A Systems Approach to Substance Use Services in Canada

CCSA · CCLAT
Canadian Centre on Substance Abuse
Centre canadien de lutte contre l'alcoolisme et les toxicomanies

Systems Approach Workbook

Integrating Substance Use and Mental Health Systems

JANUARY 2013

Who should read this brief?

- Leaders and decision makers in the substance abuse and mental health services field, such as regional directors and program managers
- Service providers and others working within mental health and substance use systems in the process of or considering integration of services

How does integration fit into the Systems Approach?

- This brief is part of the Systems Approach Workbook, which is intended to assist those using the Systems Approach report as a guiding framework for improving the accessibility, quality and range of services and supports for substance use in Canada.
- In many areas of Canada, calls for integration between mental health and substance use services are driving system change.
- This brief will help you understand why integration is being called for, what the key considerations are, what has worked to date, and how the Systems Approach and Tiered Model can provide guidance.

Canadian Centre on Substance Abuse
75 Albert Street, Suite 500
Ottawa, ON K1P 5E7
tel.: 613-235-4048 | fax: 613-235-8101 | www.ccsa.ca

Production of the Systems Approach Workbook has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

ISBN 978-1-927467-20-6

Executive Summary

Why Is Integration Necessary?

Historically, substance use and mental health systems and services have operated independently. Yet many people who access substance use services also have mental health disorders. Improving client care means ensuring people can easily access and navigate services that meet their needs, whether in substance use, mental health or both. Disconnected systems and services, in contrast, can create barriers and close doors to those seeking help.

At the broader level, the substance use and mental health systems share common goals such as decreasing stigma, improving service quality and accessibility, and focusing on prevention and early intervention. The two systems are often located under the same provincial ministry and frequently operate with similar administrative structures, suggesting efficiencies can be achieved through integration.

What Is Integration?

Integration refers to the degree of linkage or collaboration between substance use and mental health—ranging from cooperation to amalgamation—at both the service and system levels:

- **Service-level integration** can include a single clinician/worker, a program or set of clinical or psychosocial services, shared care, or an integrated network of services in the community.
- **System-level integration** includes structures and processes such as training and credentialing, policy, administration and funding models, all of which ultimately support the service level (Rush & Nadeau, 2011).

What Works in Integration?

There is no single formula for effective integration and collaboration. Different approaches are required for different conditions, services and systems. However, any effective approach to integration will include the following factors:

- Client-centered services;
- Clinical skills; and
- Building on common ground.

How Does the Systems Approach Apply in an Integrated Context?

The Systems Approach provides a framework that is applicable to substance use only as well as to integrated or collaborative substance use and mental health settings. Its principles, guiding concepts and Tiered Model emphasize the importance of a collaborative continuum in which clients are able to access the services and supports that meet their needs, regardless of where they first enter the system or how that system is structured.

Integrating Substance Use and Mental Health Systems

Case Study:

Sherry went to a local mental health clinic she found through an online provincial directory. Her doctor had suggested she might want to seek some counselling along with the anti-depressants she'd been prescribed. At the clinic, her intake assessment indicated that she might also have problems with alcohol use. The mental health clinician told Sherry she would need to address her alcohol use before dealing with her depression, referring her to an outpatient substance use program in the community. Once there, she went through a similar intake assessment and worked on a case plan to stop drinking. After completing the program, she returned to the mental health clinic, completed a new intake assessment and was accepted. While accessing services for her depression, she returned to occasional alcohol use. The mental health clinicians were not aware of and therefore unable to monitor her substance use care plan. Finally, after Sherry showed up for an appointment intoxicated, her mental health clinician referred her to a residential concurrent disorders program. The residential program was offered through the mental health system and was still not able to access Sherry's initial substance use service assessments, reports or case plans.

Sherry's experience illustrates the challenges compartmentalized systems present to people with concurrent disorders, including being passed from one specialized sector to another without a supportive referral process, and a lack of information sharing and service coordination between those sectors.

These challenges are rooted in historic separations between the two sectors, but over the past decade, substance use and mental health systems have been moving toward greater coordination and alignment. As a result, system-level strategies such as the *Systems Approach to Substance Use in Canada* need to be relevant both to the specialized substance use field and to other areas of health care and social services working within an integrated context. This relevance is demonstrated through common goals and concepts such as:

- Providing a comprehensive continuum of services and supports;
- Developing coordinated, accessible systems;
- Decreasing stigma and discrimination;
- Focusing on "upstream" prevention;
- Enhancing early identification and intervention; and
- Building community capacity.

