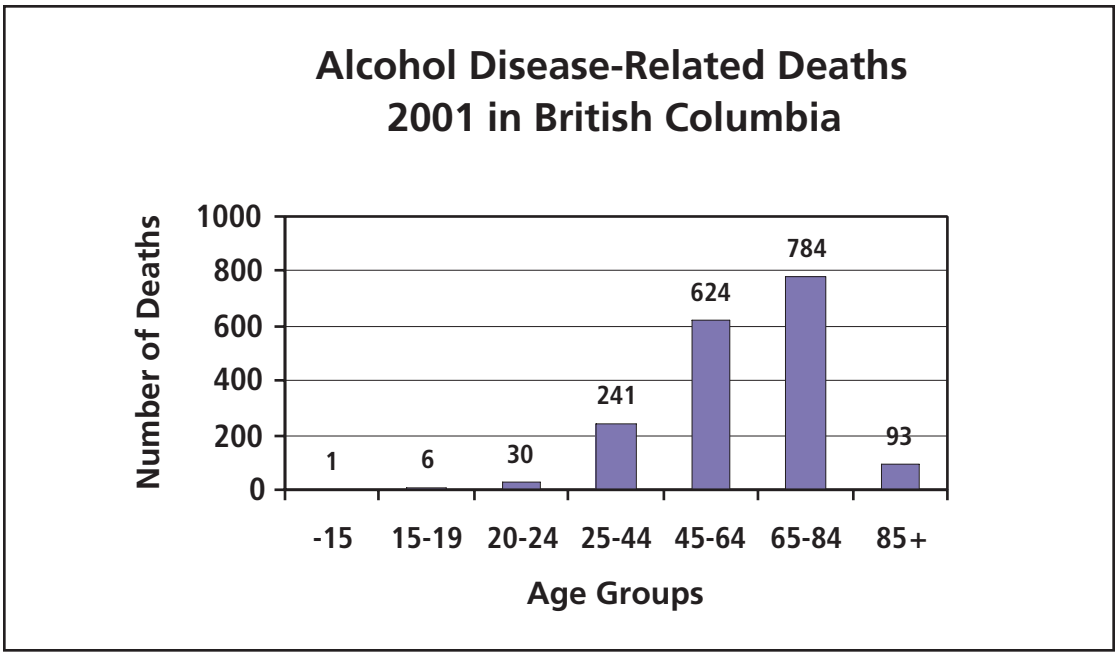
The negative consequences of heavy substance use on careers and family-life begin to compound during this period and the negative effects upon children of people with substance use problems can become pronounced.[35] The prevention of further deterioration in other aspects of their lives continues to be an important contributor to treatment success. Once again, resources such as employee assistance programs, family counseling and various supports for re-integration have a critical role to play.

As the duration of problematic substance use lengthens and the deterioration in other areas of a person's life increases, the probability of achieving successful treatment outcomes decreases. The chronic nature of substance dependency and some of the adverse health effects of chronic use mean that relapses are a normal part of the rehabilitation process. Both relapse prevention and reduction of harms associated with relapse are important components of a comprehensive response strategy. People with untreated concurrent disorders or multiple diagnoses are more likely to continue using and to experience poorer outcomes from stand-alone addictions treatment services. Integrated approaches addressing substance use and mental disorders have proven to be more effective in helping people with concurrent disorders.[36]

Some people will develop substance use problems later in life, often as a result of life-changes and losses associated with aging. Early intervention initiatives, therefore, continue to be important during this stage of life-cycle and highlight the ongoing importance of families, friends and employee assistance programs in supporting individuals who are in the early stages of developing problems related to their substance use.[37]

## Older Adults (65+)

The rate of illegal drug use is very low among seniors. However, alcohol and prescription drug use are prevalent in this population.[38] Among problem drinkers in this age group, approximately two-thirds are long-term drinkers, while one-third develop their problem in later life. Within the elderly group, signs of intoxication can be incorrectly attributed to aging, cognitive impairment or dementia. Problematic use of alcohol earlier in life may result in mental or physical deterioration at this stage: alcohol disease-related deaths peak after age sixty-five.[39]




Source: British Columbia Vital Statistics, 2001.

Mental illnesses, such as depression, increase the risk of problematic use of alcohol or prescription medications. In turn, this can raise the risk of physical injuries such as falls.[40] Medications initiated during hospitalization can also increase the chance of falling in the hospital and after discharge.[41] Elderly women are more likely to be prescribed psychoactive medications such as benzodiazepines.[42] Men consume larger amounts of alcohol but women are at greater risk for dependency on prescription drugs.

Of all age groups, seniors report the greatest average number of weeks "feeling depressed," but the lowest prevalence of major depressive episodes.[43] Age-related changes in the body's ability to metabolize drugs can result in an increased occurrence of adverse drug effects. Family members and care providers play a crucial role in identifying problematic substance use. For those who experience substance use problems, age-specific treatment programs are required to accommodate physical limitations, stressors and supports.

### Gender

The development of problematic substance use and mental disorders through the life-cycle provides a useful framework for planning and implementing community and health system responses. It is important, however, that these responses recognize and incorporate critical differences in sex and gender across the life-cycle. The differential impacts of sex and gender affect the expression and development of problematic substance use and mental disorders and the responses required to address them. Considerable variety exists in the experiences of men and women; therefore, it is important to avoid making simple assumptions about the role of sex and gender in people's lives.

Understanding of sex differences and gender influences on women's substance use has increased over the past fifteen years. The need for women-centred treatment has been highlighted in national initiatives in the U.S. and Canada.[44] In relation to health issues, recent evidence supports gender-based research, policy-making and intervention. Sex, gender and diversity may shape the specific nature of substance use problems across the range of substances, behaviours and mental disorders. Therefore, responses need to be tailored to these differences.[45]

## Who is Affected?

BACK TO TOC

There are a number of sex differences that are related to genetic and biological differences between males and females. There are differences arising from a woman's capacity to reproduce and the pregnancy-related implications of substance use. In addition, women suffer more severe health consequences from drinking, smoking and illegal drug use, including lung damage, brain damage, cardiac problems, liver disease and reproductive health problems. This may be partially because women metabolize alcohol and other psychoactive substances more slowly than men, allowing harmful metabolites to remain in the body longer. For reasons that are not fully understood, girls progress more quickly into problematic substance use than boys, even when using the same amount of substances.

Differences also occur as a result of higher rates of sexual abuse, exploitation and violence against women. The development of problematic substance use and mental disorders can be a result of histories of sexual and physical abuse. Girls are more vulnerable to sexual assault and abuse while under the influence of substances. They are also more likely to be forced into the sex trade and be exposed to associated substance use harms.

Women face unique barriers to accessing treatment. Social stigma, discrimination and fear of losing their children may deter women from seeking help. Barriers arising from lack of child-care and transportation are often more frequent for women. Sexual politics within the treatment environment can undermine treatment effectiveness.

## Concurrent Disorders or Multiple Diagnoses

Concurrent disorders or multiple diagnoses present particular challenges to individuals, families and service planners. The estimated prevalence of concurrent disorders varies; it is likely that between forty and fifty-five percent of people with substance use disorders also have concurrent mental disorders. In some populations, such as women with a history of cocaine or opioid dependence, the rate may be as high as ninety percent. In British Columbia, seventy percent of people who access community addictions services also access community mental health services.[46] People experiencing concurrent disorders or multiple diagnoses are more likely to develop substance dependencies and less likely to benefit from stand-alone addictions services.[47] In addition to mental disorders and substance use disorders, some people may also be living with additional health problems, such as blood-borne pathogens or other chronic diseases.

The prevalence of multiple health problems and concurrent disorders requires an integrated approach to treatment that involves close collaboration among health care providers and with other community partners.

## Aboriginal People

The experience of colonization and residential schools has had devastating consequences for the health and well-being of Aboriginal people. One such consequence is that Aboriginal people experience many health inequities, of which problematic substance use is a prominent example. As a group, Aboriginal people suffer from higher mortality rates due to substance use-related causes, are over represented in the injection drug use population, and are more likely to be regular tobacco smokers.[48,49] In addition, jurisdictional conflicts between federal, provincial and territorial governments have resulted in unequal access to programs for Aboriginal people and a "confusing and unsatisfactory" funding situation.[50]

Aboriginal people living in remote and rural areas may face barriers to accessing appropriate services. Cultural stereotyping and racism are also significant issues for some Aboriginal people. Services and programs that do exist may not be culturally appropriate or effective for Aboriginal people. A recent report on the mental health and well-being of Aboriginal children and youth highlights six opportunities for action:[51]

- Recognize the role that culture plays in determining health;
- Focus on implementing ecological, community-level interventions;
- Promote local leadership and develop high quality training;
- Provide mentoring and support;
- Foster links within and between communities;
- Support ongoing capacity building.

In spite of challenges, Aboriginal practitioners have years of experience in providing addictions services and are leaders when it comes to blending mainstream interventions with cultural traditions and indigenous knowledge to create innovative programs.[52]

## Vulnerable Populations

Although anyone may be affected by substance use problems, the risk of developing problems is influenced by many factors, including social inequities and power relationships. Vulnerability is an essential aspect of why some people are more likely than the general population to suffer negative health or social consequences from substance use. Vulnerable populations may require tailored responses. Individual risk-taking behaviours should be understood in the context of underlying factors that make such actions difficult to change.[53,54] Planning effective responses to problematic substance use among these populations means focusing as much on the larger environmental and societal factors that influence individual risk-taking behaviour as on the behaviour itself.

Lesbian, gay, bisexual and transgendered (LGBT) people require tailored interventions and supports, planned in partnership with these communities. A recent U.S. study of lesbian or bisexual adolescent girls shows a significantly higher rate of cigarette smoking among this group.[55] Likewise, Vancouver data show that young men who have sex with men are nearly twice as likely to smoke tobacco as members of the general B.C. male population of the same age.[56] Data from the U.S. indicate urban men who have sex with men have higher rates of problematic use of alcohol and illegal drugs.[57] People from this group may face challenges in terms of acceptance or marginalization in the form of homophobia. Substance use is perceived by some in the LGBT populations to be a part of their social world,[58] so preventing or getting help for problematic substance use may pose more difficulty. Initiatives need to be developed that build on the culture and communication strengths of LGBT individuals and their communities.

People incarcerated in provincial and federal corrections institutions in B.C. are not isolated from substance use. Incarceration often exacerbates the deterioration of family and career roles, as well as general health. Inmates in correctional facilities are more likely to have substance use disorders than the general population. The sharing of injection equipment in prisons can put inmates at significantly higher risk for contracting infections such as HIV and hepatitis C.[59] Treatment and harm reduction services in prisons for people who use substances and/or have mental disorders are essential components of comprehensive health care delivery. Intervening before individuals become involved with the justice system requires effective prevention and early identification of substance use problems and mental disorders.

# Who is Affected?

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## Summary

The magnitude and complexity of problematic substance use and mental health problems in British Columbia underline the need for planning and integration across sectors. Issues such as mobility and migration also affect British Columbia, which is home or destination to people who travel between countries, provinces and regions. People who have moved for reasons of political, social or economic dislocation may face unique vulnerabilities relating to their past or present situation. Once again, different groups have different needs for services, as "one size does not fit all" in dealing with substance use and mental health problems.

