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A Systems Approach to Substance Use in Canada

RECOMMENDATIONS FOR A NATIONAL TREATMENT STRATEGY

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We must open doors and
we must see to it they remain open,
so that others can pass through.

—Rosemary Brown (1930–2003),
the first Black woman to be elected to a provincial legislature

CONTENTS

1. EXECUTIVE SUMMARY

The harmful use of alcohol and other drugs and substances is an enormous problem in Canada—a $40 billion-a-year-problem. Yet the attention paid to problematic substance use is inadequate, and the services devoted to addressing the associated risks and harms are inadequately funded and co-ordinated. This National Treatment Strategy provides direction and recommendations to strengthen the services and supports we offer to Canadians with substance use problems, closing the gap between need and response.

The vast majority of Canadians affected by substance use problems do not use specialized addiction services. However, they do access other sectors of the health care system—as well as other systems such as social services, housing and education. A fundamental challenge in responding effectively to all potential clients is in co-ordinating a broad range of services and supports. Research findings suggest that providing appropriate services and supports across a range of systems not only reduces substance use problems but also improves a wide range of outcomes related to health, social functioning and criminal justice. Such a spectrum of services and supports is also a good investment for government, because it returns economic benefits that far outstrip its cost.

No single sector can tackle this challenge: people in need of help depend on primary care, hospital-based care, specialized addiction services, housing and employment supports, and more—in addition to their own personal resources, including families, friends and other carers. Historically, there has been little integration or effective communication within and between the systems and jurisdictions that provide services and supports to people with substance use problems. As a result, people face considerable gaps in service and barriers to accessing the help they need. People who may have significant health problems, at a time of great personal strain, must navigate a complex and ever-changing labyrinth of services and supports.

A key recommendation of this Strategy is the development of a tiered continuum of services and supports to address the broad spectrum of risks and harms conferred by substance use. Such an integrated and holistic system-level model has been articulated in the academic literature and has been implemented in other countries. The adoption of a tiered model in Canadian jurisdictions can improve care, co-ordinate services and make better use of existing investments in supports for people with substance use problems.

The tiers in the proposed model represent different levels of services and supports corresponding to the acuity, chronicity and complexity of risks and harms associated with substance use. Services and supports in the lower tiers are open to all and are intended to meet the needs of greater numbers of people, while those in the upper tiers are designed to meet the needs of smaller numbers of people, and in many cases are specialized for people with more severe substance use problems. This tiered model matches the level and kind of services and supports to the specific nature of a person's substance use problem, as well as promoting efficient use of resources.

The tiered model envisioned in this Strategy must be flexible enough to respond to the particular needs of Canada's diverse jurisdictions and populations. However, the model should be based on common principles in whatever contexts it is applied. Most importantly, people must be able to access the continuum of services and supports at

any tier, and at any time be effectively linked to appropriate services and supports that they need. Such a continuum requires an integrated system in which services and supports are linked, both within and between tiers, and in which different jurisdictions and systems must be able to easily share information to co-ordinate services and supports.

The Strategy supports these system-level improvements with recommendations in four strategic areas: knowledge exchange; developing a research program; measuring and monitoring system performance; and reducing stigma and discrimination.

Knowledge exchange and *research* are critical supports to the tiered model. While existing funding bodies promote relevant, high-quality research on improving responses to substance use problems, there is no co-ordinated national research program focused on problematic substance use or on needed services and supports. Efforts to improve evidence-informed practice can be guided by the knowledge exchange network recommended in this report.

A tiered system of services and supports depends on high-quality programs as well as a health care system that is integrated and functions effectively. *Measuring* and *monitoring* the performance of services and supports, and of the system as a whole, is a significant challenge, given the lack of comparable outcome data. We need stronger information systems to better assess the effectiveness of services and supports, and to show the value of investing in them. There is a particular need for information on services and supports offered in primary care, since the absence of assessments of efforts in the lower tiers is particularly striking.

Finally, a transformation in the way we serve and support Canadians with substance use problems is not possible until *stigma* and *discrimination* are confronted. Stigma (negative attitudes) leads to discrimination (associated negative behaviour), which prevents people from getting the services and supports they need. This Strategy recommends an evidence-based, comprehensive approach to improve public understanding and reduce stigma and discrimination related to substance use.

The recommendations of this report comprise a National Treatment Strategy—a plan of action that recognizes the wide range of jurisdictions that administer services and supports for Canadians with substance use problems. An enormous problem cannot be solved by one champion, one government, one organization or even one sector. We have described the key ingredients to start improving substance use services and supports: comprehensive, integrated care; rigorous system and program evaluation; effective research and knowledge exchange; and improved understanding.

Let the work begin.

2. INTRODUCTION

The development of this Strategy

This National Treatment Strategy is a comprehensive, collaborative report that provides direction and recommendations for improving the quality, accessibility and range of services and supports to address risks and harms associated with substance use.[1]

SCOPE AND LANGUAGE OF THIS REPORT

This report does not address the risks and harms associated with certain types of problematic substance use or addiction: important exclusions are tobacco use, and problem gambling and other process addictions, except insofar as these co-occur with alcohol or other substance use and the related problems. While these are important problems, they are beyond the scope of this document.

There is currently no agreed set of terms with which to discuss the risks and harms associated with the use of alcohol and other drugs and substances, and the responses to address them. Four terms used widely in this report are therefore defined here to ensure clarity, though with the recognition that some of these definitions may not capture all nuances for all people.

Jurisdictions, unless otherwise specified, refers to all federal, provincial and territorial, First Nations, Inuit, Métis and regional authorities who have stewardship over systems that provide services and supports for substance use.

Risks and harms acknowledges that a broad range of potential harms (i.e., risks) and actual harms are associated with substance use (e.g., the risk of fetal alcohol spectrum disorder (FASD) in babies born to pregnant women who drink alcohol, or the harms resulting from acute intoxication or from long-term heavy substance use).

Services and supports is used to convey a broad spectrum of responses—provided by health care, public health, social service, justice or other sectors—to address substance use problems or to reduce the risks and harms associated with these problems. The use of the term is not limited to "treatment," per se.

Substance use problems include problems associated with substance use, of varying acuity, chronicity and complexity, that may be primarily physical; psychological, emotional or behavioural; social; spiritual; familial; or legal. The use of the term is not limited to substance abuse or dependence as defined by diagnostic classification systems such as the *DSM-IV*.

1. See Appendix A for a full list of recommendations and Appendix B for a list of Working Group members.

The Strategy reflects the vision, principles and goals of the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005). In October 2006, at a national thematic workshop on "treatment," five strategic themes were identified for further exploration.[2] A national working group of more than 30 diverse representatives[3] from across the country was formed early in 2007 to explore these themes and develop this Strategy.

Although the working group's mandate ends with the submission of this report, it is proposed that the work that has begun continue through the establishment of a National Treatment Strategy Leadership Team, which will be linked to the leadership and co-ordination of the National Framework for Action. This Team, further outlined in the Leadership and Co-ordination section, should reflect the broad representation and expertise of the working group and will provide guidance and monitoring for the implementation of the Strategy's recommendations.

Case study

Substance use problems may take many forms and have many different effects and outcomes, depending on the person; his or her life experiences, supports and decisions; and the services the person has sought or used. To highlight some of the ways in which people with substance use problems may interact with the services and supports designed to help them, this report will include the illustrative example of a couple—Shawn and Maria—experiencing difficulties with substance use. We will return to their story at various points throughout the report.

Shawn and Maria are in their mid-twenties. Maria immigrated to Canada from Central America with her family when she was a toddler. She now works full time in office administration. Shawn was raised in a single-parent home, and spent his teenage years in and out of both school and various areas of employment while helping to support his mom. He currently works part time while finishing college. Shawn and Maria have been living together for a few years, though Maria's family maintains traditional cultural beliefs about marriage and does not approve.

Shawn has had some problems with alcohol use in the past, but since moving in with Maria has restricted his drinking to one or two beers at a time. Maria doesn't drink, but occasionally uses ecstasy while at parties or clubs with friends.