Integration *is the process of bringing together, aligning or intermixing. This brief makes a distinction between integration of system components and service components, and recognizes that there are degrees of integration rather than absolute categories.*

This brief is intended to introduce concepts, models, considerations and promising practices for those making decisions about or involved in mental health and substance use system and service integration. It also illustrates how the Systems Approach framework is applicable to and supportive of integrated contexts.

Historical Factors

The substance use and mental health systems grew out of very different perspectives on treatment and have operated separately for most of the past century, with little shared or integrated care between practitioners in the two fields. Because of the unconnected nature of these systems, services were not well coordinated for people who had both substance use and mental health needs at the same time (i.e., concurrent disorders). Both fields, however, have seen major developments in recent decades.

In the mental health field, reliance on large, long-term facilities shifted toward an emphasis on community care and rehabilitation, supported by improved drug-therapy options with less severe side effects. In the substance use field, illegal drug use and the abuse of prescription drugs emerged rapidly, adding many new challenges beyond the problems of alcohol use. Professionalization in the substance use field increased while provincial and territorial health ministries took on increased funding and service delivery responsibilities. Both mental health and addictions services expanded rapidly in the 1970s and into the 1980s.

Contrasting Historical Features	
Substance use	**Mental health**
Psychosocial and self-help models	Medical model
Community support base	Institutional treatment base
Counsellors who are in recovery	Professionally trained staff
Abstinence from all psychoactive substances	Use of drug therapy

Attention to rising costs and concern about sustainability became a prominent part of the healthcare context early in the 1990s. Major restructuring began to occur within Canada's healthcare systems. In many jurisdictions, independent health agencies, hospital boards and some government-run regional services consolidated under regional health boards. These authorities were set up to operate at arm's length from government and became responsible for most of the publicly funded health services in many communities. In many parts of Canada, mental health and addictions services were swept along as part of this structural change.

By the late 1990s, a stronger focus on concurrent disorders was developing. Reasons for this included

- The increasing complexity of clients entering the mental health and substance use systems;
- Increasing skill and capacity in both fields to manage this complexity;
- Greater recognition of the negative impact of concurrent disorders on treatment and support outcomes; and
- Greater proximity of the two fields within common administrative structures.

This focus has continued as a familiar theme in Canada ever since, supported by a developing best practice literature that includes a summary report published by Health Canada in 2002. However, practice has not kept pace with knowledge in this area; Canada's mental health and addiction systems remain largely independent and compartmentalized (Canadian Centre on Substance Abuse, 2009).

The Complexity of Concurrent Disorders[1]

"In general terms, the concurrent disorders population refers to those people who are experiencing a combination of mental/emotional/ psychiatric problems with the abuse of alcohol and/or other psychoactive drugs."
(Health Canada, 2002, p. v)

A number of facts and issues need to be kept in mind if concurrent disorders are the primary rationale for collaboration and integration:

- Clients with concurrent disorders have complex needs and are challenging to treat effectively, even in an integrated setting (Canadian Centre on Substance Abuse, 2009).
- Although our existing systems are complex, they do have many features that serve clients well. As coordination is being improved, things that are working need to be preserved and unintended negative consequences need to be avoided.
- There are substantial numbers of clients with mental health conditions on addiction caseloads (70 to 80 percent). The percentage of mental health clients with substance use conditions is much lower (15 to 20 percent), with variation according to the services being considered (Rush & Nadeau, 2011). Understandably, coordination may not seem as important to the larger mental health system where people with concurrent disorders comprise a smaller percentage of the caseload.
- Both systems have diverse client populations with varying treatment needs and rates of co-occurrence. Different approaches to integration are therefore required for different sets of concurrent disorders. *Substance Use in Canada: Concurrent Disorders* (Canadian Centre on Substance Abuse, 2009) examines several categories of mental health and substance use co-occurrence and their implications on system and service planning.
- People with concurrent disorders face greater day-to-day challenges than those who have only one of the two conditions. As such, they are more likely to end up in one of the formal service systems, making concurrent disorders far more common in these systems than in the community-at-large. It is important not to overgeneralize about community traits from within the limits of clinical experience.

Integration Concepts and Models

Integration can mean many things depending on the context in which the term is used (Rush & Nadeau, 2011; Fogg, Nadeau & Furlong, 2008). It is useful to think about integration as having two broad dimensions (see Figure 1 for a way of plotting these dimensions):

1. **Degree of collaboration (i.e., how much):** From minimal cooperation across boundaries to fully amalgamated structures.
2. **Level of application (i.e., where):** From large jurisdictional systems forming associations or making formal arrangements with each other to counsellors coordinating their work with a common client.

[1] See the System Thinking and Complexity in Substance Use Systems report for more information about system complexity.