**Tran's** family left Vietnam, where they had experienced a great deal of tragedy and loss. As a teenager in Canada, Tran didn't fit in and began getting involved in risky behaviours – street racing and taking "crystal meth". Following a car accident, he received treatment together with his family and has now made a healthy adjustment and has learned better ways of expressing his emotions.

Provincial consultations demonstrated that different populations can be vulnerable for problematic substance use for different reasons.

Substance use is deeply enmeshed in human culture and behaviour and effective responses must take into account the meanings and contexts of use.[60,61] The scope of problematic substance use in B.C. is significant and requires a proactive response that begins with prevention or stopping problems before they begin. The Framework embraces four concepts that are fundamental to prevention: population health, health promotion, harm reduction, and community capacity-building.

These concepts emphasize that health is more than the absence of disease: it is a state of physical, mental and social well-being. It is a resource for daily living. These concepts demonstrate a broad vision of health that includes the inter-related social, economic, environmental and cultural conditions within which people live.

## Population Health

The population health concept provides the most promising long-term prevention strategy and pathways for effective interventions. The population health approach considers the influence of living and working conditions, social environments, culture and access to health services on health and well-being of groups of people. It recognizes adequate income, employment, housing and social support are as important to keeping people healthy and safe as access to health care.

Population health addresses the influence of social environments and what happens when people experience stigma, discrimination, trauma or cultural dislocation. It acknowledges that some people are disproportionately affected by lack of access to resources in society and that this contributes significantly to poor health status when compared to others.[62]

## Health Promotion

Health promotion recognizes the importance of increasing individual and community control over factors that affect health. It fosters knowledge, skills, attitudinal changes and supports needed to help people engage in safer and healthier lifestyles, and seeks to create conditions that make the healthy choice the easy choice. Health promotion emphasizes societal change and supports an active role for the public in setting priorities, making decisions, planning strategies and implementation. Health promotion involves five inter-related actions: building healthy public policy, creating supportive environments, strengthening community action, developing personal health and coping skills, and re-orienting health services beyond an exclusive focus on treatment.[63]

## Harm Reduction

Harm reduction is secondary or tertiary prevention that seeks to lessen the harms associated with substance use without requiring abstinence. It rests on the assumption that there is a broad spectrum of substance use in our culture, some of which is beneficial or non-problematic. Harm reduction seeks practical solutions to the harms of problematic substance use. This includes providing information and education on substance use and helping people who use substances to address important health concerns such as housing, nutrition or hygiene. Harm reduction acknowledges the ethical imperative of helping keep people as safe and healthy as possible, while respecting autonomy and supporting informed decision-making in the context of active substance use.[64]

## Community Capacity-Building

Communities provide essential support to individuals and families in promoting and maintaining health. Healthy communities foster social inclusion and reduce the impacts of dislocation that may result from cultural or economic changes.[65]

Community capacity building involves the identification of key community assets and the development of networks and partnerships. It can prevent problematic substance use and mental health problems by strengthening individual resilience, empowering organizations, mobilizing social and economic resources, and encouraging shared responsibility and collaboration.

Faith-based organizations, community centres and schools, citizen and cultural associations, business associations, social service agencies, municipal governments and police are a few examples of the types of organizations or community assets that can work together to prevent or reduce problematic substance use and mental disorders.[66]

# Comprehensive CONTINUUM OF SERVICES

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A comprehensive continuum of services is an effective response to problematic substance use and mental disorders. The services include health promotion, prevention, harm reduction, early identification, treatment, long-term rehabilitation and re-integration support (See Tables 1 & 2 in Appendix II). These services are not mutually exclusive and, taken together, form an integrated and evidence-based system of care.

<table>
<tr><th colspan="7">Continuum of Services for<br>Problematic Substance Use and Mental Disorders</th></tr>
<tr><td rowspan="3">Health Promotion</td><td colspan="2">Primary Prevention</td><td>Secondary Prevention/ Harm Reduction</td><td colspan="3">Tertiary Prevention/ Harm Reduction</td></tr>
<tr><td rowspan="2">Universal Prevention</td><td rowspan="2">Selected Prevention</td><td rowspan="2">Indicated Prevention</td><td colspan="3">Treatment, Monitoring & Relapse Prevention</td></tr>
<tr><td>Early Identification & Treatment</td><td>Treatment & Self-Management with Selected Supports</td><td>Intensive Treatment, Long-term Rehabilitation & Support</td></tr>
</table>

## Health Promotion

A public health approach to addressing problematic substance use begins with health promotion. The role of the health system is to advocate for the development of healthy public policies and supportive physical and social environments that will enable people to make healthier choices, thereby preventing or reducing problematic substance use. This also means working with partners from different sectors at the local, provincial and national levels to prevent problematic substance use.

## Prevention

Preventing harmful substance use before problems begin is the most effective way to ensure favorable health outcomes for individuals and communities. Prevention is inextricably linked with overall health promotion aimed at changing the underlying individual, social and environmental determinants of health.[67]

Prevention initiatives strive to: delay age of first substance use, avoid high-risk substance use by children and youth, prevent alcohol and other substance use by pregnant women, and/or prevent problematic use of alcohol or medications by adults and seniors.

**Primary prevention** is prevention of the onset of problematic substance use and includes universal and selective prevention. *Universal prevention* targets whole populations not identified on the basis of individual risk. It aims to strengthen protective factors and minimize risk factors within individuals, families and communities. *Selected prevention* targets people with identifiable risk factors that predispose to problematic substance use, and aims to alter potential susceptibility or reduce exposure.

Examples of universal prevention include:

- School-based prevention strategies, e.g. Tobacco Strategy/Smoking, Health Career & Personal Planning curricula in B.C. schools;
- Media literacy programs to counteract alcohol or tobacco advertising;
- Public awareness initiatives, e.g. warning signs related to tobacco use or alcohol use in pregnancy;
- Culturally responsive community-based approaches to increase awareness and prevention of Fetal Alcohol Spectrum Disorder (FASD) and support early childhood development and families, e.g. Aboriginal Early Childhood Education Initiative, which has 37 initiatives including collaborative FASD Prevention Committees, FASD awareness campaigns and community-based support circles for pregnant and parenting women to support healthy early childhood development of Aboriginal children prenatal to age 6;
- Aboriginal Health Initiatives Program, e.g. Vancouver Island Health Authority's Wachiay Friendship Centre in Campbell River, the Tahltan Nation's Stay Safe — Alcohol/Drug Awareness program in Northern health region.

Examples of selected prevention include:

- Co-ordinated drug strategies developed jointly at the municipal level, e.g. Vancouver Agreement, Victoria's Four Pillar Approach, Kelowna municipal drug strategy, North Shore Substance Abuse Strategy;
- Co-ordinated provincial strategies, e.g. components of the Priorities for Action in Managing the Epidemics: HIV/AIDS in BC 2003 – 2007 strategy;
- Prevention and Treatment working group of Vancouver Coastal Health Authority's Methamphetamine Response Committee;
- Co-ordinated local strategies, e.g. Healthier Babies – Brighter Futures, a Building Block Program in Burns Lake, providing individualized support to high-risk pregnant women and their families. This group has developed partnerships with local liquor vendors providing pregnant women with free non-alcoholic beverages and the local mill providing FASD-awareness events on company time;
- British Columbia Aboriginal Health Centres, e.g. Vancouver Native Health Society, which provides a range of activities related to substance use issues for the Aboriginal population.

**BEST EVIDENCE:**

– *Identify protective factors, as well as risk factors, in primary prevention strategies to promote resilience and better support individuals and families in preventing and reducing problematic substance use.*

– *Focus on factors that most directly promote health or that contribute to substance use problems in the population of interest.*[68]

– *Programs for youth must be realistic and acknowledge that a desire to experiment and take risks is a normal aspect of human development.*[69,70]

– *School-based drug education efforts need to be embedded within broader community initiatives.*[71]

– *Routine screening of pregnant women for alcohol and other substance use.*[72]

**Secondary prevention** includes *early detection and intervention* to identify and reduce substance use problems. It targets people with early signs of problematic substance use. It aims to reduce harms, limit disability, prevent dependency, and promote social inclusion and community functioning.

Secondary prevention includes *indicated prevention*, which targets individuals whose biological or sociological markers indicate a predisposition to problematic substance use but who show minimal signs of substance use problems.

Some examples of secondary prevention initiatives and resources include:

- Programs aimed at health of high-risk populations, e.g. Health Canada, BC Centre for Disease Control and AIDS Vancouver Gayway program which has three campaigns underway to reduce high-risk behaviour in gay men;
- Reproductive health services, such as early intervention and support in pregnancy and prenatal screening to reduce alcohol and other drug use, e.g. Reproductive Care Program at the Children's and Women's Health Centre of British Columbia and St. Paul's Hospital;
- School-based programs for personal development and well-being, e.g. BC Ministry of Education's Personal Planning curriculum and graduation portfolio in BC schools;
- Culturally-sensitive harm reduction training, e.g. Healing Our Spirit with Community Health Associates of BC training for front-line Aboriginal service providers;
- Prevention programs targeted to specific substance use, e.g. Reduce Speed, a video produced by local street youth in Victoria to address crystal methamphetamine use among teenagers;
- Peer education programs, e.g. IslandKidz, a peer education outreach organization for youth at all-night dance parties on Vancouver Island;
- HIV/AIDS prevention and harm reduction programs, e.g. province-wide needle exchange and needle recovery programs, BC Centre for Disease Control pilot project distributing crack pipe mouthpieces;
- Provincial resources dedicated to the prevention of problematic substance use and providing information about substance use, addictions and mental health, e.g. BC Alcohol and Drug Information and Referral Service province-wide toll-free 1-800 telephone line, BC Partners for Mental Health and Addictions Information: Empowerment Through Information.

**Tertiary prevention** lessens the disability resulting from problematic substance use and mental disorders, reduces co-morbidity and restores effective functioning. It aims to reduce further damage or impact of long-term disease and disability to people with substance use disorders. Tertiary prevention minimizes suffering and maximizes life expectancy and quality of life.

The health risks associated with problematic substance use and mental disorders make it critical that service providers provide ongoing, comprehensive assessments and interventions to reduce impact of disease and disability and promote positive health outcomes.

Some examples of tertiary prevention initiatives include:

- Community HIV/AIDS and hepatitis C programs, e.g. member organizations of the Pacific AIDS Network;
- Harm reduction programs, e.g. province-wide needle exchange and needle recovery programs;
- Concurrent disorders programs, e.g. Fir Square Program's Combined Care Unit at Children's and Women's Health Centre of British Columbia which includes maternity care treatment for women and their babies to stabilize or withdraw from substance use;
- Peer education and empowerment for people who use drugs, e.g. Vancouver Area Network of Drug Users, and i2i Peer Support, a web-based harm-reduction support network.