2. This was one of a series of thematic workshops, each addressing a priority theme identified under the National Framework for Action. The five themes emerging from the thematic workshop on treatment were to articulate the core continuum of care; to implement and share best practices within the specialized addiction treatment system and the broader health system; to identify facilitators, barriers and corresponding knowledge exchange activities for decision makers, funders and policy makers; to develop an integrated national database for services and supports for people with substance use problems; and to take a population-informed approach.

3. The representatives included provinces and territories, relevant federal departments; First Nations and Inuit organizations; non-governmental organizations; academic institutions; substance use agencies and service providers; people who access substance use services and supports; family members; and community members. The working group was co-chaired by two members of the Canadian Executive Council on Addictions (CECA), also representing the Centre for Addiction and Mental Health (CAMH) in Ontario and B.C. Mental Health and Addiction Services (BCMHAS).

Problematic substance use in Canada

The physical and mental health of Canadians, and the communities in which we live, are seriously affected by our use of alcohol and other drugs and substances. Potential harms (i.e., risks) and actual harms associated with substance use are distributed throughout the population and vary in their presentation. Harms include acute injuries that occur when a person is intoxicated, chronic illness resulting from years of heavy substance use, and everything in between. In 2002, the total annual economic costs associated with substance use in Canada were estimated at $39.8 billion, or $1,267 per capita (Rehm et al., 2006).

Because problematic substance use confers such a broad range of risks and harms, no single system or sector can be expected to provide the full range of services and supports required to adequately meet the needs and wants of people with substance use problems, and those of their families, friends and other **carers**.[4] Indeed, in 2002, while specialized treatment services for substance use problems were provided at an estimated cost of $1.2 billion, the cost to the broader health care system alone was estimated at nearly $3.5 billion (Rehm et al., 2006). Other sectors involved in providing services and supports include corrections, housing, social assistance and education.

Research findings suggest that the provision of appropriate interventions across this broad range of sectors—an integrated, system-level response—not only reduces people's substance use problems but also improves a wide range of outcomes related to health, social functioning and criminal justice. Such a range of services and supports is also a good investment for government, in that it returns economic benefits that far outstrip its cost (e.g., McLellan et al., 2000; Raistrick et al., 2006).

Currently, however, there are major challenges in co-ordinating and integrating these many sectors, resulting in significant service gaps for people who need help. The sectors that help Canadians who have substance use problems are also challenged to provide a **population-informed** response—that is, to tailor their services and supports to the different risk factors, varying prevalence and severity, and unique characteristics of substance use problems among specific populations. A further challenge is that Canada's tremendous geographical diversity, and the resulting shortage of even basic health and social services in isolated and remote areas of the country, also affects the availability and accessibility of evidence-informed services and supports for substance use problems. Depending on where they live, people seeking help may receive very different services and supports for the same problems, and in some cases may have difficulty finding any help at all.

Case study (continued)

After high school, Shawn worked in a small northern town, where his drinking caused him some problems. While the local Alcoholics Anonymous meetings were helpful for many of his friends, Shawn wasn't comfortable with the group setting and the focus on abstinence. No other services were available in the area and it was not until Shawn moved back to the city that he was able to access individual outpatient counselling.

4. Terms hightlighted in bold are explained in the glossary on page 36.

In Canada, a population-informed response must include addressing the unique circumstances of **Aboriginal** people (**First Nations**, **Inuit** and **Métis**). The health and social well-being of Aboriginal people has been compromised by multi-generational loss of culture, traditions, language and homeland. The experience of colonialization—compounded by the negative impacts of residential school policies and ongoing racism and discrimination—has also been identified as being strongly linked to the current high rate of substance use problems in many Aboriginal communities. Social risk factors, including poor housing, lack of educational and meaningful employment opportunities, and physical and sexual abuse, are also significant contributing factors. While cultural and spiritual values have been identified as protective factors against substance use problems for Aboriginal people, there are considerable gaps in the availability of culturally informed services and supports across Canada. Jurisdictional and geographical factors also create gaps in eligibility for and accessibility of specialized addiction and mental health services that are delivered by provincial or municipal agencies.

One example of system-level responses to a need for population-informed services is the establishment of the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Native Addiction Partnership Foundation (NNAPF). NNADAP was established in 1982 to support community-run prevention, intervention and aftercare services for First Nations and Inuit communities. These services are primarily staffed and delivered through the communities themselves. In 1996, as the result of a comprehensive review of NNADAP's programs, NNAPF was established. NNAPF's mandate is to promote knowledge of, access to and quality of substance use services and supports for First Nations people and Inuit, and to provide a national voice for First Nations and Inuit substance use services.

Services and supports for substance use problems in Canada: Past and present

Services and supports for Canadians experiencing harms associated with substance use have evolved over many decades against the background of a system in which health care falls under several different types of jurisdiction, which vary widely in their structure, organization, accountability, accessibility, ideology and sources of funding. Generally, health and social service sectors such as **primary care**, public health and social services, along with the **specialized addiction treatment system**, provide services under regional jurisdiction through provincial and territorial funding. Services for specific populations, such as on-reserve First Nations people, the military and federal offenders, fall under federal jurisdiction. Individual jurisdictions have developed their own systems of services and supports, with little emphasis on consistency and co-ordination within or between jurisdictions. The result has been fragmentation and inconsistency, rather than the integrated systems of services and supports proposed in this Strategy.

Another historical gap—one that persists today—is that while the diversity of substances of use has been acknowledged, too little attention has been paid to the diversity of people seeking help for substance use problems (e.g., differences in gender, age, ethnocultural background, sexual orientation), despite evidence supporting a tailored, population-informed approach.

Since the 1980s, increasing appreciation of the broad, biopsychosocial causes of substance use problems has resulted in wide advocacy for an integrated, systems approach to planning and delivering services and supports for substance

Case study (continued)

Access to helpful information and safe discussions about substance use, including its sex-specific impact, are often not made available to young women such as Maria who may use illegal or prescription drugs. Without the opportunity to discuss substance use, their experimental use may become problematic in many dimensions: physical health, emotional health, relationships, employment and involvement with the legal system.

use problems, an approach that identifies and addresses problems before they become more pronounced (though movement toward such an approach has been limited). This approach acknowledges the risks—not just the harms—associated with substance use, and leads naturally to the incorporation of health promotion and prevention, primary care, emergency care, hospital-based care, housing and employment services, educational institutions, correctional and other justice-related services, family and social services, and prenatal services. Today there is a stronger need than ever for an integrated approach, incorporating a co-ordinated continuum of services and supports, to which people's unique needs and strengths are matched by means of careful assessment.

In recent years, the following trends have come to the fore, the responses to which have varied both within and between jurisdictions:

- regionalization and increased accountability of health care systems
- increasing **population-specific** needs corresponding in part to the increasing diversity of the general population (e.g., health literacy targeted to specific linguistic or cultural groups)
- increasing awareness of different levels of harm among various population groups (e.g., higher-than-average rates of substance use–related harm among Aboriginal people)
- changing patterns of substance use in many regions (e.g., use of prescription and non-prescription opioids, inhalants and methamphetamine)
- increasing complexity of problems, including high rates of co-occurring mental health problems (e.g., depression, posttraumatic symptoms) and physical health problems (e.g., hepatitis C and B, HIV/AIDS)
- decreasing social supports among people seeking help (e.g., limited housing, employment)
- the increasing prominence of **harm reduction** approaches.

These trends, and the varying responses to them, have further highlighted the shortcomings of a fragmented system, and have added to the need to address substance use problems by better integrating systems of services and supports.

A number of parallel initiatives are attempting to provide leadership and direction to the planning and provision of services and supports for people with substance use problems, and this National Treatment Strategy will benefit from co-ordinating with and building on these efforts. They include the following:

The National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005) is the product of extensive multisectoral consultation, and underscores the need for a range of approaches to address substance use problems (e.g., adequate funding, evidence-informed practice, the integration of services and supports between different systems). The Framework includes 13 priorities, including Alcohol, Treatment, Youth, First Nations and Inuit, Workforce Development, Fetal Alcohol Spectrum

Disorder, and Offender-Related Issues. The recommendations and implementation strategies for each priority will link with the National Treatment Strategy to promote partnerships and collaboration under the Framework.