Figure 1. Dimensions of Integration

			Degree of collaboration (How much is happening)				
			Networking, sharing information	Coordinating, changing services	Cooperating, sharing resources	Collaborating, cross-training	Integrating, merging structure
Level of application (Where it is happening)	SYSTEM	Jurisdictional leaders					
		Senior managers of large systems					
		Regional leaders					
	SERVICE	Program leaders					
		Caseworkers, clinicians, direct service providers					

On the Integration of Mental Health and Substance Use Services and Systems, a report prepared by the Canadian Executive Council on Addictions in 2008, describes substance use and mental health integration issues, models and definitions (Rush, Fogg, Nadeau & Furlong, 2008).

This report suggests that, when thinking about the level of integration within organizations, two general levels can be applied:

- **Services-level integration** can include a single clinician or worker, a program or set of clinical or psychosocial services, or an integrated network of services in the community.
- **Systems-level integration** can include structures and processes such as training, credentialing, policy, administration and funding models, all of which ultimately support the service level (Rush & Nadeau, 2011).

The main reasons for considering degrees of integration or collaboration can be quite different depending on the organizational level. So, too, might the challenges, benefits and implications for each partner and the work they do (Leutz, 1999; Kodner, 2012).

Rationale at the service level

The goal for integration or collaboration at the service level is to improve access, quality of care and health outcomes for clients. Clients often find systems confusing and hard to navigate, which means many do not get their needs met in a timely way. For example, some mental health service admission criteria exclude individuals with a substance use problem and vice versa. In other cases, clients may be directed to substance use and mental health services sequentially, resulting in a "revolving door" between the two systems. In response, much work has been done to improve collaboration within and across program units. The growing recognition of concurrent disorders has helped drive efforts to improve service-level collaboration and integration (Health Canada, 2002).

Rationale at the system level

The goals for integration at the system level include improved client service and administrative efficiency so as to reduce duplication and make more effective use of resources. For example, substance use and mental health systems might have parallel management and administrative structures that can be combined rather than operated independently. Structural changes in health care have been driving this discussion, sometimes reinforced by a desire to raise the priority given to substance use and mental health within the broader health system. The effective integration of substance use and mental health systems is also being looked at in some jurisdictions as a starting point for collaboration and integration with the broader primary care and public health sectors.

National leadership and support for integration

National leadership on enhancing collaboration between the two fields can play an important role in promoting best practices and consistency across jurisdictions. The Canadian Centre on Substance Abuse (CCSA) and the Mental Health Commission of Canada (MHCC) are two leading voices for substance use and mental health policy, public awareness and collaboration. These two agencies have worked collaboratively in recent years, focusing on areas where system and service alignment is needed. For example, CCSA developed a comprehensive report on concurrent disorders in 2009 that summarized current knowledge and identified priorities for improving client outcomes (Canadian Centre on Substance Abuse, 2009). The Canadian Executive Council on Addictions is now working with the MHCC, CCSA and other national leaders and experts to develop a framework to report collaborative practice in Canada.[2] In the United States, the Substance Abuse and Mental Health Services Administration (SAMHSA) was created in 1992 and has coordinated work on mental health and addiction issues from a single national agency.

Integration Issues and Considerations

Various forms of integration and collaboration between mental health and substance use services are occurring in nearly every jurisdiction in Canada. But for some leaders, the emphasis on integration is worrisome because it may not be the best solution for all systems, services and clients. The intended benefits might not be well defined or even probable, and risks might not have been thought through adequately. As this movement continues, there are some important things to keep in mind.[3]

Who, what, why and how?

Organizational change can be complicated,[4] time consuming and even threatening. It is particularly important to think through the intended outcomes, the degree of collaboration being considered and the best approach. The benefits should outweigh the costs and make the effort worthwhile. Improving service access and quality should be the driving force behind the process; integration should not be an end in itself but a means of improving system and service quality (Kodner, 2011).

---

[2] This framework is anticipated in summer 2013. Updates will be provided at www.ccsa.ca.

3 The following subsections derive from the work of Rush, Fogg, Furlong and Nadeau (Rush, Fogg, Nadeau & Furlong, 2008; Rush & Nadeau, 2011).

[4] CCSA has developed the Systems Approach Workbook, an online collection of tools and information to support change management for substance use systems and services.

Possible downsides

In addition to its benefits, integration has a number of possible negative implications:

- An emphasis on either substance use or mental health at the cost of the other;
- A strained work environment because of staff uncertainty about training, competencies and client expectations; and
- Unanticipated costs and delays because of the scope of change.