**BEST EVIDENCE:**

- *Peer-based education engages higher-risk populations who may perceive some information sources as lacking credibility.*[73]
- *Materials and messages developed with very specific groups in mind, that avoid fear-arousing messages, and that reflect the hierarchy of risks are most effective.*[74]
- *Testing "ecstasy" pills at dance parties is a low-threshold means of engaging young people in order to provide them with health and safety information.*[75]
- *Needle distribution and exchange have been demonstrated to limit the spread of diseases such as HIV among vulnerable populations of people who inject drugs.*[76]
- *Supervised injection facilities are effective at improving contact with highly marginalized populations and enhancing recruitment into medical care and treatment for substance use disorders.*[77,78,79] *(A pilot supervised injection site is currently operating in Vancouver's Downtown Eastside as part of a scientific investigation to determine the effectiveness of this type of intervention in B.C.)*

## Treatment, Monitoring and Relapse Prevention

Treatment, monitoring and relapse prevention systems of care require programs targeted to *early identification and treatment, treatment and self-management with selected supports, intensive treatment, long-term rehabilitation and supports.*

### Early Identification and Treatment

Early identification and treatment is targeted to individuals showing early signs and symptoms of problematic substance use or those first experiencing a mental disorder. Early treatment, like secondary prevention, is intended to slow progression of substance use disorders and mental disorders, limit disability and promote individual functioning within the family and community.

Early identification and treatment includes the following activities:

- Identification and referral at the onset of problematic substance use;
- Rapid and appropriate response to the referral;
- Significant efforts to develop a long-lasting therapeutic alliance;
- Motivational interviewing with screening for substance use and mental health problems, including brief interventions;
- Prompt initiation of treatments;
- Minimization of negative effects associated with assessment and treatment;
- Relapse prevention service;
- Completion of outcome assessments to assure quality service delivery and refine future services.

Some examples of early identification initiatives and resources include:

- Reproductive health services, such as screening and withdrawal management and support in pregnancy to reduce alcohol and other drug use, e.g. Reproductive Care Program at the Children's and Women's Health Centre of British Columbia and St. Paul's Hospital;
- Early identification and family support, e.g. From Grief to Action's family resource toolkit;
- Early identification initiatives, e.g. province-wide Depression and Anxiety Disorders Screening and Education Day;
- Early identification and treatment programs, e.g. Early Psychosis Intervention (EPI) Program aimed at detecting, diagnosing and treating psychotic symptoms in children and young people;
- School-based early identification and intervention programs, e.g. FRIENDS program, an early intervention and prevention program being piloted with Grades 4 and 5 students in seven school districts, to reduce risk of anxiety disorders in children and youth and to support families;
- Co-ordinated drug strategies developed at the municipal level, e.g. Prevention and Treatment Working Group of the Methamphetamine Response Committee (MARC), Victoria Downtown Service Providers Coalition efforts that resulted in the Sobering and Assessment Centre in Victoria;
- Home/Outpatient Detox, e.g. Vancouver Coastal Health Authority's Home/Outpatient Detox services supporting withdrawal management for youth and adults without interrupting family, employment or school;
- Residential detox/withdrawal management services, e.g. Fraser Health Authority's Maple Cottage Detox Centre, Detox/Assessment Unit in Prince George;
- Outreach programs, e.g. BC Centre for Disease Control Street Nurse program;
- Peer support or mentoring programs.

**BEST EVIDENCE:**

- *Early identification of mental health problems or substance use problems may lead to early treatment and self-management, with a relatively high potential for mitigating future mental disorders or an addiction with a high probability of better outcomes.*[80]
- *Denial, shame, guilt and memory lapses (as may sometimes be the case with seniors) may contribute to under-diagnosis of substance use disorders, therefore assessments must be broad in scope including multiple sources of information.*[81]
- *Services need to attend to the needs of pregnant substance-using girls and those at risk for becoming pregnant, through comprehensive services that include family planning, Fetal Alcohol Spectrum Disorders (FASD) education, and parenting courses.*[82]

## Treatment and Self Management with Selected Supports

People who engage in problematic substance use or who may have substance use disorders and/or mental disorders require access to a continuum of treatment services and information. The range of treatment services needed depends on extent of substance use disorders, stage of recovery, personal circumstances, gender, culture and age.

Treatment includes a range of specialized services, such as withdrawal management (inpatient detox, daytox, home-detox), inpatient and outpatient treatment (individual counselling, family therapy, cognitive behavioural therapy, social skills training), case management, residential treatment, client monitoring and relapse prevention. "Least intrusive treatment" is the first option.

Self-management refers to the central role of the individual in managing his or her own health and health care. This includes development of ability to make informed choices about health and wellness and health services.

Self-management is supported through knowledge and skill development and information about available resources.

Some examples of treatment and self-management supports include:

- Daytox/withdrawal management services, e.g. Richmond's Alcohol and Drug Action Team's DAYTOX Program;
- Opioid replacement therapy, e.g. BC Methadone Maintenance Treatment Program;
- Reproductive health services, including treatment and support during pregnancy and childbirth to reduce alcohol and other drug use, e.g. Reproductive Care Program at the Children's and Women's Health Centre of British Columbia and St. Paul's Hospital;
- Self-management information about mental disorders and addictions, e.g. toolkits developed by BC Partners for Mental Health and Addictions Information;
- Concurrent disorders programs, e.g. Nanaimo Concurrent Disorders Program;
- Case management as part of an integrated treatment plan, e.g. Assertive Community Treatment/Bridging Teams in Vancouver.

**BEST EVIDENCE:**

- *Treatment should be evidence-based, matched to individual and family needs, and include relapse prevention that fosters knowledge, attitudes, skills and abilities necessary for self-management of disorders.*[83]
- *Treatment for youths is most effective within the context of a "system"– of family, peers, community and others (school, counselors and correctional staff). Wherever possible, families should play an important part in treatment. If there is no current stable family, a family of "significant" adults should be created.*[84]
- *Girls have greater need for family and trauma-related services. Transition houses, sexual assault centres and other trauma-related services have found sex-segregated treatment for trauma foundational to healing, and growth of trust in future relationships.*[85]
- *Pharmacotherapy plays an important role in treatment but drugs with an addictive potential must be used with caution and monitored regularly.*[86]
- *Cognitive-behavioural treatment is recommended for concurrent substance use and mood and anxiety disorders, including post-traumatic stress disorder. Special attention is warranted to ensure that gender and diversity experiences (e.g. traumatization) inform treatment choices.*[87]
- *Counseling, training and education related to parenting skills, re-parenting as well as grief counseling must be incorporated in the treatment plan as required.*[88]
- *Seniors are often reluctant to acknowledge a substance use problem or seek help from specialized services. Community-based treatment that is flexible and provided in a broader context of support for health and activities of daily living is more effective.*[89]

### Intensive Treatment

Intensive treatment and long-term rehabilitation reduces disability resulting from substance use disorders, mental disorders and other health conditions. It includes highly specialized services to meet complex needs. These services are effective when integrated and co-ordinated with other health care services.

Examples of intensive treatment include:

- Specialized Residential Treatment and Rehabilitation, e.g. Seven Oaks in Victoria and Iris House in Prince George;
- Residential, intensive day treatment and specialized after-care programs that are gender-specific, e.g. Aurora Centre, Children's and Women's Health Centre of British Columbia that provides residential, day treatment and specialized after-care for women ages 19 and over with substance dependencies;
- Specialized Concurrent disorders programs, e.g. Nanaimo Concurrent Disorders Program;
- Specialized programs for high-needs sub-populations, e.g. Fir Square Program's Combined Care Unit at BC Women's Hospital which includes maternity care and treatment for women and their babies to stabilize or withdraw from substance use.

**BEST EVIDENCE:**

- *Criteria for entry into intensive treatment must be different for males and females. Programs must address different needs for information about reproductive and other health issues associated with puberty, different levels of maturity and potential for self regulation among youth of the same age and the differential impact of substance use on girls' and boys' bodies.*[90]
- *Treatment and support for concurrent disorders must be planned and implemented together, unless there are compelling clinical reasons for focusing on one of the disorders first (e.g. life-threatening factors).*[91]
- *The "Resiliency Model" focuses on positive attributes, builds on strengths and avoids deficit thinking.*[92]
- *Effective case management is critical to meet the unique and multiple needs of people with concurrent disorders.*[93]
- *Psychosocial needs of people with concurrent disorders, particularly co-occurring mental disorder, are significant. Issues such as housing, childcare, nutrition, access to social networks, income support and transportation can seriously disrupt the best intentions of dealing with substance use or other aspects of the co-morbidity.*[94]
- *Residential treatment is warranted and effective for a small number of clients and certain points of the treatment continuum.*[95] *Residential programs that include childcare and parenting support are increasingly effective as a strategy to engage women in treatment and improve treatment retention.*[96] *All treatment must be balanced with the woman's choice of outpatient or residential treatment.*
- *Treatment must address diversity and incorporate cultural and spiritual elements into the overall plan of care (e.g. healing practices of Aboriginal people).*[97]

## Long-Term Rehabilitation and Supports

Long-term rehabilitation and support refers to the restoration of effective functioning and re-integration within the family and community. These services address key determinants of health, are gender and diversity-sensitive, and provide ongoing follow-up and linkages to community-based supports.

Examples of long-term rehabilitation and support include:

- Ongoing treatment and recovery supports, e.g. supported housing that is conducive to recovery from substance use disorders and provides access to social and economic skill-building to assist in productive community re-integration;
- Supportive competitive employment programs, e.g. Canadian Mental Health Association – BC Division's Supportive Competitive Employment Services; Phoenix Society's Empowerment Program for youth;
- Retraining programs, e.g. skill-based training programs and apprenticeships;
- Case management services integrated with treatment and ongoing follow-up.

**BEST EVIDENCE:**

– *A diverse array of community and treatment settings allow people to be supported based on their health and social support needs associated with a particular type or severity of the problem/disorder and ensure flexibility that considers age, gender, culture and community strengths and needs.*[98]

– *Treatment recognizes and accommodates relapses. Relapse prevention and treatment explores triggers to relapse and is essential to support post-treatment after-care and maintain ongoing follow-up contact.*[99]

– *Community asset building is essential and must be included across the mental health and addictions continuum.*[100]

**Annie** at 26, feels her life is getting better for the first time in 10 years. She left home at 16 because of constant fights between her mother and stepfather, both of whom are heavy alcohol drinkers. Annie became addicted to cocaine and heroin and worked the sex trade to pay for the drugs. Now on methadone maintenance, she no longer uses cocaine or heroin and is living life with hope for a better future.

# Collaborative MODEL OF RESPONSE

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The Framework is an integrated model of response for problematic substance use and mental disorders. It is based on five levels of co-ordinated community and health system responses. Each level describes an approach to partnerships, collaboration of sectors, strategies for community mobilization and service specialization. Each level of response contributes to prevention and health promotion, identification, early intervention and referral, treatment and self-management, and long-term rehabilitation and support.