The National Anti-Drug Strategy (2007) is a federal government initiative that comprises three areas of effort: prevention, treatment and enforcement. The budget for the treatment component is $32 million. Funding announced to date includes $30.5 million for First Nations and Inuit services, $10 million for treatment in Vancouver's Downtown East Side, a separate $2 million for treatment targeting Aboriginals in the Downtown East Side, and $220,000 for Aboriginal youth involved with drugs and/or gangs.

Health Canada's Drug Treatment Funding Program, which replaces the Alcohol and Drug Treatment Rehabilitation Program allocates $111 million in funding over five years for treatment initiatives in the provinces and territories. The program has two funding streams, targeted respectively at strengthening *systems* of services and supports for substance use problems and at providing support for *specific* services.

The First Nations and Inuit Mental Wellness Advisory Committee. In response to the important health and substance use problems facing First Nations people and Inuit, and with the aim of seeking culturally appropriate solutions, this committee was established to provide strategic advice to the First Nations and Inuit Health Branch of the federal government. A holistic approach is being taken that grounds all individual and community healing efforts in the interrelationship of mental, physical and social life, and that sees mental wellness as requiring multi-dimensional solutions that address the broader determinants of health. The report of this Committee also includes a separate sub-report from Alianait, the Inuit-specific Mental Wellness Task Group.

The First Nations Addictions Advisory Panel was convened in 2008 to develop a national program framework to strengthen and renew NNADAP's addiction prevention and treatment services for First Nations communities. To achieve this task, the Panel will oversee a comprehensive review, both regionally and nationally, of addiction services to ensure that First Nations people have access to a range of culturally appropriate, effective, and sustainable services and supports. The Panel consists of researchers, health professionals and First Nations community representatives, and was assembled as a result of a partnership between the First Nations and Inuit Health Branch of Health Canada, the Assembly of First Nations, and the National Native Addictions Partnership Foundation. A separate process is being investigated for Inuit communities in the North.

The Mental Health Commission of Canada (2007)**.** While mental health and substance use problems are often interrelated, the relevant services and supports have historically operated in mutual isolation. The 2006 report of the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, put forth several recommendations relating to substance use problems, while a new national Mental Health Commission has since been developed with the intent of encompassing both mental health and addiction, and of partnering with other organizations as applicable.

Government tools for gender- and diversity-based analysis. Also of relevance is federal policy work on **gender- and diversity-based analysis** and related international agreements and treaties, such as the United Nations Convention to Eliminate All Forms of Discrimination against Women (CEDAW) and the Convention on the Elimination of Racial Discrimination (CERD). Other national initiatives (e.g., Health Canada, CIHR) are engaged

in defining and promoting the use of a population-balanced approach that reflects gender- and diversity-based analysis and linkages to other determinants of health. In addition, the Assembly of First Nations has also called for a gender-based analysis that includes consideration of historical context and intergenerational trauma.

The development of organizations by and for people with substance use problems. Another important trend is the growth of peer-based organizations providing advocacy, information and assistance to people seeking help for substance use problems. Such organizations reflect the aspiration of many people who use services and supports to help others access appropriate care. These organizations seek to participate in shaping and delivering local services and supports, and to inform service planning at the policy level. In its 2006 inquiry into the state of mental health services in Canada, the Standing Senate Committee on Social Affairs, Science and Technology recognized the value of this participation and encouraged support for its further development.

Components and principles of this Strategy

Consultations and research leading to the development of this National Treatment Strategy identified a wide variety of issues and recommendations, including co-ordinated, multisectoral responses to the risks and harms associated with substance use, and the pressing need for continued research and evaluation of programs and policies. The Strategy groups these issues and recommendations into three strategic areas for action:

- building capacity across the continuum of services and supports
- supporting the continuum of services and supports
- moving the Strategy forward.

To ensure effective change in knowledge, attitudes and practices, the proposed activities in each of these areas must be sustained and must be co-ordinated between jurisdictions and sectors. These activities should also reflect the following core principles that guided the development of the Strategy's recommendations:

1. The full range of risks and harms associated with substance use must be recognized. The harms associated with substance use are not limited to diagnosable substance use disorders, but include a much broader range of problems. Whether or not harms have been experienced, substance use also confers a tremendous range of risks.

2. A co-ordinated multisectoral approach is required to address the risks and harms. A comprehensive, holistic and integrated approach is needed to address risks and harms. The continuum of services and supports includes not only "treatment" but also a much broader spectrum, both upstream and down-stream, provided collaboratively by multiple sectors.

3. Practices must be informed by evidence. Appropriate and effective services and supports reduce the risks and harms faced by people with substance use problems and by their families and other loved ones and communities. They also reduce the overall health, social and economic burden of problematic substance use. Services and supports should reflect best and emerging practices that are informed by the highest-quality evidence.

4. Systems must be based on need. The varying needs of Canada's different regions and populations are important considerations in funding decisions and system planning. Funding should

be on the basis of need and required system capacity rather than on historical projections. System planning must be based on current, accurate prevalence data, and on both established and emerging patterns of substance use and harms among different populations, while maintaining a strong focus on those substances causing the greatest harm in the population as a whole.

5. Services and supports must be informed by gender- and diversity-based analysis. The planning and provision of services and supports should be responsive to the ways in which people's particular needs, choices and service engagement are influenced by the interaction of factors such as gender, culture, ethnicity, socioeconomic status, disability, sexual orientation, migration status, age and geography.

6. Services and supports must be person-centred. A person-centred approach requires that services and supports be planned and provided with an appreciation and understanding of the needs, strength and choices of each person seeking help.

Case study (continued)

The outpatient counselling program that Shawn accessed back in the city included a work skills component that helped Shawn see how his love of the outdoors could be applied to a degree in forestry. The strengths-based program also helped Shawn use his strong ties to his family to develop a treatment plan and to honestly explore the health and social impacts of his alcohol use.

7. Families and other loved ones are integral. The harms associated with substance use extend beyond the person with a substance use problem. To most effectively address substance use problems, and to strengthen families and communities, the role of families, friends and other carers in the lives of people with substance use problems must be acknowledged and incorporated into the planning and delivery of services and supports.

8. Services and supports must focus on both risk and readiness. Many services and supports are aimed at people experiencing substance use problems who are deemed ready to seek and respond to help. A shift in emphasis would see services and supports aimed at all people with substance use problems (and those affected by the substance use problems of family, friends and other loved ones), taking into account their state of readiness, along with more upstream emphasis on health promotion and prevention efforts targeted to the general and at-risk populations.

9. Systems are accountable for providing effective services and supports. Evaluation, monitoring and quality assurance are integral to ensuring that services and supports are effective. Leadership, active participation, commitment and shared responsibility are integral to promoting the collaborations, resources and initiatives required to improve services and supports for Canadians at risk of or experiencing harms related to substance use.

3. STRATEGIC AREAS FOR ACTION

Building capacity across a continuum of services and supports

At present, access to appropriate and effective services and supports for substance use problems is impeded by numerous factors, including the harmful effects of stigma and discrimination, and variations in services and supports both within and between jurisdictions and sectors (e.g., gaps in the range of services provided, selective eligibility for services, varying service quality).

One of the major challenges for people seeking help is the need to navigate different systems of services and supports that are not well co-ordinated and that do not communicate effectively with each other. While pockets of excellent collaboration exist, a comprehensive and better-integrated response is needed to effectively address people's needs and wants regarding the broad range of risks and harms they experience.

In presenting recommendations to improve this situation, the Strategy draws on two key concepts: the complex and evolving nature of peoples' substance use problems, and the "doorways" and "pathways" through which people access services and supports.

The complex, evolving nature of substance use problems. The range of harms associated with substance use can be described along three dimensions: *acuity*, *chronicity* and *complexity*. A person may experience acute problems that are relatively mild (e.g., a minor fall) or more severe (e.g., serious injuries resulting from a motor vehicle accident after driving while intoxicated). Similarly, chronic problems may be less severe (e.g., mild depression, recurring absences from work) or more severe (e.g., severe substance dependence, ongoing family dysfunction, liver disease).