These issues need to be anticipated and worked into a change-management plan (Canadian Centre on Substance Use, 2012). For each service or process, the pros and cons of various levels of integration or collaboration should be thought through. In the end, some functions or processes might work best if they continue to operate separately. The impact on client services and outcomes should inform decisions about the nature and extent of integration required.

Professional cultures

Because of the different histories of the substance use and mental health service and support systems, the values, skills, training, experience and preferred approaches of professionals are often quite different. In most jurisdictions, the mental health system is several times larger than the substance use system; with integration, there is the potential for substance use systems to lose influence and professional identity. Differences need to be acknowledged and respected so projects looking to enhance collaboration or integration can benefit from diversity without loss of expertise, competition or excessive conflict. As is the case with any blending of cultures, flexibility, openness and respect are key.

The Systems Approach Workbook provides tools for a change-management approach to support changes in professional cultures.

How wide should the integration net be?

Substance use and mental health are not the only types of disorders that can be concurrent. Many people visit their general practitioner or get hospitalized for other health conditions, but have substance use or mental health concerns that play a contributing or aggravating role. Substance use is frequently a factor in criminal behavior (Correctional Service of Canada, 2011), while families engaged in the child welfare system tend to have high rates of mental health and substance use problems (Public Health Agency of Canada, 2010). Addictions and mental health leaders therefore need to look for partnerships that will serve common client groups outside their traditional service settings.

Guiding concepts

The question of integration can also be considered in light of the Systems Approach guiding concepts, as illustrated in Table 1. The examples provided are intended to show that benefits can be achieved at various levels and degrees of integration and collaboration, and are not intended to suggest the one “best” option given that this will vary according to the considerations previously discussed.

Table 1. Systems Approach guiding concepts as a focus for integration

Guiding Concept	Integration Considerations and Examples
No wrong door	What level and degree of integration will ensure that clients are able to access the services they need from any contact point in the substance use, mental health or other health and social systems? *Example: A fully integrated system might have a single intake process or a centralized database and referral system accessible from all services.*
Availability and accessibility	What level and degree of integration will ensure availability and accessibility of services for the full spectrum of substance use and mental health concerns, from distinct to co-occurring? *Example: A coordinated system in which some programs are fully integrated at the service level might be able to offer specific substance use services for those without mental health concerns as well as integrated services for those with concurrent disorders.*
Matching	What level and degree of integration will ensure that clients are matched to services and supports appropriate to their needs, preferences and characteristics? *Example: A collaborative system in which substance use service providers are cross-trained in mental health might be able to offer services that better match the mental health concerns of the majority of clients accessing specialized care.*
Choice and eligibility	What level and degree of integration will ensure that clients are able to make informed choices between services for which they are eligible? *Example: A networked substance use and mental health system could maintain comprehensive information on services and supports that both clients and service providers can consult to inform service options.*
Flexibility	What level and degree of integration will ensure that clients are referred to appropriate places in the system as their needs change? *Example: A coordinated system might offer a single intake process or a streamlined referral and entry process for clients moving from one substance use or mental health service to another.*
Responsiveness	What level and degree of integration will ensure that clients are provided with the support needed to move to lower-intensity or lower-tiered services over time? *Example: A collaborative substance use and mental health system might cross train service providers to ensure they are able to identify the need for and assist clients to move to less or more specialized services as required.*
Collaboration	What level and degree of integration will ensure that clinical, administrative and organizational collaborations facilitate the client's journey through the system? *Example: A collaborative substance use and mental health system might have integrated care protocols at the service level for clients with substance use and mental health concerns.*
Coordination	What level and degree of integration will facilitate information sharing to support clinical practice as well as planning, monitoring and evaluation? *Example: An integrated system could have one centralized database, including client outcome monitoring information, through which clients' progress can be monitored and system efficacy in addressing substance use, mental health and concurrent disorders can be evaluated.*

[5] More information on the Systems Approach guiding concepts is available in *Systems Approach to Substance Use in Canada* and in the *Developing a Continuum of Services and Supports* summary.

What Works

The evidence base for what works in the integration of substance use and mental health systems is still developing. Ongoing evaluation and synthesis of information is important to advance what we know. There will not likely be a single best model. The most appropriate approach in any given system will depend on that system's context, objectives and characteristics (Rush, Fogg, Nadeau & Furlong, 2008; Kates et al., 2011; Kodner, 2012). However, several key factors for effective approaches to integration have emerged from the research to date: a client-centred service emphasis, clinical skills and building on common ground.