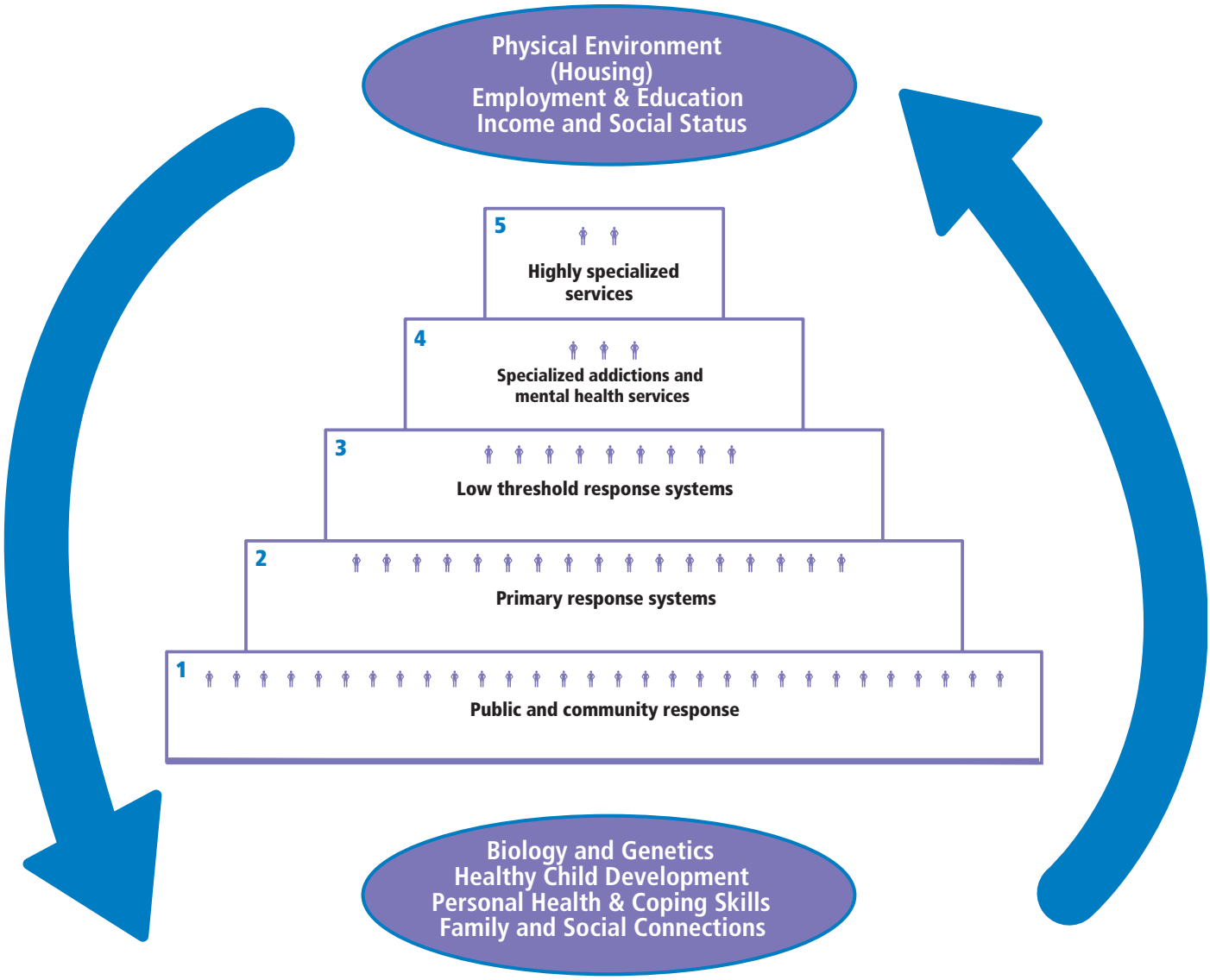
The model addresses substance use disorders and mental disorders as chronic diseases and incorporates elements of British Columbia's Expanded Chronic Care Model. The following components are highlighted within this model:

- Strengthening health determinants
- Supporting healthy public policy
- Creating supportive environments
- Strengthening community action
- Supporting self-management
- Promoting collaborative care and decision supports.

For example, the model supports self-management by ensuring mental health literacy among individuals, families, service providers and the public. Mental health literacy is the ability to gain access to, understand and use information in ways that promote and maintain good mental health. Mental health literacy also refers to the knowledge, beliefs and abilities that promote the recognition and management of problematic substance use and mental disorders.

Within the model, as the level of service specialization increases to meet need, the total number of individuals requiring these services decreases.

# COLLABORATIVE MODEL OF RESPONSE




**1 to 2 – Shared responsibility of health authorities and partners.**
**3 to 5 – Primarily health authority responsibility.**

## Level 1: Public and Community Response

Public and community response is the broadest level of response. It includes resources in a community that affect the prevention or management of problematic substance use on an individual and community basis. On an individual basis, it includes family, friends and co-workers and those who interact with affected individuals who support the individual to access services or resources. On a community basis, it includes initiatives that influence the determinants of health for the local population, such as recreational services, social service agencies and faith communities and services.

*Prevention and health promotion* includes all efforts to increase individual or family resilience, stigma reduction, promotion of healthy alternatives, harm reduction and all efforts to positively affect the determinants of health.

The public and community response contributes significantly to *identification, early intervention and referral* through the dissemination of information about risk factors, "warning signs" and self-management options. A key component of this response is the development of effective crisis interventions that motivate affected individuals to contact resources in the community.

Communities also have a critical role to play in *treatment and self-management and long-term rehabilitation and support*. For example, the mobilization and strengthening of social support for individuals with substance use disorders is an important determinant of treatment outcomes and relapse prevention.

## Level 2 & 3: Primary and Low Threshold Response Systems

The primary and low threshold response includes all sectors, systems, organizations and individuals that have first contact with people who use substances problematically. These "first responders" include families, friends, schools, police, corrections workers, family physicians, public health workers, social workers and community service providers.

First responders have a critical role to play in ensuring that "every door is the right door" for entry into the service system. The systems of care involved in this response play a major role in *prevention and health promotion* through their ability to influence the social determinants of health and promote healthy public policies.

Low threshold services refers to all interventions that are directed at reducing substance-related harm to individuals who may be engaging in problematic substance use but who are not yet ready to engage with the treatment system. Low threshold services help to prevent harms such as infections, blood-borne pathogens and other health problems, and to prevent the adoption of higher-risk substance use and other behaviours.

Primary response and low threshold services are critical to the effectiveness of strategies to enhance *identification, early intervention and referral*. They provide assessment, screening and referral to appropriate services within the treatment system.

This response contributes to *treatment and self-management* by providing critical information and support in self-management to people with substance use disorders and their family members. This response also has an important role to play in *long-term rehabilitation and support* and *re-integration* through the provision of housing services, life skills and occupational training and supportive employment programs.

## Level 4: Specialized Addictions and Mental Health Services

This response includes the components of the formal addictions treatment system and includes withdrawal management, pharmacotherapy, individual counseling, family therapy, residential treatment and case management.

The main contribution of this response to *prevention* is the provision of family support to mitigate the adverse impact on children and family members of people with substance use disorders and/or mental disorders. The contribution of specialized services to *identification*, *early intervention and referral* is to accurately assess and match clients to appropriate services within the treatment system.

This response is primarily involved in *treatment and self-management and long-term rehabilitation and supports*. The latter is achieved through collaborations with community partners to provide access to housing services, life skills and occupational training, and supportive employment programs.

## Level 5: Highly Specialized Services

Highly specialized services are designed to meet the complex needs of people who are not well served by mainstream services. This response targets population groups for whom services and supports are inadequate, inaccessible or mismatched to client needs. For example, this response includes treatment for concurrent disorders or multiple diagnoses, as well as specialized housing and community re-integration supports for offenders.

**Veronica** has had bipolar disorder (manic-depressive illness) throughout her adult life. When depressed, she drank alcohol to block her feelings of sadness, which only worsened her situation. With regular treatment her illness is well stabilized and she is able to avoid problems with drinking. Veronica now works and volunteers in the community.

The Framework provides guidance to key stakeholders in addressing problematic substance use and mental disorders. These stakeholders include individuals and families, communities, health authorities, Ministry of Health Services, Minister of State for Mental Health and Addiction Services and other provincial government ministries. Each stakeholder has different roles in helping to plan and manage an effective response to problematic substance use and mental health problems.

## Individuals and Families

The role of individuals and families is critical in responding effectively to problematic substance use, from prevention through chronic management of problematic substance use. The role of individuals is to develop the knowledge and ability to manage their own health. The individual has a role in working with health care providers and family to establish realistic health plans and give feedback to service providers. The *BC Partners for Mental Health and Addictions Information* assists people experiencing substance use problems and/or mental disorders and their family members by promoting mental health literacy and providing information about local resources. The social support provided by families, friends and peer networks can prevent development of problematic substance use and/or mental disorders and support individuals in self-management. For example, *From Grief to Action* assists family members with information, problem-solving and coping with the challenges associated with problematic substance use.

## Community

There are many organizations and coalitions at the community level whose work impacts and is impacted by people living with problematic substance use and mental disorders. Enabling people and groups at the community level to be active participants in, rather than passive targets of, efforts to address problematic substance use is another component of an effective response.

Community organizations provide critical support by engaging members of groups most vulnerable to problematic substance use, fostering social inclusion, supporting individuals and families, and by providing a vital bridge for knowledge transfer.

In British Columbia, some examples of community and collaborative responses to problematic substance use include the Victoria "Reclaiming Downtown" task group, the Methamphetamine Response Committee in the Lower Mainland, and the Central Okanagan Four Pillars Coalition.

British Columbia has a network of addictions and mental health services, advocacy organizations and coalitions that work to support people with substance use problems and mental disorders. For example, Association of Substance Abuse Programs in BC, Kaiser Foundation, Vancouver Area Network of Drug Users, YouthCo AIDS Society and Canadian Mental Health Association - BC Division.

The justice system plays a vital role in the response to both legal and illegal substance use. Substances such as alcohol and tobacco are regulated commodities. Monitoring and enforcement are essential to ensure compliance with laws related to regulated substance production, marketing, distribution, and use. Illegal substances remain widely available despite supply reduction efforts and they continue to pose challenges for the justice system. The justice system has a special role to play in responding to both regulated and illegal substance issues.

## Health Authorities

Health authorities have a direct role to play in addressing problematic substance use and mental disorders. Health authorities are responsible for planning, delivery and evaluation of prevention and health services. This includes working with regional and local partners in the identification and development of best responses to problematic substance use and mental disorders. Health authorities draw on best available evidence to develop a complete service continuum and accomplish objectives within ongoing resource constraints.

The Provincial Health Services Authority (PHSA), with its province-wide mandate, has a role in service delivery and capacity building efforts that cross regional boundaries. The Fir Square maternity program at Children's and Women's Health Centre of British Columbia, for expectant mothers who use substances, is an example of PHSA's cross-regional or highly specialized services.

## Ministry of Health Services

The Ministry of Health Services has a vital role to play in responding to problematic substance use and mental disorders in the province. The Ministry, in addition to setting broad strategic direction, maintains a planning and monitoring function that enables the government and health authorities to anticipate and respond to emerging trends. In keeping with the Ministry's goal of ensuring accessible, high quality health care, the Ministry helps to ensure there is a consistent level of service quality across regions with no significant service gaps.