Many people who have substance use problems, or who are affected by the substance use problems of a family member, friend or other loved one, face combinations of chronic and acute conditions (e.g., substance dependence combined with acute medical crises, or concurrent substance dependence and mental disorder). These combinations characterize the complexity of the person's problems. Complexity also often reflects the social factors that may contribute to a person's harmful substance use (e.g., lack of stable housing and other basic needs) and other health and social issues that the person may experience along with chronic substance use problems (e.g., a history of mental health problems, psychosocial deprivation, violence, past trauma or—as in the case of First Nations people and Inuit—intergenerational trauma).

The route by which a person enters the system of services and supports, and his or her ensuing experience, will depend on this combination of acuity, chronicity and complexity, along with other factors such as ethnicity, gender, parenting status, location and role (i.e., whether the person experiences substance use problems directly, or is the family member, friend or other loved one of someone affected by substance use problems). For instance, one person may be more likely to access services through primary care,[5] while another may

5. "Primary care" refers to the front-line delivery of health services, which in Canada includes family medicine (or general practice) physicians, nurses and nurse practitioners.

regularly use hospital emergency services. A third person may enter a specialized treatment program, while a fourth might prefer to engage with a mutual aid group such as Alcoholics Anonymous, Narcotics Anonymous or Al-Anon, and a fifth may be more likely to take part in a web-based support group or to use interactive online materials for education and self-improvement. Still others might enter the system by way of social or family services in their community, or may enter mandated treatment through the criminal justice system. How a person accesses services and supports will vary according to his or her individual situation at a particular time.

Thus the situation is complex: substance use confers a broad range of risks and harms that vary in acuity, chronicity, complexity and severity from one person to another; and that also vary within each individual person over time.

Case study (continued)

Shawn is back to drinking several nights a week with his friends, and Maria often finds empty beer bottles in the kitchen when she comes home from work. She has tried to find out what intensive treatment options are available, but the residential treatment centre listed in the phone book has a long waiting list. When she calls another program, she mentions that she believes Shawn's drinking might be related to depression, and is told that the facility does not deal with clients who have serious mental health issues. When Shawn goes to his family physician for a checkup, he is given a prescription to help with his depression, but his physician does not explore Shawn's use of alcohol.

Doorways and pathways. As described above, when a person seeks help for a substance use problem, he or she may choose from multiple entry points, or *doorways*, into the system of services and supports. From that doorway, a range of possible *pathways* exists through the system. Ideally—though not always in practice—the initial doorway will open onto services or supports that are appropriate to the person at that time, and will connect to pathways that lead the person to further needed services and supports. Through a person's history of seeking help, he or she may enter many doorways and follow many pathways, some appropriate and others not.

People should be able to receive adequate help (i.e., services and supports that meet their needs and wants) for substance use problems, *irrespective of the doorway through which they have entered*. To achieve this goal, a thoughtfully designed, comprehensive, multisectoral system of services and supports is required. Such a system will also ensure that people receive help in transitioning within and between sectors as needed.

An example will illustrate the concept of doorways and pathways: A person visits his or her primary care physician for a routine health check (the initial doorway). The physician, suspecting that the person's history of accidents and relationship difficulties may be linked to substance use, conducts a formal screening test and then refers the person to a specialized program for a more comprehensive assessment (pathway 1). This assessment in turn leads to a series of outpatient counselling sessions (pathway 2), after which the person is referred back to the physician for ongoing monitoring and support (pathway 3).[6]

6. Appendix C provides a schematic diagram of these multiple doorways and pathways, and shows how a person might ideally move within a "tiered" model of services and supports, such as the one described on the following pages.

Case study (continued)

In Shawn's case, an integrated system of doorways and pathways might have resulted in Maria being given a list of available services and supports from the first program she contacted, with Shawn agreeing to attend an intensive outpatient program targeting both mental health problems and alcohol use. Alternatively, Shawn's physician might have screened for substance use problems, engaged Shawn in a brief intervention for risky alcohol use, and encouraged him to consider a more specialized program such as psychosocial counselling for depression. Shawn's physician might also have discussed substance use with Maria, recognizing that she too may have substance use concerns and that Shawn's problems are likely having an impact on their relationship and on her as an individual. As well, the physician might have given Maria information about community-based supports for family, friends and other carers of people with substance use problems, in case she wanted additional support herself.

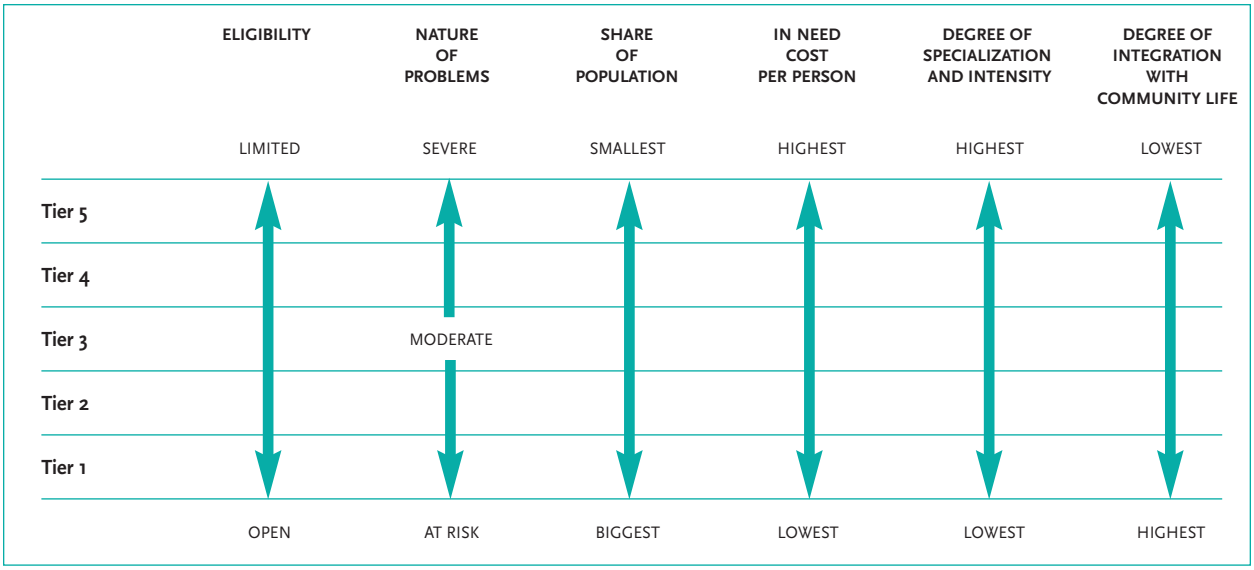
A TIERED MODEL OF SERVICES AND SUPPORTS

Excellent system-level responses to substance use problems must be the cornerstone of a National Treatment Strategy. The Strategy proposes the adoption of a "tiered" model for organizing services and supports to address substance use problems. This model encompasses the concepts outlined above, including the premise implicit in the notion of doorways and pathways that "every door is the right door."[7] The proposed tiered model is based on a literature review and the study of other jurisdictions' efforts to improve the system-level response to substance use problems. Variations on this model can be found in Quebec, the United Kingdom and Australia. The model presented here draws on all of these, with particular emphasis on the U.K.'s approach.

This model comprises five tiers, representing logical groupings of services and supports. Each tier is not an entity per se, but rather represents a cluster of services and supports that offer similar levels of access or eligibility, that address problems of similar severity, and that are of similar intensity and specialization. Figure 1, on the next page, summarizes the characteristics of the five tiers along these and other dimensions.

7. The premise captured by this phrase also underlies reform efforts in British Columbia and elsewhere; see www.housing.gov.bc.ca/ptf/framework_for_substance_use_and_addiction.pdf.