Client-centred service emphasis

The Systems Approach emphasizes that when clients need more than one type of care, services and supports should be readily coordinated. Integrated referral processes can ensure supports and services are accessible from any point in any system. Clear and simple service pathways for clients have also been a key goal of integration. Many systems have refined assessment protocols, improved communication between service providers, merged intake functions and co-located some program functions. Many have also introduced case management roles to help clients transition across services and diverse sectors. When these steps are taken, clients often get better service faster and more easily, and there is less chance of them "falling through the cracks." Models for clinical care pathways and shared care are useful tools for identifying existing collaborations and gaps, and for promoting a client-centred approach.

Clinical skills

The historical separation of mental health and substance use care systems has meant that specialized knowledge and skills were difficult to share. Integration initiatives have led to the inclusion of broader competencies in staff recruitment, as well as greater staff enrollment in cross-training activities. As a result, more clinicians now have a basic understanding of the substance use and mental health service systems and client populations. With more professional skills and capacity, strengthened by training and better communication, professional staff can provide more effective service and support to their clients (Skinner, O'Grady, Bartha & Parker, 2004).

Building on common ground

The fields of substance use and mental health have many parallels and common challenges:

- **Relationship with primary care:** Substance use and mental health have similar relationships with primary care, including being conditions with high prevalence in the population that contribute to and aggravate other health concerns; uncertainty among doctors in supporting patients with these conditions; and significant individual and population health, social and economic benefits through effective identification and intervention.
- **The complexity of concurrent disorders:** The substance use and mental health systems face similar challenges in addressing the needs of individuals with concurrent disorders as those outlined above in The Complexity of Concurrent Disorders.

- **Common determinants:** Mental health and substance use disorders are influenced by the way early life stresses and experiences affect brain development and personal capacity. Effective prevention has to start early and must address common risk and protective factors, including social determinants of health (Raphael, 2009).
- **Social impact:** All Canadians are affected by substance use and mental illness, either personally or through a family member, friend or colleague (Health Canada, 2002; Statistics Canada, 2003). When people have either condition or both, other social and economic problems are often aggravated (e.g., unemployment, child neglect, family violence, crime, low education, physical illness). The interacting patterns can become very difficult for clients to resolve and move beyond.
- **Impairment:** With both substance use and mental illness, mental capacity is compromised, which makes responding to typical life challenges and solving problems effectively more difficult.
- **Stigma:** Clients and programs in both substance use and mental health systems experience stigma and discrimination. They feel shame, and frequently experience blame and disrespect from others.
- **Unmet needs:** Because of the effects of stigma and impaired capacity, the majority of people who need professional help never ask for it. The people who know them and care about them often do not know what advice to give or how to help.
- **Economic burden:** The financial cost of both mental health and addictions in Canada is immense—in the tens of billions each year (Rehm et al., 2006; Lim et al., 2008).
- **Family and community:** Family involvement and community support are critical to effectively treat and support both substance use and mental health conditions (CCSA, 2009; Skinner et al., 2004; Rush, Fogg, Nadeau & Furlong, 2008).
- **A muted voice:** The public profile of both conditions is low compared to the other serious issues that compete for public attention and funding (e.g., surgical and diagnostic waiting lists, heart disease, cancer, education, public safety, the economy and jobs, corporate interests).
- **Chronic conditions:** Mental health and substance use conditions can be long lasting for many people, and chronic care approaches and models can improve service and support responses in both systems (Rush, Fogg, Nadeau & Furlong, 2008).
- **Planning frameworks:** Both mental health and substance use have used a continuum-of-care framework to help plan local and regional treatment and support systems. More recently, tiered frameworks are being used to support the planning of more integrated mental health and substance use systems (Rush, 2010).

The National Treatment Indicators report found that in 2009–2010, five to 10 percent of those accessing substance use services did so for someone else's benefit (e.g., a friend or family member).

Illustrating the Tiered Model in Integrated Systems

With the above elements in common in addition to the shared weight of concurrent disorders, a great deal of work on the alignment and integration of mental health and substance use services is occurring in Canada. Several of the models used for integrated, system-level strategies directly reflect the Tiered Model found in the Systems Approach report and other published work (Rush, 2010). The following models used in provincial substance use and mental health strategies illustrate the Tiered Model's applicability within an integrated substance use and mental health approach.

British Columbia. Mental health and substance use services are fully integrated at the provincial level in British Columbia, with the regions in various stages of progress toward greater collaboration and integration. The province undertook an extensive planning process to develop a combined mental health and addiction strategy. The plan, *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia*, uses a four-tiered model to illustrate intervention approaches relative to population size and service intensity (Government of British Columbia, 2010).