Building on concepts developed at the World Health Organization, the Ministry's role can be described as:

- Articulating consistent, ethical and evidence-based policy positions;
- Managing information by assessing trends and comparing performance;
- Setting the agenda for and stimulating research and development;
- Catalyzing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable province-wide capacity;
- Negotiating and sustaining intergovernmental and intersectoral partnerships;
- Setting, validating, monitoring and pursuing the implementation of norms and standards;
- Stimulating the development and testing of new technologies, tools and guidelines for health promotion, harm reduction, health care management, and service delivery.

## Minister of State for Mental Health and Addiction Services

The Minister of State for Mental Health and Addiction Services advocates across government to ensure that mental health and addictions issues are given a greater priority in all provincial ministries. The Minister of State is committed to promoting inclusive participation of individuals, families and professionals in British Columbia's health care system.

Within this broader mandate the Minister of State for Mental Health and Addiction Services has a key role that includes building on work in progress by all partners to:

- develop a more effective system of mental health and addictions services which includes community, primary, secondary and tertiary services;
- improve education, prevention, self-management and treatment of mental health problems and problematic substance use;
- in concert with local governments, develop an integrated mental health and addictions service system.

## Ministry of Children and Family Development

The Ministry of Children and Family Development has a critical role in addressing problem substance use through providing support to children and families. The ministry offers services for child protection and family development, early childhood development, special needs children and youth, adult community living, child and youth mental health, youth justice and youth justice addiction services. Child and Youth Mental Health services provides direct and contracted community-based services to children, youth and their families. Services are often provided through partnership with families and community partners. This ministry plays the lead role in the implementation of the provincial strategy to reduce Fetal Alcohol Spectrum Disorder.[101]

## Provincial Government

Apart from the Ministry of Health Services and the Ministry of Children and Family Development, other provincial ministries have an important role in addressing the broader social and economic issues that underlie problematic substance use and mental disorders. Health determinants influence whether an individual or groups of people will engage in behaviours that place them at risk of problematic substance use. They also influence an individual, family or community's ability to manage and live with problematic substance use and mental disorders. Co-ordinated efforts across government departments to address social health determinants that contribute to vulnerability are essential to an effective response.

There is a critical role for provincial ministries, such as the ministries of Public Safety and Solicitor General and Attorney General in enforcing legislation and increasing awareness about the legal ramifications of problematic substance use. In addition, their policies can significantly impact the health of people with substance use problems and mental disorders.

The ministries of Education, Advanced Education and Skills Development contribute through education, awareness and prevention, retraining and support for re-integration in the community. The ministries of Human Resources and Community, Aboriginal and Women's Services have a key role in supporting individuals and families with income assistance, housing, employment opportunities and community supports.

Solid foundations are needed to sustain an effective response to problematic substance use and mental disorders. These foundations have implications for capacity development at many levels, including service providers, programs and organizations, health systems, health authorities and allied sectors.

## Leadership

Strong leadership is a critical success factor. The key responsibilities of leadership are strategic direction, healthy public policy development, and collaboration with multiple sectors and advocacy.

Strategic leadership is required to:

- articulate and promote a shared vision for responding to problematic substance use and related mental health problems in BC;
- engage and sustain the participation of a wide variety of stakeholders;
- foster relationships and alliances with partners;
- mobilize resources and inspire public support;
- facilitate the development of collaborative responses;
- nourish innovative research and knowledge transfer.

Effective leadership requires the development of a range of skills and competencies that must be fostered and enhanced over time. Concerted efforts are required to recruit and support skilled and respected individuals to assume key positions of responsibility in addressing problematic substance use and mental disorders.

## Partnership Development

Comprehensive and integrated responses to problematic substance use require strong public, private and non-profit partnerships between diverse disciplines, sectors, governments and institutions. Partners may include health, education, social services, child and family development, enforcement and corrections.

Government partners may include municipalities, band councils, regional authorities, and provincial and federal ministries. Institutional partners may include universities, as well as research and policy centres.

Potential service partners include:

- clients and their advocates
- families and peers
- volunteers
- health and allied service providers
- municipalities
- health authorities
- Ministry of Health Services and provincial government ministries/partners
- provincial mental health and addictions agencies
- Centre of Addictions Research of BC (CAR-BC)
- UBC Mental Health Evaluation and Community Consultation Unit
- BC Centre for Excellence in HIV/AIDS
- BC Centre for Excellence in Women's Health.

## Workforce Development

The complexity of problematic substance use, advances in prevention and treatment knowledge, and escalating demand for services present major challenges for workforce development. The integration of mental health and addictions services has created many opportunities and challenges for health authorities and their funded agencies. Chief among these is the harmonization of diverse organizational structures and processes, service philosophies and practices, and work cultures. Ongoing collaborative efforts among academic institutions, professional associations and employers are also needed to ensure an integrated workforce has the knowledge, skills, resources and support to respond effectively to consumer needs.

## System Integration

System integration can minimize the fragmentation that allows people to "fall through the cracks." However, it is important to recognize that the complexity of system integration necessarily means that change is evolutionary and non-linear. It takes time and patience.

Mental health and addictions services in the community have typically worked in isolation and often from competing perspectives.[102] The need to address concurrent disorders and multiple diagnoses is supported by the evidence. The prevalence of co-morbidity is high in the general and treatment-seeking populations and has largely been ignored in planning, implementation and evaluation by both mental health and addictions services. Co-morbidity also changes the course, cost and outcome of care. It presents significant challenges for screening, assessment, treatment and support, and outcome monitoring.

An effective response to concurrent disorders and multiple diagnoses requires a comprehensive, integrated and evidence-based continuum of addictions and health services. These services include health promotion, prevention, harm reduction, early identification, treatment, long-term rehabilitation and relapse prevention, community re-integration and support.

System integration means the development of enduring linkages, between service providers, disciplines, areas within a system, or across multiple systems, to facilitate the provision of service to individuals and families at the local level. Health authorities, for example, use multiple strategies to achieve administrative and clinical integration. Examples of administrative tools include:

- information systems for planning services and monitoring performance;
- program and housing registries to monitor availability;
- referral agreements to formalize program linkages;
- protocols with ministry partners and other sectors at the regional level to clarify roles and communication;
- training to increase skills and promote shared values and vision among providers;
- non-judgmental philosophy with user-friendly information and welcoming environments to increase engagement of individuals and families.

## Research, Evaluation and Knowledge Transfer

Regular, well-conducted research and evaluation is an essential foundation for action. It provides the evidence needed to formulate sound policies and practices, allocate resources efficiently and effectively, and support decision making at all levels to address problematic substance use and mental health problems.

Various types of research and evaluation are required, including:

- epidemiological, demographic and population health studies;
- biological and social science research;
- clinical research;
- peer or community-based research;
- innovative approaches and/or demonstration projects;
- best practices and experiences from within and other jurisdictions;
- program and system level evaluations, including needs assessment, process, outcome, client satisfaction and economic evaluations;
- system-wide performance measurement, including measures of system integration and collaboration.

In British Columbia, there is a growing need to move research findings, surveillance and community information from those who generate it to policy makers and service providers in forms that have direct and immediate application. The effective transfer of knowledge requires the application of research to all stages of planning, practice and policy making. Knowledge transfer also involves making relevant information available and accessible through interactive engagement with key stakeholders and supported by user-friendly materials and a communications strategy. Those engaging in effective knowledge exchange relationships find the interaction mutually beneficial; those with operational responsibilities understand and integrate the information presented while assisting researchers and other knowledge producers in ensuring new efforts are relevant to current circumstances.[103,104]

The following principles and attributes, identified through a provincial consultation process, are critical for an effective system. They express the values and fundamental assumptions that will guide the development and implementation of an effective response to problematic substance use and mental disorders.

## Client-Centred

The term "client-centred" refers to the unique needs, strengths, motivations and goals of individuals. It also recognizes the impact of larger social and economic factors, such as trauma and poverty, on vulnerability to problematic substance use, as well as on the effectiveness of interventions for substance use disorders. Client-centred responses "meet people where they are" by removing barriers to access and respecting individual readiness to change. Given the co-morbidity of substance use disorders and mental disorders, client-centred also means providing an integrated and evidence-based system of mental health and addictions care.

## De-stigmatizing, Respectful and Compassionate

These characteristics address the impact of stigma and discrimination on vulnerability to problematic substance use, as well as on the effectiveness of interventions for substance use problems and mental disorders. System responses and individual services designed to be de-stigmatizing, respectful and compassionate are better able to foster collaboration and reduce the social exclusion of people with problematic substance use and mental disorders.

## Gender and Diversity-Sensitive

Gender and diversity-sensitive responses recognize the differential impact of sex, gender, sexuality and culture on vulnerability to problematic substance use, as well as on the effectiveness of interventions for substance use disorders and mental disorders.

## Health Promoting

Health promoting responses focus on the promotion of optimal physical, mental and spiritual health. These responses combine public health and population-based prevention strategies with treatment and rehabilitation services and supports in addressing problematic substance use. Actions to promote health and resilience, and reduce harms are required within all systems and all levels of response.

## Ethical

Ethical responses to problematic substance use are guided by values of beneficence, justice and autonomy. They ensure health services are conducted in accordance with accepted standards of professional practice. They seek to avoid harms associated with treatment or other interventions. Ethical responses conform to rights and freedoms and are guided by values of social justice and inclusion. They recognize the existence of conflicting interests and seek to address them in a just and fair manner.

## Evidence-based

Evidence-based responses utilize the best available knowledge and evidence from a wide variety of sources and areas of inquiry. These responses actively seek and promote the use of best practices and focus on the achievement of outcomes for individuals, families and communities.

## Balanced Continuum of Responses

A balanced continuum of responses includes health promotion, prevention, harm reduction, early identification and treatment, rehabilitation and support. This continuum involves complementary and mutually reinforcing actions by many groups and sectors in addressing problematic substance use and mental disorders.

## Co-ordinated

Co-ordinated responses to problematic substance use and mental health problems/disorders ensure that "every door is the right door" for entry into a system of care. The various components and partners in the system collaborate to provide multiple points of entry, timely referral to appropriate prevention, treatment and support, including effective transition through the system.

## Cost-Effective

Cost-effective responses recognize the enormous human, social and economic impacts of problematic substance use, addictions and mental disorders and strive to reduce these costs through strategic investment in comprehensive prevention, treatment and support. Cost-effective responses can target those populations at greatest risk for problematic substance use and mental disorders, those who bear the heaviest burden of associated disease, and/or the general population.

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Problematic substance use and mental disorders directly affect hundreds of thousands of British Columbians of all ages. Indirectly, problematic substance use negatively affects families, neighborhoods and communities across the province.

The challenges associated with problematic substance use are complex. A collaborative and co-ordinated response is required to mobilize individuals, organizations and sectors. Both the problems and the solutions are "everybody's business."

Treatment services make an important contribution to this response and there is a growing body of best-practice information that can be used to guide treatment planning to ensure that services increasingly fulfill this important role. The dimensions of the problem, however, are daunting. There will never be enough resources to provide treatment to all people who are struggling with the challenges of problematic substance use and mental disorders.