FIGURE 1: DIMENSIONAL DESCRIPTION OF THE FIVE TIERS



As the figure shows, services and supports in the lower tiers (tiers 1 and 2) have open eligibility criteria and are intended to meet the needs of greater numbers of people than those in the upper tiers. Lower-tier services and supports are not always focused exclusively on substance use, are integrated into community life, and are of relatively low intensity and cost. They should be available in most communities. People seeking services and supports in these tiers may include:

- those at risk for developing substance use problems
- those experiencing problems of low severity (i.e., low acuity, low chronicity and low complexity)
- those who have higher levels of need but who have chosen to seek help from services in a lower tier (e.g., their primary care physician in Tier 2) rather than an upper tier (e.g., a specialized treatment program in Tier 4 or Tier 5)
- those who have used services in the upper tiers for more complex needs and require less intensive but ongoing support (i.e., continuing care) to maintain their well-being.

Services and supports in the upper tiers (tiers 4 and 5) are designed to meet the needs of smaller numbers of people, are in many cases highly specialized and intensive, address the needs of people with substance use problems that are more severe (i.e., high acuity, high chronicity and/or high complexity), and consequently are more costly than those in the lower tiers. Eligibility to use services in the upper tiers is usually based on formal admission criteria and may require a referral. While these services, by virtue of lower demand, higher specialization and high cost, are less widely available than services and supports in the lower tiers (i.e., they are provided in fewer communities), they should be accessible across a broad catchment area (e.g., a region, a province or territory).

The five-tier model provides a continuum of services and supports with multiple potential pathways for an individual.

A key premise of the tiered model is that no two people—or their needs and wants—are alike, and indeed that no one person—or his or her needs or wants—stays the same over time. As a result, individuals do not reside within a given tier—there is, for example, no "Tier 5 consumer." Rather, at given points in his or life, a person may seek

services and supports from one or more tiers, sequentially or simultaneously.

Pathways through the tiered system are thus individualized and inherently client-centred. In such an environment, service and support providers in every tier must have the breadth of training and expertise to effectively serve a diverse clientele; yet equally, each system should be able to provide services and supports that are targeted to certain specific populations.

The guiding concepts of the tiered model are outlined in the box below.

GUIDING CONCEPTS OF THE TIERED MODEL OF SERVICES AND SUPPORTS

No wrong door. A person may access the continuum of services and supports by way of any of the five tiers and, upon entry, should be linked to other needed services and supports, either in the same tier or in a different tier. Co-ordination of this linkage is the responsibility of the system, not the individual. To ensure that this principle can be applied in practice, all sectors should routinely screen people for substance use problems and provide ready access to comprehensive assessment services if needed.

Availability and accessibility. Services and supports in all tiers should be both available and accessible within a reasonable distance and travel time of each person's home community, or should be facilitated by different means (e.g., telehealth, online or mobile services).

Matching. A person should be matched to services and supports whose intensity is appropriate to his or her needs and strengths. Matching implies a need not only for standardized screening and assessment tools, but also for processes that respect each person's informed choice of what type of care may work best for him or her (based on cultural relevance, language group or other considerations).

Choice and eligibility. If more than one service or support meets a person's needs, the person should be able to choose among those services and supports for which he or she is eligible. A person should be able to access services and supports within a given tier and across different tiers, as needed over time, though the focus might be in a particular tier at a given time.

Flexibility. A person should be referred from a lower tier to a higher tier (stepped up) or from a higher tier to a lower tier (stepped down) as appropriate to his or her needs.

Responsiveness. People—and their needs—change over time and with changing circumstances. As a person travels along pathways and through the lifespan, he or she should be given the help needed (e.g., information, referral, assessment, treatment) to ultimately shift the focus to services and supports in lower tiers.

Collaboration. A person's journey through the pathways should be facilitated by collaboration between providers of distinct kinds of services and supports. Collaboration should occur both at the clinical level (e.g., through shared service protocols between different providers) and at the administrative and organizational levels (e.g., through partnerships and inter-agency agreements), and should always include the person seeking help.

Co-ordination. To facilitate service delivery as well as system planning, monitoring and evaluation, health information systems should allow easy sharing of information between systems.

Case study (continued)

Shawn's drinking continues to increase, and he eventually ends up with a three-month prison sentence after putting someone in the hospital during a bar fight. The court establishes a link between Shawn's violence and his alcohol use, and applies for him to serve his time in a "drug-free wing" with intensive substance use programming. While in prison, Shawn begins to address his drinking, as well as exploring the relationship between his substance use, his depression and the trauma he experienced from witnessing domestic violence as a child. At the end of his sentence, Shawn's probation conditions include abstaining from alcohol and regularly attending AA meetings, even though he had previously had greater success with individual rather than group-based services.

An integrated approach to providing substance use services and supports would have ensured continuity between the program Shawn was receiving while incarcerated and a compatible program in the community. For example, the services in prison could have been provided by an "inreach" component of a community program, through a cross-jurisdictional service agreement with the provincial corrections authority (collaboration). Shawn's probation officer could have supervised a direct transition to the community aspect of the program following Shawn's release (co-ordination), ensuring that he continued to receive services that were suited to his needs (matching).

The following descriptions of the respective tiers include examples of the kinds of services and supports in each tier, and demonstrate how services and supports will communicate, co-ordinate, collaborate or integrate with those in other tiers. These descriptions are not intended to imply a fixed structure that will necessarily work for all jurisdictions. Nor is it expected that every type of service and support listed for a given tier must be available in a given jurisdiction. It is critical however that a comprehensive *continuum* of well-integrated services and supports be provided *across the five tiers* to meet the range of people's needs. With this in mind, for each tier, minimum levels of services and supports are identified that should be provided in every jurisdiction. Three criteria are used to identify these required services and supports:

- *Reduce risks and harms.* Required services and supports are those that, within each tier, will have the greatest impact, by reducing harms and risks for the greatest number of people entering that tier.
- *Facilitate movement within each tier.* Required services and supports are those that serve as doorways to other needed services and supports within the same tier, allowing people to benefit from collaboration between providers.
- *Facilitate movement between tiers.* Required services and supports are those that serve as doorways to other needed services and supports in higher and lower tiers, allowing people access to the full continuum of services and supports.

Certain types of services (e.g., withdrawal management) are more accurately seen as overarching categories of service that might be offered in different tiers (e.g., social withdrawal management would likely be situated in Tier 3, while medically managed withdrawal would more likely be found in Tier 5).

Tier 1

Services and supports in Tier 1 are broad efforts that draw on natural systems and networks of support for individuals, families and communities. They provide a foundation for a healthy population, and have broad eligibility criteria, allowing anyone access to them.

Tier 1 services and supports may include:

- prevention and health promotion initiatives targeted to the general population (e.g., a neighbourhood association, online information about responsible drinking, a fetal alcohol spectrum disorder (FASD) prevention awareness initiative, a family service)
- prevention and health promotion initiatives targeted to at-risk populations (e.g., school-based prevention and education programs directed respectively to teenaged boys and to teenaged girls, social support for families in need)
- resources and supports to help people manage and recover from less severe substance use problems on their own
- aftercare or continuing care for people who have previously accessed services and supports in higher tiers
- other supports that are open to all in which people with problems of varying severity may choose to participate (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous, Al-Anon, online support groups).

Services and supports in Tier 1 function as doorways to those in higher tiers. These Tier 1 services may be maintained while a person accesses service in a higher tier, or they may be returned to subsequently.

The following types of Tier 1 services and supports should be within reach of all communities in all jurisdictions:

- community-based and outreach services, open to all, that provide broad responses such as basic health information, and are capable of linking people to other services and supports
- community-based support groups, including mutual aid programs such as AA, that can help people manage and recover from their substance use problems, and reintegrate valued aspects of their lives.

Tier 2

Services and supports in Tier 2 provide the important functions of early identification and intervention for people with substance use problems that have not previously been detected or treated. These may include screening, brief intervention and referral. Systems well-positioned to provide such services include primary care physicians, social services (e.g., supportive housing), emergency care, public health and employment programs.

Tier 2 services and supports function as doorways to services and supports in Tier 1 or in higher tiers, and provide continuing support while people seek services from other tiers. To the extent that their capacity allows, this includes providing ongoing consultation and assistance with transitions between services (e.g., discharge and after-care planning).

The following types of Tier 2 services and supports should be available in most communities in all jurisdictions:

- screening, brief intervention and referral, along with ongoing services and supports shared with providers across sectors (i.e. primary care, public health, social services, community mental health).