Alberta. The Government of Alberta merged its independent mental health and addiction systems in 2009. The integrated approach and strategy developed in Alberta is described in *Creating Connections: Alberta's Addiction and Mental Health Strategy* (Government of Alberta, 2011). The strategy uses a five-tiered model to illustrate system functions and the central role of the client, family and community.

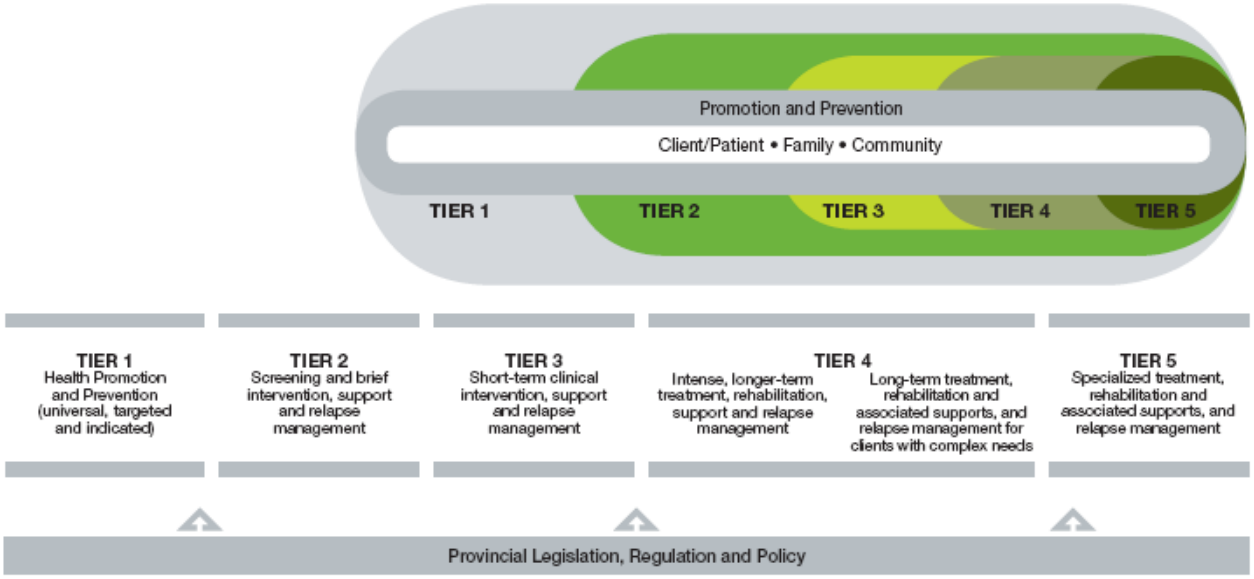
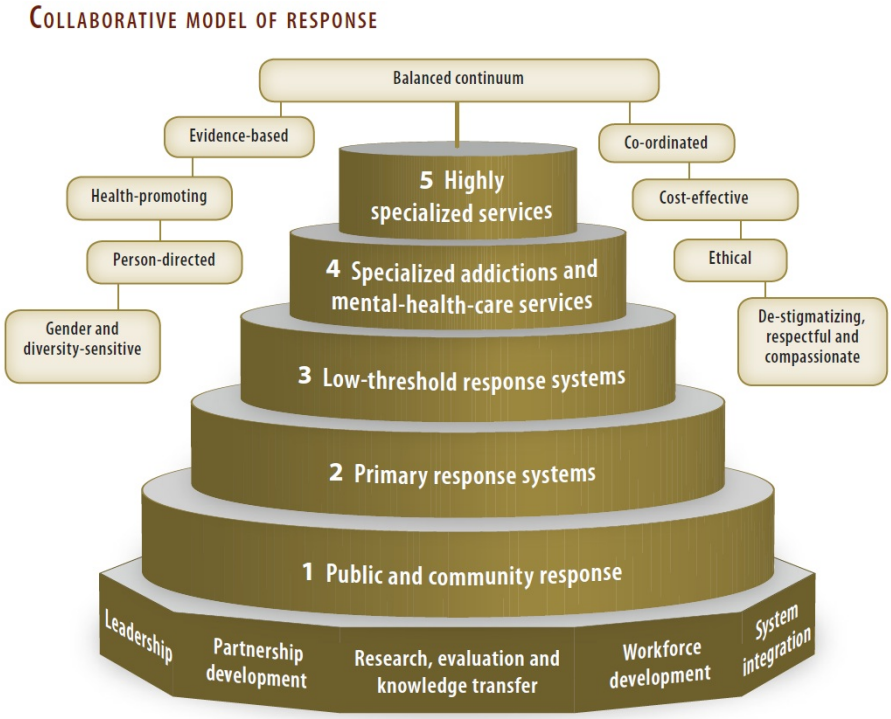


Image reproduced with permission from *Creating Connections: Alberta's Addiction and Mental Health Strategy*, Government of Alberta.