At the same time, there is mounting evidence that not every person who is affected by these problems requires traditional forms of treatment. The emergence of effective approaches to self-management, as well as increased understanding of how self-management is facilitated through public policy and service design, is one example of many potential solutions waiting to be tested, evaluated and built into practice.

These promising developments in treatment and self-management cannot mask the fact that child and youth health will ultimately depend on the success of efforts to prevent the development of problematic substance use and mental disorders, rather than just upon the ability to treat them. The foundations of an effective response will be comprehensive health promotion and prevention strategies that provide children and adolescents with meaningful and constructive opportunities to develop their interests, abilities and resilience.

The challenges of problematic substance use and mental disorders are profound, but they can be met. A multi-faceted approach that prevents the development of problems among young people, provides treatment to those who will benefit most, and supports self-management and reduces harm, offers the best hope of meeting this challenge. This Framework has been created to facilitate the development of such a response.

# Appendix I

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## ADVISORY COMMITTEE

## Terms of Reference

### Background

The Ministry of Health Services (MOHS) considers problematic substance use to be a health issue, which has varying degrees of biological, psychological, social and spiritual impacts. Mental health and addictions services reform in British Columbia is focused on evidence-based practices and a recovery-oriented model that includes: health promotion, prevention, early identification, treatment, rehabilitation, relapse prevention, and self-management of illness to produce better health outcomes.

On April 1, 2002 Addictions Services were transferred to health authorities. Each health authority received varying types of services and programs that were transferred based on the geographic location of the service in the province. Health authorities therefore, are challenged to create a continuum of services and supports to serve the needs of their residents engaged in problematic substance use and/or with mental health problems, in an evidence-based, integrated, co-ordinated manner.

To ensure a standard continuum of services across the province, this Planning Framework for B.C. has been developed in partnership with academic and research experts in the field of substance use, addictions and mental health; health authorities; front-line experts; clients and families; and other Ministries and community stakeholders.

By providing a comprehensive model that has incorporated evidence and broad-based input, the Planning Framework is intended to help guide the continuing improvement of approaches to problematic substance use, addictions and mental health in B.C. and foster a cohesive and well-co-ordinated set of prevention and treatment services.

The Planning Framework will support health authorities as they:

- assess strengths, challenges and priorities in responding to problematic substance use, addictions and related mental health problems;
- develop integrated health service delivery plans;
- work with partners; and
- monitor progress, evaluate and plan improvements in service delivery.

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### Purpose

The Advisory Committee will provide advice to the Ministry of Health Services in its efforts to develop a Planning Framework to support an evidence-based, comprehensive, integrated addictions and mental health continuum of service in B.C.

### Activities

1. To provide advice related to the provincial consultation process.
2. To review and provide feedback on the Drafts of the Planning Framework.
3. To identify potential issues of concern and challenges related to the development and dissemination of the Planning Framework and recommend ways to resolve these concerns and problem-solve.
4. To raise awareness in BC of the importance of the Planning Framework in guiding future planning, service delivery and research activities.

### Membership

Membership is composed of representatives from academic, clinical, research and policy in the field of mental health and addictions in B.C. and other jurisdictions. The current membership list is on the first page of this publication.

### Chair

The Chair will be responsible for ensuring the Advisory Committee is briefed in a timely manner and facilitate opportunities for the Advisory Committee to complete their mandate.

### Term

February 2003 – September 2004

### Meetings

Meetings will be held as determined by the Chair or committee members. Teleconferencing will be used for the meetings since members come from varying geographic locations. MOHS staff will provide logistical support.

### Accountability and Reporting

The Advisory Committee is accountable to the Executive Directors of Mental Health and Addictions, Planning and Innovation, and Communicable Disease and Addictions Prevention, Population Health and Wellness in the Ministry of Health Services and their respective Assistant Deputy Ministers.

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## CONTINUUM OF SERVICES (TABLES 1 AND 2)

(see next pages)

## Table 1: Continuum of Services for Problematic Substance Use, Substance Use Disorders and Mental Disorders*

| Health Promotion & Primary Prevention | | Secondary Prevention (Early Intervention)<br>Early detection and treatment of disease, interventions targeting those displaying early signs/symptoms of a disorder &/or experiencing first episode - intended to cure disease, slow progression, limit disability & promote community functioning | | Tertiary Prevention<br>Alleviation/limitation of disability resulting from disease, reduction of co-morbidity and rehabilitation/restoration of effective functioning | |
|---|---|---|---|---|---|
| | | Indicated Prevention | Treatment, Monitoring & Relapse Prevention | | |
| **Universal Prevention**<br>Provided to general public or whole population not identified on basis of individual risk | **Selective Prevention**<br>Targeted to individuals or subgroup of population with increased risk of developing a disorder in order to prevent disease by altering the susceptibility or reducing the exposure for susceptible individuals | Targeted to high-risk individuals showing minimal signs and symptoms of a disorder or whose biological markers indicate predisposition | **Identification & Early Treatment** | **Standard Treatment & Self-Management with Selected Supports** | **Intensive Treatment, Long-Term Rehabilitation & Support** |
| BC Partners Mental Health and Addictions Information, e.g. Primer Fact Sheets on Mental Health and Addictions, 1-800 Mental Health and Addictions Information Line | BC Partners Mental Health and Addictions Information, e.g. 1-800 Mental Health and Addictions Information Line | BC Partners Mental Health and Addictions Information, e.g. Mental Health Toolkit, 1-800 Mental Health and Addictions Information line | BC Partners Mental Health and Addictions Information, e.g. Family Resource Toolkit | BC Partners Mental Health and Addictions, e.g. Self-Management Tools on depression, anxiety disorders, and addictions | BC Partners Mental Health and Addictions Information (To be developed) |
| Awareness Weeks/Events on: Mental Health, Mental Illness, Drug Awareness, Eating Disorders, Injury and Disease Prevention, Healthy Child Development, Well Baby, healthy eating, improved nutrition. | Awareness Weeks/Events on: Mental Health, Mental Illness, Drug Awareness and Eating Disorders | Awareness Weeks/Events on: Mental Health, Mental Illness, Drug Awareness and Eating Disorders and Depression and Anxiety Disorder Screening & Education Day | Awareness Weeks/Events on: Mental Health, Mental Illness, Drug Awareness and Eating Disorders and Depression and Anxiety Disorder Screening & Education Day | | |
| | | Primary Care: GP, Psychiatrists | Primary Care: GP, Psychiatrists | Primary Care: GP, Psychiatrists | Primary Care: GP, Psychiatrists |
| Tobacco Strategy/Smoking & Health<br><br>Priorities for Action in Managing the Epidemics HIV /AIDS in BC: 2003-2007 | Directional document: "Addressing Problematic Substance Use in BC" | Reproductive Mental Health & Addictions Services:<br>- Maternal health promotion<br>- Prevention services, early intervention and support in pregnancy and post- partum mental disorder and substance use disorders | HA Community-Based Services<br>- Self Management Supports<br>- Case Assessment, Coordination & Treatment<br>- Early Intervention Services<br>- Outreach Services<br>- Concurrent Disorders Services<br>- Family Education<br>- Peer Support<br>- Sessional Services - GPs & Psychiatrists (MSP) | HA Community-Based Services<br>- Self Management Supports<br>- Case Assessment, Coordination & Treatment<br>- Rehabilitation Services<br>- Outreach Services<br>- Concurrent Disorders Services<br>- Family Education<br>- Family/Caregiver Respite<br>- Peer Support<br>- Sessional Services - GPs & Psychiatrists (MSP) | HA Community-Based Services<br>- Self Management Supports<br>- Case Assessment, Coordination & Treatment<br>- Mental Health Residential Care<br>- Mental Health Family Care Homes<br>- Mental Health Supported Housing<br>- Rehabilitation Services<br>- Outreach Services<br>- Concurrent Disorders Services<br>- Family Education<br>- Family/Caregiver Respite<br>- Peer Support<br>- Sessional Services - GPs & Psychiatrists (MSP) |
| | | HA Addictions Services:<br>- Supervised Injection Site<br>- Needle Exchange | HA Addictions Services:<br>- Home/outpatient Detox<br>- Counseling<br>- Methadone Maintenance Therapy<br>- Needle Exchange | HA Addictions Services:<br>- Home/outpatient Detox<br>- Counseling<br>- Methadone Maintenance Therapy<br>- Needle Exchange<br>- Residential Addictions Treatment Facilities<br>- Supported Recovery Facilities | HA Addictions Services:<br>- Counseling<br>- Methadone Maintenance Therapy |
| | | | Acute Care Services (Secondary and Emergency services) | Acute Care Services (Secondary and Emergency Services) | Tertiary Mental Health and Addiction Services (Riverview devolvement, Children's & Women's Health Centre of BC)<br><br>Forensic Hospital and Community Services |
| | | | Fair Pharmacare, Plans B, C and G | Fair Pharmacare, Plans B, C and G | Fair Pharmacare, Plans B, C and G |
| ← Utilization of Data to Assess Quality and Cost-effectiveness of Services/Outcomes; Support Evidence-based Research and Evaluation → | | | | | |
| ← Public Policy → | | | | | |
| ← **COMMUNITY ASSET BUILDING** → | | | | | |

* This is not an exhaustive list of Mental Health and Addictions Programs.

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## Table 2: Partner Services which Work with the Mental Health and Addictions Sector in Assisting/Supporting Individuals in Achiev ing Self-Determination*