Tier 3

Services and supports in Tier 3 are intended to engage people experiencing substance use problems who are at risk of secondary harms (e.g., HIV, victimization). They include active outreach, risk management, and basic assessment and referral services. While the people served in Tier 3 experience a wide range of substance use problems, they do not necessarily require intensive services.

Tier 3 services may include general outpatient counselling, home-based withdrawal management, supervised injection sites and methadone and buprenorphine maintenance treatment.

The task for services and supports in this tier is to:

- identify people with substance use problems
- manage a person's intoxication and associated acute medical problems (e.g., withdrawal, pain), and keep the person engaged in treatment of the medical problems
- maximize the opportunities for the person to move on to treatment for his or her chronic substance use problems.

Services and supports in Tier 3 function as doorways to services and supports in lower or higher tiers.

The following types of Tier 3 services and supports should be available in most semi-urban or urban communities in every jurisdiction, and in other areas where demand is high enough to warrant them:

- emergency and other acute care services that provide active outreach, risk management and referral services
- comprehensive, standardized assessment and referral services
- methadone maintenance treatment
- other services and supports, including needle exchange programs, that can engage people who are at risk and can provide active outreach and risk management.

Tier 4

Tier 4 comprises services and supports that are more intensive than those in Tier 3 and in many cases offer specialized services for people with substance use problems. People seeking services in this tier may have multiple problems that need services and supports from more than one sector or tier. In such complex cases, multidisciplinary or team approaches may be needed.

Tier 4 services and supports may include:

- comprehensive assessment to build a solid foundation for structured treatment planning; case management; outpatient counselling; intensive day programming for early recovery (e.g., "daytox"); structured residential services; services that link people with concurrent mental health and substance use problems to the full range of needed assessment, treatment and support services
- active outreach services such as assertive community treatment (ACT) teams, as well as other intensive outreach services in hospitals (including emergency services), shelters and correctional facilities.

Services and supports in Tier 4 function as doorways to services and supports in Tier 5 or in lower tiers.

The following types of Tier 4 services and supports should be available in most semi-urban and urban communities in all jurisdictions, and in other areas where demand is high enough to warrant them:

- structured and specialized outpatient services that can provide comprehensive assessment, treatment planning and counselling services.

Tier 5

Services and supports in Tier 5 are intended to address only the needs of people with highly acute, highly chronic and highly complex substance use and other problems, for whom lower-tier services and supports are inadequate.

Tier 5 services and supports may include:

- services that link people with highly complex concurrent substance use and mental health problems to the full range of needed assessment, treatment and support services
- intensive treatment services in correctional facilities
- residential or hospital-based services[8] (e.g., residential programs for the treatment of concurrent disorders, hospital-based medical withdrawal management services).

Services and supports in Tier 5 function as doorways to needed follow-up services and supports in lower tiers.

The following types of Tier 5 services and supports should be available in urban communities and accessible across a broad catchment area (e.g., a region or province):

- structured residential services that can provide intensive, multidisciplinary, specialized treatment services for people with severe and complex substance use problems.

8. While the respective tiers do not correspond directly to particular physical settings, residential and hospital-based services are more likely to be found in the uppermost tiers. Services and supports in these tiers are also more likely to reflect the highest levels of both intensity and specialization (e.g., an intensive treatment program for pregnant women with substance use problems).

It is important to reiterate that neither particular clients nor particular subsets of substance use problems reside within a given tier. This point may be illustrated with the case of people experiencing concurrent mental health and substance use problems. Such a person may be identified through a screening process in a primary care setting (Tier 2) and then be referred for further mental health and substance use assessment (Tier 2). The person may eventually receive ongoing counselling, medication management and support from an ACT team (Tier 4); simultaneously participate in a mutual aid group tailored for people with concurrent disorders, such as Double Trouble (Tier 1); and occasionally require services and supports for psychiatric crisis or acute medical conditions in a specialized, integrated residential or day program for people with concurrent disorders (Tier 5).

Many people seeking help will make one or more transitions within a tier or across tiers. Services and supports will be needed to help ensure that these transitions are successful. This linkage function is an essential aspect of the tiered model. The nature of the appropriate supports will vary by tier. For example, in Tiers 4 and 5, various models of case management or **wraparound** services[9] would be appropriate, while in Tier 2, a primary care physician could serve this function. In Tier 1, mutual aid groups could continue the function they have historically provided in helping people access needed services and supports. More work is needed to develop and evaluate alternative models to support people in their transitions.

IMPLEMENTATION CONSIDERATIONS

As noted earlier, the tiered model described above is not intended to be rigidly structured or prescriptive, but rather should be seen as a somewhat flexible framework for the continuum of services and supports, from Tier 1 to Tier 5, within a given jurisdiction. Given this, the fundamental consideration for jurisdictions in allocating resources will be to ensure that for each tier, services and supports are in place that meet the fundamental criteria of reducing harm and facilitating people's movement both within and between tiers.

The cost per person increases as services and supports become more specialized and intensive.[10] Consequently, investment in the lower tiers pays dividends over time by reducing the number of people eventually requiring services in the upper tiers. This goal may be achieved in part by providing lower-tier responses, particularly those targeted to children and youth, that aim to prevent or delay the onset of substance use, reduce the risk of substance use problems from developing, or minimize the escalation of existing problems into more severe problems.

It will be important to ensure that adequate funding is allocated to implement the tiered model effectively, and that it is allocated equitably both within and between jurisdictions. In this regard, needs-based planning models must be developed that:

- build on population-level data regarding the extent of substance use problems
- incorporate the estimated demand across the full continuum of services and supports
- to the extent possible, take into account population, geographical and jurisdictional factors affecting access to services and supports.

9. Another emerging model to support people's entry into substance use treatment is the "linkage manager."

10. In absolute terms, the higher per-person cost in the upper tiers is offset to some degree by the lower number of people requiring these services.

As jurisdictions work toward adopting and implementing the tiered model, they will need to consider a number of questions to determine how to apply the model to their own unique situations. The precise form the tiered model takes in any jurisdiction will be influenced by a variety of interrelated factors, including:

- the structure and organization of service delivery
- the unique population mix and geography
- the demand for different types of services and supports
- the ways in which services and supports interact with those in other jurisdictions (e.g., when more than one jurisdiction exists in the same geographical area, as with federally funded Aboriginal programs and regionally provided services).

Case study (continued)

The small northern community where Shawn initially sought help for his risky drinking identifies the need to improve the services available to deal with increasing rates of substance use problems among young adults working seasonally in the area. The regional health authority works with the major seasonal employer to provide intensive outpatient counselling in the community (Tier 4) with follow-up at the actual work site located outside of town (Tier 1). The health authority also arranges access to beds at the residential treatment centre located in the closest city, and at the closest NNADAP treatment centre for Aboriginal workers seeking culturally appropriate services (Tier 5)—and it ensures that transportation is available for those in need of these more intensive services. Case managers (Tier 2) working in the community counselling centre facilitate communication between the services to ensure that clients are referred efficiently from one program to the other, as their changing needs require. The community also establishes a partnership between the provincially funded outpatient services and the community-based NNADAP services in neighbouring First Nations communities, to meet the needs of Aboriginal seasonal workers interested in services that use traditional approaches to addressing substance use problems.

RECOMMENDATIONS

1. Build capacity along the full continuum of services and supports by adopting and implementing the principles and elements of the tiered model. This includes:
   a. assessing the extent to which existing services and supports reflect the principles and elements of the tiered model
   b. investing sufficient resources and developing infrastructure to ensure that:
      i. the services and supports required within each tier are available in all jurisdictions
      ii. people have universal and timely access to a minimum standard of services and supports, in all sectors and in each tier
   c. ensuring intersectoral collaboration and co-ordination in planning and delivering services and supports, including the development of shared service protocols, agreed service and support pathways, and interdisciplinary, collaborative models of service delivery **(all jurisdictions)**.
2. Involve consumers, advocates, families, friends and other carers in designing, delivering and continually evaluating services and supports, and include people with experience as consumers in all policy, planning and regulatory bodies **(all jurisdictions)**.
3. Co-ordinate the preparation of a toolkit to help jurisdictions to estimate the optimal level of services and supports across the continuum of care **(National Treatment Strategy Leadership Team)**.
4. Review inter-jurisdictional cost-sharing mechanisms to facilitate access to service across jurisdictional boundaries **(Health Canada and the FPT Liaison Committee on Problematic Substance Use)**.