New Brunswick. In 2007, New Brunswick established a mental healthcare task force to transform its mental health system. Based on this task force's report, in May 2011 the province released the *Action Plan for Mental Health in New Brunswick 2011–18*, which uses a tiered model to illustrate a collaborative response across levels of service. Substance use and mental health services are currently distinct in New Brunswick; however, integration is being explored and specialized substance use services are recognized as having a place in the mental health model.



Mental Health Commission of Canada. The MHCC released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* in May 2012. The strategy recommends structuring the mental health system according to tiers representing clusters of services and supports with similar levels of intensity, directly reflecting the Tiered Model recommended in the Systems Approach report.

Conclusion

Sherry's story looks quite different under a fully integrated, comprehensive system. She first accesses a mental health clinic where she is assessed and assigned to a case manager who admits her to a program that will address both her alcohol use and depression concurrently. Once she completes the core program she enters a follow-up phase where risk and resiliency factors for both concerns are regularly assessed. This follow-up identifies that Sherry is demonstrating risk factors for a return to alcohol use, so her case manager refers her to a low-intensity substance use program in the community. Although the program focuses on substance use, the clinicians are cross-trained in mental health and are able to monitor the need for more complex services. Fortunately, the early intervention prevented the further escalation of either substance use or mental health concerns. Sherry's follow-up information is also aggregated and reported at the system level to allow the system to monitor the degree to which substance use and mental health concerns are being identified concurrently. The existing services are also monitored for their ability to meet both the needs of these clients and those without concurrent disorders through existing integrated and distinct programs.

'Finding the right balance of collaboration, alignment and integration between various services and systems in the substance use and mental health field is a complex task. Integration is taking place within broader system developments such as improving clinical skills and strengthening client-centred approaches. There are many factors to think about as well as many good models and successes from which to learn.

This brief has attempted to introduce the main issues related to integration and to identify resources for leaders to consider as they weigh their options. The Systems Approach provides a framework that is applicable to substance use only in addition to integrated substance use and mental health contexts. The principles, guiding concepts and Tiered Model presented in this brief emphasize the importance of a collaborative continuum in which clients are able to access the services and supports that meet their needs, regardless of where they first enter the system or how that system is structured.

More information and tools for developing a Systems Approach to substance use is available at www.nts-snt.ca, including:

- A change management workbook to help you approach change in an informed way;
- Customizable templates for context analysis or implementation planning;
- Case studies from colleagues in the field explaining how the Systems Approach has supported their work; and
- Details on what treatment systems look like at the provincial and territorial level across Canada.

References

Canadian Centre on Substance Use. (2012). *Systems approach workbook*. Retrieved from: http://www.nts-snt.ca.

Canadian Centre on Substance Use. (2009). *Substance use in Canada: Concurrent disorders.* Ottawa: Author. Retrieved from: http://www.ccsa.ca/2010%20CCSA%20Documents/ccsa-011811-2010.pdf.

Correctional Service of Canada. (2011). *Substance use among male offenders (2009)*. Research snippet no. 09-2. Retrieved from: http://publications.gc.ca/collections/collection_2011/scc-csc/PS82-3-9-2-eng.pdf.

Government of Alberta (2011). *Creating connections: Alberta's addiction and mental health strategy*. Retrieved from: http://www.health.alberta.ca/newsroom/pub-mental-health.html.

Government of British Columbia. (2010). *Healthy minds, healthy people: A ten-year plan to address mental health and substance use in British Columbia*. Retrieved from: http://www.health.gov.bc.ca/library/publications/year/2010/healthy_minds_healthy_people.pdf.

Government of New Brunswick. (2011). *Action plan for mental health in New Brunswick, 2011–18.* Fredericton: Author. Retrieved from: http://www.gnb.ca/0055/pdf/2011/7379%20english.pdf.

Government of Nova Scotia. (2012). *Come together: Report and recommendations of the Mental Health and Addictions Strategy Advisory Committee*. Retrieved from: http://www.gov.ns.ca/health/mhs/reports/MHAS_2012_Full.pdf.

Government of Ontario. (2011). *Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy*. Retrieved from: http://www.health.gov.on.ca/english/public/pub/mental/pdf/open_minds_healthy_minds_en.pdf.

Health Canada. (2002). *Best practices: Concurrent mental health and substance use disorders.* Ottawa: Public Works and Government Services Canada. Retrieved from: http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/bp_disorder-mp_concomitants/index-eng.php.