| Health Promotion & Primary Prevention | | Secondary Prevention (Early Intervention)<br>Early detection and treatment of disease, interventions targeting those displaying early signs/symptoms of a disorder &/or experiencing first episode - intended to cure disease, slow progression, limit disability & promote community functioning | | Tertiary Prevention<br>Alleviation/limitation of disability resulting from disease, reduction of co-morbidity and rehabilitation/restoration of effective functioning | |
|---|---|---|---|---|---|
| | | **Indicated Prevention** | **Treatment, Monitoring & Relapse Prevention** | | |
| **Universal Prevention**<br>Provided to general public or whole population not identified on basis of individual risk | **Selective Prevention**<br>Targeted to individuals or subgroup of population with increased risk of developing a disorder in order to prevent disease by altering the susceptibility or reducing the exposure for susceptible individuals | Targeted to high-risk individuals showing minimal signs and symptoms of a disorder or whose biological markers indicate predisposition | **Identification & Early Treatment** | **Standard Treatment & Self-Management with Selected Supports** | **Intensive Treatment, Long-Term Rehabilitation & Support** |
| Chambers of Commerce<br><br>School Boards<br><br>Labour Unions | FASD Prevention (MCFD)<br><br>Developmental Disabilities & Mental Illness (MCFD) | Women's Mental Health (MCAWS, MPSSG):<br>- Prevention services and early identification for women with concurrent illness, substance misuse, victims of violence, etc. | | | |
| Municipalities<br><br>Parks and Recreation Boards<br><br>Brain Injury Associations of BC | Municipal Programs including Safe, Secure and Affordable Public Housing, Recreation & Supporting Diversity | Municipal Programs including Safe, Secure and Affordable Public Housing, Recreation & Supporting Diversity | Municipal Programs including Safe, Secure and Affordable Public Housing, Recreation & Supporting Diversity | | |
| | | Child and Youth Mental Health Case Management (MCFD) | Child and Youth Mental Health Case Management (MCFD) | | |
| | | Addictions Services for Youth in Correctional Setting (MCFD) | Addictions Services for Youth in Correctional Setting (MCFD) | | |
| | | School-Based Education/ Identification Services (MCFD/MOE) | School-Based Education/ Identification Services (MCFD/MOE) | | |
| | | Education<br>- Retraining (MHR/MOE/MAE)<br>- School Retention (MCFD/MOE)<br>- Personal Development & Well-Being (MOE) | Education<br>- Retraining (MHR/MOE/MAE)<br>- School Retention (MCFD/MOE)<br>- Personal Development & Well-Being (MOE) | Education<br>- Retraining (MHR/MOE/MAE/MSDL) | |
| | | | Employment (MHR/HRDC) | Employment (MHR/HRDC) | Employment (MHR/HRDC) |
| | | | Income Support/Employment and Assistance Benefits (MHR) | Income Supports/Employment and Assistance Benefits (MHR) | Income Supports/Employment and Assistance Benefits (MHR) |
| | | | Housing<br>- transition, emergency shelters,<br>- special needs, subsidized (BCHMC/MCAWS) | Housing<br>- transition, emergency shelters,<br>- special needs, subsidized (BCHMC/MCAWS) | Housing<br>- transition, emergency shelters,<br>- special needs, subsidized (BCHMC/MCAWS) |
| | | | Police and Emergency Services (MPSSG) | Police and Emergency Services (MPSSG) | |
| | | | Screening, Needs & Risk Assessment, Early identification for correctional clientele (MPSSG) | | |
| | | | Mental health and addiction services for correctional clientele (MPSSG/Corrections Canada) | Mental health and addiction services for correctional clientele (MPSSG/Corrections Canada) | Mental health and addiction services for correctional clientele (MPSSG/Corrections Canada) |
| | | | Court Ordered Assessments & Alternative Measures Referrals (MAG) | | |

*This is not an exhaustive list of Mental Health and Addictions Programs.
Full form of abbreviations on next page.



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| | |
|---|---|
| MCFD | Ministry of Children and Family Development |
| MCAWS | Ministry of Community, Aboriginal and Women's Services |
| MPSSG | Ministry of Public Safety and Solicitor General |
| MOE | Ministry of Education |
| MHR | Ministry of Human Resources |
| MAE | Ministry of Advanced Education |
| MAG | Ministry of Attorney General |
| MSDL | Ministry of Skills Development and Labour |
| BCHMC | BC Housing Management Commission |
| HRDC | Human Resources Development Canada |

# Appendix III

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## THE ADDICTIONS FIELD – HISTORY AND NEW DEVELOPMENTS

The addictions field has evolved through several phases over the past century. What follows is a brief overview of some of these changes in belief about the basic nature of "addiction" or substance dependence, how to prevent its occurrence and how to intervene once dependence has become established. This discussion describes three historical views of addiction and the growing consensus that is emerging. Addiction has been viewed as an individual moral problem, a medical disease and a behavioural disorder. To varying degrees these views continue to fuel the current debates and each contributes, in its own way, to the emerging consensus. A broader discussion of this material can be found in previous publications by Marlatt and colleagues.[105,106]

Addiction may be the most controversial topic that has been addressed in the public health and medical communities over the years. Dictionary definitions often appear circular: "Addiction: the fact or process of being addicted, especially the condition of taking a drug habitually and being unable to give it up without adverse effects" [The Canadian Oxford Dictionary, 2000]. "Addict" is defined in the same dictionary as "a person addicted to a habit, especially one dependent on a drug". These definitions focus on "habit" as the defining characteristic of addiction, with use of a drug as the prime example. But what is the nature of this "habit"? Among eight definitions of "habit", the Canadian Oxford Dictionary includes the following: "A practice that a person does often and almost without thinking, especially one that is hard to give up." This is probably what most people think of as a "bad habit" and is a major factor underlying the moral model of addiction. Medical specialists, on the other hand, would be more likely to define the habit as a symptom of an underlying addictive disease. Behavioural experts would emphasize that all habits are "acquired" via basic principles of learning and reinforcement and that "strong habits" are the most resistant to change.

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## The Moral Model

What is often called the "moral model" is a belief system based on a dichotomous moral theory. According to this theory, people are individually responsible for their behavioural choices, which may be either good or bad. Those who choose good behaviour should be praised, and those who choose bad behaviour need punishment. Since addiction is a bad habit, it follows that addicts should be punished. Much of the stigma faced by individuals with an addiction problem is based on this underlying moral model that labels anyone with a "bad habit" as a "bad person".[107]

The downside of the moral model has become increasingly clear over the years. Alcohol prohibition (in the United States) failed to eliminate drinking behaviour and increased criminal activity through black market sales of alcohol. A program in British Columbia that required people addicted to heroin to undergo compulsory treatment was considered unsuccessful and was discontinued in the 1970s.[108] The "War on Drugs" has led to the highest incarceration rate in American history with little evidence of reduced illegal drug use as a result.[109,110] People with addictions problems are stigmatized and are often demoralized by feelings of self-blame, shame, and guilt to the extent that they are unwilling or unable to seek help or treatment.

## The Disease Model

In the middle of the 20th Century, a new model began to be formulated, based on alcoholism as the prototype of addiction.[111] In contrast with the moral model that "blamed the victim" for the development of addiction, the new view was that addiction was a disease caused by genetic and biological factors. No longer was the addict held personally responsible for engaging in "bad habits" since the determinants of their habitual behaviour were biogenetic factors beyond their individual control.[112] The disease model was first advanced by academic specialists in the alcoholism field. In more recent years, the concept of alcoholism as a disease has been generalized to other habitual drug use. In the US, the National Institute of Drug Abuse has officially designated addiction as a "disease of the brain". By defining addiction as a physical or biological disease, a strong argument could be made that addicts were patients deserving treatment instead of criminals deserving punishment.

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The 12-step recovery movement and the accompanying treatment system in North America, endorsed the disease model. Officially, addiction was a progressive disease for which there was no cure. The disease could only be arrested by a lifelong commitment to total abstinence. Any use of alcohol or other drugs, was regarded as relapse, whether or not it resulted in any harmful consequences.[113]

Despite the wide acceptance and appeal of the traditional disease model (over 90% of US alcohol and drug treatment programs subscribe to it), a number of shortcomings and limitations have emerged. Research has yet to pinpoint the genetic basis of alcoholism or other forms of addiction. Although alcoholism tends to run in families[114,115,116] the relative impact of genetic or biological determinants has yet to be documented. Although pharmacological treatment methods are increasingly available (including antabuse, naltrexone, methadone and nicotine replacement) most are successful only when combined with other forms of behavioural therapy or counselling. Ironically, those who subscribed to the traditional medical model of addictions tended to reject traditional medical interventions. Many programs did not accept any form of pharmacotherapy except for withdrawal management. Within traditional treatment, there was a tendency toward a "one-size-fits-all" approach to recovery, which contributed to high dropout rates. By defining addiction as an incurable progressive disease, the capacity for people to change their addictive behaviour or decide to give up alcohol or drug use on their own is difficult to explain and may discourage self-management efforts.[117]

# Appendix III

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## The Behavioural Model

In recent decades, an alternative model has emerged that challenges the traditional disease model and its "one-size-fits-all" approach to recovery. Drawing on behavioural and social cognitive theory, the behavioural model of addictions is based on the assumption that addictive behaviour has multiple determinants and that individuals vary in risk depending on their unique bio-psycho-social history. Because both habit acquisition and habit change processes are primarily influenced by cognitive and behavioural principles, this approach has come to be known as a cognitive-behavioural (CB) model. A major emphasis in the CB model is placed on the reward consequences of engaging in the addictive behaviour, including the experience of both positive reinforcement (enhanced euphoria associated with the experiential "high") and negative reinforcement (self-medication resulting in tension reduction or relief). This is covered in more depth in *Cognitive Behavior Therapy*.[118]

Recent developments in behavioural economic theory also have been applied to the analysis of addictive behaviour.[119] Presented with a choice between an immediately available, short-term reward and a long-term delayed reward option, consumers will typically opt for the immediate reward even if it is of less value than the delayed alternative. According to experts in behavioural economic theory, the problem of immediate gratification is not unique to the study of addictive behaviour, since it is considered to be a normal decision-making process in the psychology of consumer choice.

By bringing attention back to the consumer, the science of behavioural economics provides a "user-friendly" perspective that has important implications for working with people who have addictive behaviour problems. In the traditional disease model, with its "top down", mandated approach, treatment goals are strictly set by the program provider, with abstinence as the only acceptable option. Behavioural economics shifts the choice of treatment goals back to the consumer, providing a menu of options for selection. Consistent with the CB model, the individual can choose from a variety of goals, ranging from abstinence to reductions in harmful consequences. By placing the choice in the hands of the individual, there is acknowledgement that most addictive behaviours represent a problem in self-management that can be resolved by the individual. Research reveals that many people are capable of changing addictive behaviour on their own initiative (such as quitting smoking on their own), while others benefit from outside support and professional counselling.[120] Self-efficacy is a potent predictor of the successful maintenance of habit change.

The CB model respects client choice and is linked with a client-centred philosophy that attempts to meet the client "where they are at" in the stages of behaviour change. It differs sharply from the traditional disease model, with its emphasis on client confrontation and enforcement of abstinence as the only acceptable goal. Nonetheless, proponents of a narrow cognitive-behavioural approach have tended to focus almost exclusively on individual choices addressed by cognitive-behavioural therapy (CBT). The systemic factors that constrain those choices are acknowledged, but tend not to be addressed. Practitioners of CBT have often rejected the use of medication in treating addictions as strongly as those within the traditional medical model.

## An Emerging Holistic Model

A new consensus seems to be emerging associated with a more holistic approach to health and well-being. It incorporates the strengths of the various models of the past and uses these various insights to effect change. New understandings of chronic disease are significantly altering the approach of modern medicine to a whole range of diseases. Social, economic, cultural and environmental conditions, as well as behavioural choices, impact both psychological status and biological states. In turn, psychological and biological changes influence behavioural patterns. Within the chronic disease management model, active participation by individuals in self-management, treatment and recovery activities is recognized as an essential component of disease management. Motivational techniques, brief intervention, consumer education, cognitive-behavioural therapy and pharmacotherapy co-exist with new approaches, including acupuncture, meditation and stress management. The importance of healthy public policy and changing social norms are also acknowledged. While it is difficult to sort out those responses that are evidence-based from those that are not, what is emerging is a much greater awareness of the competence of individuals to manage their lives when information and supports are available.

This new holistic model is consistent with a public health approach. It recognizes the complex set of determinants that impact addictive behaviour. It also recognizes the complex relationship between addictive behaviour and harmful consequences for both the individual and community. The goal within this public health model is the reduction in problem consequences. The holistic model accepts and works with individual differences in client characteristics in both preventing and responding to problems. These include unique risks associated with gender, age, cultural identity and concurrent mental health problems.