Supporting the continuum of services and supports

KNOWLEDGE EXCHANGE

Knowledge exchange is a critical mechanism in building capacity to address substance use problems. The broad goals of knowledge exchange activities include more evidence-informed decision-making, and research that is better informed by the needs of decision makers. Knowledge exchange is also integral to reducing the stigma and discrimination experienced by people with substance use problems and those around them, including families, friends and other carers, and even service and support providers.

However, it is widely recognized that there is great variability in the degree to which reliable knowledge is applied in different contexts. The growing expectation for evidence-informed health care makes it imperative that we focus on knowledge exchange. People have the right to services and supports that are informed by evidence[11] and by critical cultural and population differences.

Promising steps to address the gap between "what we know" and "what we do" include the roster

11. There are many types and "levels" of evidence, including academic research, culturally based knowledge and the direct experience of people who use or have used substances. Knowledge exchange strategies should encourage promising and best practices, while also leaving room for innovation and evaluation.

of best practice reports produced and disseminated by Health Canada, and the development of websites and technical resources to better inform policy makers, program managers and front-line workers about key research findings and their implications for organizing and delivering services. Many agencies and professional networks in Canada already have mandates related to knowledge exchange, and governments and other funding and supervisory bodies are increasingly demanding accountability for evidence-informed services and supports. What is still needed is a comprehensive strategy to facilitate the development of an improved knowledge exchange infrastructure, through which jurisdictions will use evidence as a routine aspect of system planning and service delivery. Further work is first needed, however, to identify the components of the existing infrastructure, to define the gaps that impede the flow and use of knowledge, and to more effectively co-ordinate the existing components. The improved knowledge exchange infrastructure should:

- be flexible, credible and responsive to a broad range of stakeholders in a variety of contexts
- be able to synthesize knowledge and provide guidance for policy and practice
- be able to identify and employ effective mechanisms to introduce new knowledge and to support and reinforce its use
- engage those involved in research and implementation in partnerships to define questions and seek answers that advance evidence-informed practice (to ensure that a population-informed approach is used, these partnerships must include representation from the full diversity of people who experience substance use problems, as well as affected family, friends and other carers)
- ensure that researchers and service providers are engaged in bidirectional knowledge exchange.

Case study (continued)

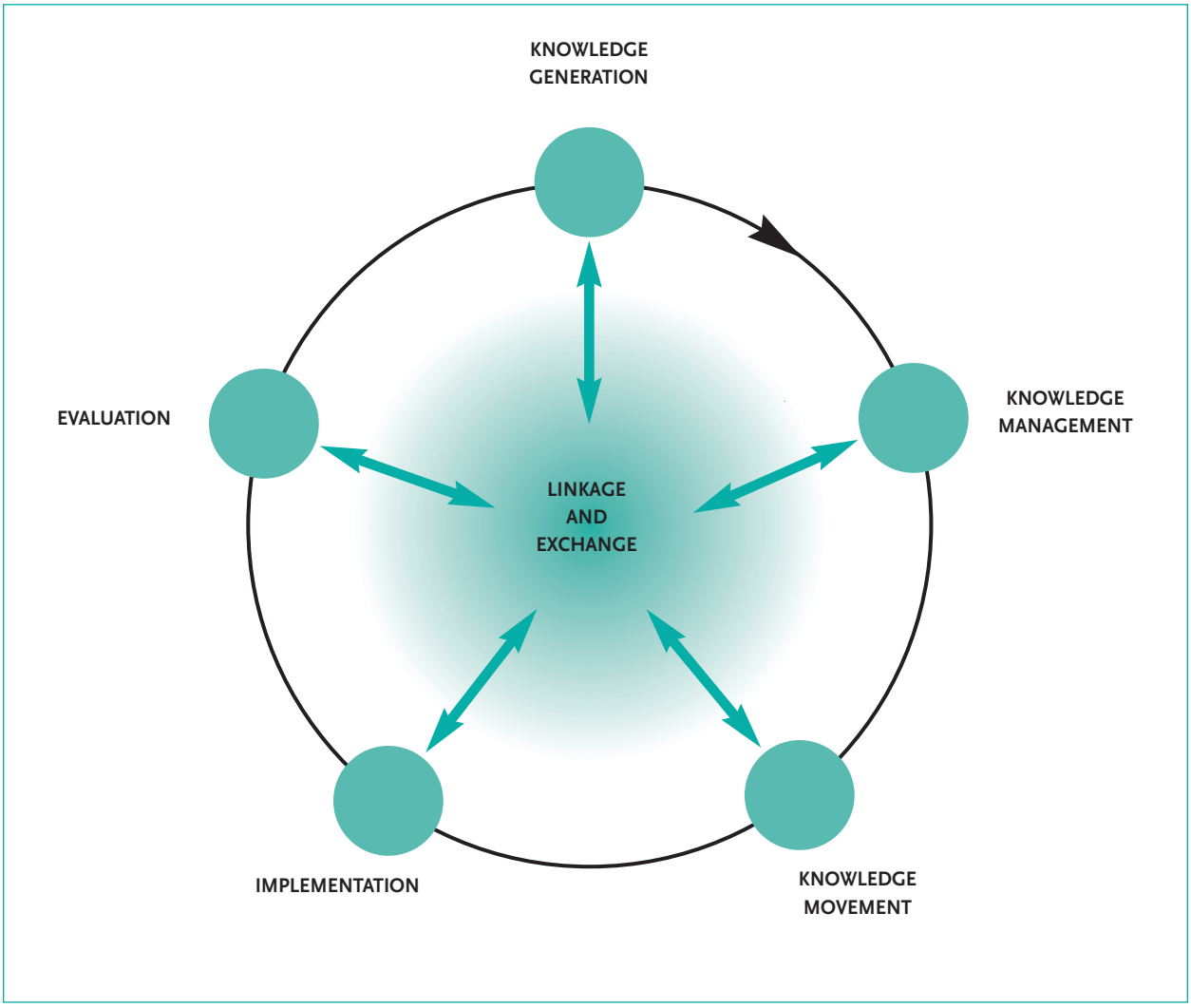
When Shawn first visited his family physician, the physician realized that he lacked the knowledge and resources to address patients with substance use problems. Shortly afterward, the physician receives a call from one of the medical associations he belongs to, informing him of a substance use workshop about best practices for primary care providers (such as screening and brief intervention). Shawn's physician attends the workshop, and volunteers to participate in a pilot project evaluating new referral and follow-up guidelines based on an integrated case management model.

The model illustrated in Figure 2, on the next page, identifies the key phases of a comprehensive strategy to facilitate the development of an improved knowledge exchange infrastructure. At the heart of the model are the processes of linkage and exchange, which at each phase facilitate the two-way movement of knowledge between those who produce it and those who use it (e.g., the linking, through informal and formal networks, of community-based research and research-focused training). Linkage and exchange between knowledge producers and knowledge users ensure that both partners understand the problems that arise in the knowledge exchange process, and their solutions. Linkage and exchange are critical to achieving sustained changes in policy and in practice, as are incorporating different perspectives and fostering ongoing professional development of service and support providers.

This model links participants with different knowledge sets and different roles in the production, management and use of knowledge, as follows:

- *Knowledge generation* takes place in multiple contexts (e.g., research, clinical and community settings) and involves adding to what we know through the accumulation of evidence.
- *Knowledge management* is the bringing together of new and existing evidence into knowledge that can be put into action.
- *Knowledge movement* involves a variety of techniques to transform knowledge and to transfer it from one context to another.
- I*mplementation* involves applying what we know, and entails an active process of change management that assesses and nurtures readiness for change, sets priorities, supports those who use services and supports, and targets changes that are practical and feasible.
- *Evaluation* measures the process and results of applying knowledge.