Health Canada. (2002). *A report on mental illness in Canada.* Ottawa: Author. Retrieved from: http://www.phac-aspc.gc.ca/publicat/miic-mmac/pdf/men_ill_e.pdf.

Kates, N., Mazowita, G., Lemire, F., Jayabarathan, A., Bland, R., Selby, P., Isomura, T., Craven, M., Gervais, M., & Audet, D. (2010). *The evolution of collaborative mental health care in Canada: A shared vision for the future*. Position paper: Canadian Psychiatric Association and The College of Family Physicians of Canada. Retrieved from: http://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Collaborative%20mental%20health%20care-2011-49-web-FIN-EN.pdf

Kodner, D.L. (2012, October). *Integrated health care: The what, why, how and how not.* Paper presented at the Health Council of Canada National Symposium on Integrated Health Care, Toronto. Retrieved from: http://www.healthcouncilcanada.ca/tree/symposium2012/P1_IntegratedHealthCare_Kodner_EN.pdf.

Kodner, D.L. (2011, January). *An introduction to integrating health-related systems, services & care: Background, concepts, performance & lessons*. Presentation to the Ontario Community Support Association's Integrated Care University, Toronto. Retrieved from: http://ocsa.on.ca/userfiles/Kodner_Integrated_Care_University_Toronto_January_2011_FINAL.pdf.

Leutz, W.N. (1999). Five laws for integrating medical and social services: Lessons from the United States and the United Kingdom. *The Millbank Quarterly, 77*(1), 77–110.

Lim, K-L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C.S. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Diseases in Canada, 28*(3).

Mental Health Commission of Canada. (2012). *Changing directions, changing lives: The mental health strategy for Canada*. Calgary: Author. Retrieved from: http://strategy.mentalhealthcommission.ca.

National Treatment Strategy Working Group. (2008). *A systems approach to substance use in Canada: Recommendations for a national treatment strategy*. Ottawa: National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.

Public Health Agency of Canada. (2010). *Canadian incidence study of reported child abuse and neglect, 2008: Major findings*. Retrieved from: http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfnts-cis-2008-rprt-eng.pdf.

Raphael, D. (2009). Restructuring society in the service of mental health promotion: Are we willing to address the social determinants of mental health? *International Journal of Mental Health Promotion, 11*(3).

Rehm., J. Baliunas. D., Brochu, S., Fischer, B., Gnam, W., Patra, J. et al. (2006). *The costs of substance use in Canada, 2002: Highlights*. Ottawa: Canadian Centre on Substance Use. Retrieved from: http://www.ccsa.ca/2006 CCSA Documents/ccsa-011332-2006.pdf.

Rush, B. (2010). Tiered frameworks for planning substance use service delivery systems: Origins and key principles. *Nordic Studies on Alcohol and Drugs, 27*, 1–20.

Rush, B., Fogg, B., Nadeau, L., & Furlong, A. (2008) *On the integration of mental health and substance use services and systems: Main report*. Retrieved from: http://www.ccsa.ca/ceca/pdf/Main-reportFINALa.pdf.

Rush, B., Fogg, B., Nadeau, L., & Furlong, A. (2008) *On the integration of mental health and substance use services and systems: Summary report*. Retrieved from: http://www.ccsa.ca/ceca/pdf/Summary-reportFINAL-Dec18-08.pdf.

Rush, B.. & Nadeau, L. (2011). On the integration of mental health and substance use services and systems. In D. Cooper (Ed.), *Responding in mental health-substance use* (pp. 148–175). Oxford, UK: Radcliffe Publishing Ltd.

SAMHSA. (2007). *Service integration overview, paper 6*. Retrieved from: http://store.samhsa.gov/shin/content//SMA07-4294/SMA07-4294.pdf.

SAMHSA. (2007). *Systems integration overview, paper 7*. Retrieved from: http://store.samhsa.gov/shin/content//SMA07-4295/SMA07-4295.pdf.

Skinner, W., O'Grady, C.P., Bartha, C., & Parker, C. (2004). *Concurrent substance use and mental health disorders: An information report*. Toronto: Centre for Addiction and Mental Health. Retrieved from: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/concurrent_disorders/concurrent_substance_use_and_mental_health_disorders_information_report/Pages/concurrent_substance_use_and_mental_health_disorders_information_report.aspx.

Standing Senate Committee on Social Affairs, Science and Technology. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Ottawa: Senate of Canada.

Statistics Canada. (2003). *Canadian Community Health Survey: Mental health and well-being.* Ottawa: Author. Retrieved from: http://www.statcan.gc.ca/pub/82-617-x/index-eng.htm.