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## CONSULTATION PARTICIPANTS

Province-wide consultation occurred during August and October 2003. The opportunity to participate was available through focus groups, key informant interviews and online. The following groups were invited to participate and ensured broad stakeholder involvement:

- Association of Substance Abuse Programs of BC
- Aurora Centre, Children's and Women's Health Centre of British Columbia
- Child and youth service providers
- Federation of BC Youth In Care Networks
- From Grief to Action
- Northshore Task Force for Substance Abuse
- Richmond Health Services – Community and Family Health, Mental Health and Addictions
- Vancouver Women's Service Provider Network

- Fraser Health Authority
- Interior Health Authority
- Northern Heath Authority
- Vancouver Coastal Health Authority
- Vancouver Island Health Authority
- Provincial Health Services Authority

- Ministry of Advanced Education
- Ministry of Attorney General and Minister Responsible for Treaty Negotiations
- Ministry of Children and Family Development
- Ministry of Community, Aboriginal and Women's Services
- Ministry of Education
- Ministry of Health Services
- Ministry of Human Resources
- Ministry of Public Safety and Solicitor General

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## GLOSSARY

***Addiction***
Addiction is defined as a harmful behavioural preoccupation, generally accompanied by a loss of control, and a continuation of the behaviour despite negative consequences. Addictions may develop around a range of behaviours, including substance use. The World Health Organization stopped using the term "addiction" in 1964 and instead adopted "substance dependence" to describe this clinical condition. See also "Problematic Substance Use" and "Substance use disorders."

***Benzodiazepines***
Benzodiazepines are central nervous system depressants designed to slow down brain functions. Benzodiazepines include drugs such as Valium (Diazepam), Xanax (Alprazolam), Halcion (Triazolam), and Librium (Chlordiazepoxide). People are prescribed benzodiazepines because they can be effective for treating stress, panic attacks and sleeping problems. However, benzodiazepines also trigger the brain's reward system and, therefore, have potential for problematic use and dependence. Many people find they suffer physical and mental withdrawal symptoms if they cut down or stop taking the drugs after prolonged use.

***Cognitive Behavioural Therapy (CBT)***
An evidence-based treatment mode that helps individuals gain insight into their current patterns of thinking and behaviour and learn healthier skills, habits and coping techniques. CBT is flexible and easily individualized. While it is useful in formal treatment settings, CBT is also an effective approach for brief interventions in various contexts. CBT has been associated with motivational interviewing, which attempts to meet the client where they are at and provide empathic support to help the client work through ambivalence and arrive at an action plan of their own choosing. CBT supports the client's sense of self-efficacy (one's confidence in being able to cope successfully and avoid setbacks or relapse) and should inform supports for self-management.

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***Counselling***
An intensive interpersonal process designed to assist people in achieving their goals or function more effectively. Counselling may consist of cognitive-behavioural techniques, which aim to restructure the client's thoughts if the way they are thinking is causing unwanted feelings and behaviours. It may also involve psychotherapy, which is generally a longer-term process concerned with larger changes in more fundamental psychological attributes.

***Crystal Meth***
Methamphetamine is a potent, long-acting synthetic stimulant drug that has been used for both military and medical purposes in the past. It is sometimes known on the street as "speed". In the past decade or so an easily smokable chemical variation known as "crystal" methamphetamine (aka jib, ice, crystal, crank) has become popular in many Asian countries, Hawaii, and the western United States. In the past several years police and medical responders have become concerned about its growing popularity in Canada. Prolonged intense use of crystal meth can lead to adverse physiological and psychological health effects, including in some people, psychotic breaks.

***Harm Reduction***
Harm reduction is a public health philosophy that makes the reduction of potential harm from substance use the highest priority. It supports policies and practices aimed at addressing risky substance use behaviours without requiring abstinence. While recognizing that it is impossible to keep people from engaging in certain risky behaviours while valuing individual autonomy, harm reduction seeks to ensure individuals are fully informed and provided the means to make safer choices. Policies and practices should be measured according to their actual impact in preventing and reducing harm. Success is not reflected primarily through a change in use rates but rather by a change in rates of death, disease, crime, and suffering.

***Health Literacy***
Health literacy is the ability to gain access to, understand and use information to promote and maintain good health.

***Health Promotion***
Health promotion is defined by the World Health Organization as "the process of enabling people to increase control over, and to improve their health." Health promotion activities encourage individuals, families, and communities to make healthy lifestyle choices and to take a more active role in their health.

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***Housing***
An individual's housing situation can significantly influence the impact substance use has on their health. It can also compromise the effectiveness of treatment. To improve their prospects of recovery, clients who do not have stable and supportive home environments (such as those living on the streets, in sub-standard housing or with a substance-dependent or abusive partner) need to be linked with appropriate supports to help them find stable housing.

***Life Skills***
Life skills can be defined as the set of competencies necessary to successfully navigate normal daily life. Many individuals severely impacted by problematic substance use may have limited skills in shopping, cooking, personal care, banking and money management or social interaction. Unless these issues are addressed within a comprehensive system of care, clients will continue to face added stressors and treatment effectiveness will be compromised.

***Low Threshold***
Low threshold services impose very few requirements on those who access the services. In particular, they typically do not require that clients achieve or maintain abstinence. Low threshold services seek to engage individuals who use substances and to reduce substance-related harm to the individual or others. These services often function as "first contact" and are appropriate for individuals who may or may not be willing to consider change.

***Occupational Skills***
Boredom presents a major risk of relapse. Many of those severely impacted by substance use disorders have difficulty productively occupying their time. Occupational skills are needed to address this situation. Substance-dependent individuals may have been out of the workforce for some time or may lack the skills and training required for employment. The focus of occupational skills training should not be limited to employment as this may not be immediately achievable. A broader focus on productive use of time will be beneficial to a wider range of clients and effective in reducing relapse rates.

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***Opioids***
Opioids are the family of substances derived from alkaloids of the opium poppy *(Papaver somniferum)*. These substances are potent analgesics (pain-relievers). Naturally occurring opioids, such as codeine and morphine, are termed "opiates." Examples of synthetic and semi-synthetic opioids include methadone, Demerol (meperidine), Oxycontin (oxycodone), fentanyl and heroin (diacetylmorphine).

***Outreach***
Outreach includes a range of community-based activities that seek to facilitate improvements in health and reduction of drug-related risk or harm for individuals and groups that may not normally access fixed location services. Outreach services usually involve making staff available in locations frequented by people who use substances, rather than expecting them to come to the services. Effective outreach services should help link individuals to other health or social services.

***Pharmacotherapy***
Pharmacotherapy refers to interventions that treat health problems, including substance dependencies, with medications (drugs). Pharmacotherapies are usually used in one of two modes in the treatment of substance use disorders. One is to relieve or manage the symptoms caused by withdrawal from a substance. The other is as a maintenance or replacement therapy. This involves prescribing a controlled dose of the substance that has been used or a substitute drug. The goals of maintenance or replacement therapies are to eliminate or reduce use of a particular substance, especially if it is illegal, or to reduce harm from a particular method of administration, such as injecting.

***Prevention***
Defined as "actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability or, if none of these is feasible, retarding the progress of disease and disability" (World Health Organization). There are three levels: *primary prevention* seeks to help individuals and communities take health-promoting actions to address risks (such as training in effective socialization and decision-making skills and programs to increase attachment to family, school and community)—the goal is to prevent or delay onset of problematic substance use; secondary prevention involves early detection and prompt intervention to prevent the spread and minimize the impact of problematic substance use or dependence (including early detection by school counsellors or home care workers); and tertiary prevention seeks to eliminate or reduce impairment, disability and harm that may result from problematic substance use or dependence (needle exchange is an example).

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***Problematic Substance Use***
Problematic substance use refers to instances or patterns of substance use associated with physical, psychological, economic or social problems or use that constitutes a risk to health, security or well-being of individuals, families or communities. Some forms of problematic substance use involve potentially harmful types of use that may not constitute clinical disorders, such as impaired driving, using a substance while pregnant, binge consumption and routes of administration (i.e. ways of taking a substance into one's body) that increase harm. Problematic substance use also includes "substance use disorders" (i.e. clinical conditions defined by the DSM-IV, including dependence or "addiction"). Problematic substance use is not related to the legal status of the substance used, but to the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm. See also "Addiction," "Substance Use" and "Substance Use Disorders."

***Screening***
Screening refers to examining significant numbers of at-risk individuals to determine level of risk and to provide early detection of emerging problems. Effective screening requires the development of easily-administered tests or techniques and a context in which to administer them efficiently. Several tools have been developed and tested for screening for substance use disorders. Effort must be made to administer these effectively in contexts like primary care, home care or screening days.

***Services***
Services refers to any intervention or response to problematic substance use whether or not it is delivered by professionals, peers, family members, or other community members. Services include proactive responses from different systems, such as prevention and health promotion, various treatment activities, as well as a wide range of support functions and resources.

***Substance Use***
Substance use refers to the use of any substance that is psychoactive (i.e. alters consciousness). Psychoactive substances include alcohol, tobacco, caffeine, illegal drugs, some medications and some kinds of solvents and glues. The use of psychoactive substances is an almost universal human cultural behaviour and has been engaged in since the beginning of human history. Substance use may range from beneficial to problematic, depending on the quantity, frequency, method or context of use. See also "Problematic Substance Use."

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***Substance Use Disorders***
The term "substance use disorders" denotes a subset of problematic substance use behaviours or patterns of use that meet the criteria of a clinical disorder. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (4th Edition), or the DSM-IV, outlines a range of substance-related disorders. See also "Problematic substance use" and "Addiction."

***Treatment***
Treatment includes a range of interventions designed to help people deal with problematic substance use. Treatment assists people to manage the adverse health and social consequences arising from problematic substance use. The goal may be to achieve and maintain abstinence as an effective way to maximize health and well-being or to control one's use or find other means to minimize harm. Treatment usually involves two phases: (1) stabilization or withdrawal management; and (2) rehabilitation and relapse prevention.

***Withdrawal Management***
Refers to a group of treatment interventions with the primary purpose of supporting a person in overcoming physical and/or psychological dependence on a substance (also referred to as detoxification or "detox"). The immediate aims are to alleviate the physical symptoms of withdrawal, to achieve at least a temporary state of abstinence from the substance(s) and to treat any co-morbid physical or psychiatric conditions.

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# Appendix VI

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## Additional Websites

BC Partners for Mental Health and Addictions Information
www.heretohelp.bc.ca

British Columbia Academic Health Council (BCAHC)
www.bcahc.ca

Health, Education and Enforcement in Partnership (HEP)
www.ccsa.ca/HEP/index.htm

National Learning Initiative
www.vsi-isbc.ca/eng/hr/nli.cfm

Voluntary Sector Initiative
www.vsi-isbc.ca

# Appendix VII

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**What are the major strengths of this Framework?**

**Do you have suggestions for improvements?**

**Do you have any other comments?**

**Are you?**

[ ] A person with substance use or mental health problems

[ ] A family member of a person with substance use or mental health problems

[ ] A service provider

[ ] An interested member of the public

Please send your comments to **Mental Health and Addictions, Ministry of Health Services, 6-1, 1515 Blanshard St., Victoria V8W 3C8**


Ministry of Health Services