FIGURE 2: KEY PHASES OF A COMPREHENSIVE KNOWLEDGE EXCHANGE STRATEGY



RECOMMENDATIONS

5. Develop and co-ordinate a national knowledge exchange network to ensure linkage and exchange between knowledge producers and knowledge users, and to promote the implementation of each phase of the proposed knowledge exchange strategy **(National Treatment Strategy Leadership Team)**. The network's efforts should:
   a. build on and enhance existing collaborations at the jurisdictional level, such as the National Workforce Development initiative
   b. identify and address knowledge needs; collect and synthesize existing knowledge; identify factors that respectively facilitate and impede the effective use of knowledge; make this knowledge accessible across the full continuum of services and supports, to policy-makers, service providers, and to the public; and determine how best to support the implementation of knowledge
   c. be directed as a priority at lower-tier services and supports, in order to address the existing gaps in knowledge and practice regarding substance use problems and co-ordinated responses to them
   d. be grounded in the needs of diverse populations and acknowledge culturally appropriate healing practices.
6. Develop and implement clear knowledge exchange strategies to:
   a. improve the effectiveness of services and supports
   b. ensure that decisions regarding policies on the design and funding of the various health care systems that address substance use problems are informed by evidence
   c. improve the public's knowledge and skills to make healthy choices regarding substance use, leading to better self-management and the reduction of stigma and discrimination
   d. ensure a two-way flow of information between those producing research and those using it, including service providers and political decision makers **(all jurisdictions)**.
7. Make funding available to support activities consistent with the proposed knowledge exchange strategy **(all jurisdictions and research funding bodies)**. This should include an annual call for proposals for the development of inter-jurisdictional and intra-jurisdictional mechanisms to:
   a. collect and synthesize knowledge
   b. ensure its implementation across the full continuum of services and supports.

   Specific priorities for each call for proposals should be recommended by the National Treatment Strategy Leadership Team in consultation with the national knowledge exchange network.
8. Fund the development of a best practices toolkit (or toolkits) to build capacity and to support the development of proactive, targeted knowledge exchange activities at all jurisdictional levels, the system level and the agency level. The toolkit(s) should be updated periodically, given the evolving nature of new interventions and technologies **(Health Canada)**.

REDUCING STIGMA AND DISCRIMINATION

Unlike most other health issues, substance use problems are often attributed to a person's moral and personal failure, resulting in stigmatization of and discrimination against those who are affected. Stigma (negative attitudes) and discrimination (associated negative behaviour) are serious impediments to the well-being of people with substance use problems—particularly for women and those with chronic problems—and their impact often persists far beyond the resolution of the immediate problem.

People with concurrent substance use and mental health problems face a double stigma that can be a significant barrier to accessing services and supports. Eligibility criteria for mental health services and supports may exclude people who have substance use problems, and vice versa, while some mental health service providers may simply not want to deal with people who have substance use problems.

Stigma is rooted in a lack of awareness and understanding. For example, most Canadians attribute the harms associated with substance use primarily to illegal drug use, when in fact the health and social costs associated with alcohol use in Canada are more than twice those associated with illegal drugs. The reality is that substance use problems do not affect only a small number of marginalized drug users, but rather they have a direct or indirect impact on the majority of Canadians in all walks of life.

The harmful effects of stigma and discrimination manifest at systemic, community and individual levels:

- At the systemic level, stigma and discrimination can be seen in policies that govern funding for services and supports, eligibility criteria for social assistance, and the kind of services and supports that are offered (e.g., people with substance use problems face discrimination with regard to accessibility of health care, housing and employment). Perhaps the strongest evidence of systemic discrimination is the tremendous gap between the magnitude and cost to society of substance use problems and the comparatively small investment in services and supports, relative to the investment in tackling other health care problems (e.g., cancer, diabetes).
- At the community level, stigma and discrimination may affect the manner in which schools, employers, child welfare officials and health care providers respond to people with substance use problems, and to their families.
- At the individual level, stigma and discrimination often prevent a person from seeking needed services and supports, create profound changes in the identity of the stigmatized person, and change the way in which others perceive the person.

Certain groups of people who have experienced the effects of discrimination (e.g., due to physical disability or to sexual orientation) have successfully used a long-term, comprehensive approach to create greater awareness, understanding and acceptance, change attitudes, and ultimately reduce discriminatory practices. Research findings show that comprehensive, integrated approaches to reducing stigma and discrimination can increase knowledge and change attitudes and behaviours. Recommended approaches:

- are based on best practices and a review of existing awareness, anti-stigma and anti-discrimination programs
- are targeted to the characteristics (e.g., age, gender, culture, ethnicity, faith, sexual orientation, parenting status) and needs of particular populations, and to particular settings (e.g., schools, workplaces, primary health care, emergency care, social services)
- include messages targeted to a range of audiences,

and provide a voice to people who are and have been affected by substance use problems

- are supported by proactive, targeted knowledge exchange activities
- include supportive policies (e.g., employment, housing, social assistance)
- are based on principles of human and civil rights, empowerment, participation and dignity.

Case study (continued)

Maria realizes that she may be pregnant. She has used ecstasy once or twice during the last few weeks and is terrified that this may have harmed her baby. She is more worried, though, that if anyone finds out, the baby may be taken away at birth. She decides not to tell her physician about her ecstasy use, but she finds that the stress of hiding it increases the urge to use. She is also afraid that her pregnancy will further disrupt her relationship with her parents, and feels very isolated.

Fortunately, the local pregnancy outreach program has conducted awareness and outreach activities that publicize their safe, non-judgmental support for women wanting to have healthy pregnancies. The program also conducts community development activities to ensure that service providers are equipped to respond appropriately to the needs of women with substance use concerns during pregnancy.

Maria's physician asks her empathically whether she has any concerns about substance use, and this supportive approach encourages Maria to open up about her concerns. After discussing things with her physician, Maria decides that she is willing to meet with a counsellor at an outpatient program for women with substance use and/or mental health problems (Tier 4). However, Maria finds the program too intimidating, and in a follow-up appointment the counsellor refers her to the lower-intensity pregnancy outreach program (Tier 1). There Maria is offered a booklet that presents information on the effects of different drugs in pregnancy and while breastfeeding. She is able to draw on peer support, talking with other women over lunch about how they are managing to reduce their substance use, manage challenges in their relationships and care for themselves in other ways that reduce stress.

RECOMMENDATIONS

9. Develop, implement and evaluate an evidence-based, comprehensive strategy, involving the specialized addiction treatment system, broader health and social service systems, people with substance use problems and others affected by substance use, to increase awareness and understanding and thereby reduce stigma and discrimination related to problematic substance use **(National Treatment Strategy Leadership Team).**
10. Identify the range of potential partners and develop collaborative workplans with individuals and organizations already engaging in anti-stigma and anti-discrimination initiatives (e.g., Mental Health Commission of Canada, First Nations and Inuit Mental Wellness Advisory Committee) **(National Treatment Strategy Leadership Team).**

DEVELOPING A RESEARCH PROGRAM

The main priority for research should be to directly support and enhance efforts to build system capacity and thus improve responses to substance use problems across the full continuum of services and supports. While Canada has a base of relevant high-quality research,[12] promoted by existing funding bodies,[13] there is no co-ordinated national research program focused on problematic substance use or on needed services and supports. In addition, there are limited opportunities for researchers and their community partners in knowledge exchange—including people who access services and supports for substance use problems—to propose and initiate collaborative research projects.

In mapping out research directions to improve the quality, accessibility and range of services and supports within the tiered model, two issues need to be addressed:

- increasing capacity to pursue a targeted research program
- articulating the priority areas for such a program.

Building research capacity will require high-level collaboration among multiple funding sources and research leaders, including the Canadian Institutes of Health Research (CIHR), the scientific research community, various levels of government and all jurisdictions. Capacity building will include:

- career development for scientists at all career stages (e.g., key Chairs in Addiction Research, Strategic Training Initiatives in Health Research grants, distinguished scholar awards, doctoral and post-doctoral fellowships, and graduate traineeships)
- the development of infrastructure needed to foster and sustain long-term programs of applied research (e.g., institutional arrangements to support research partnering, and support for university-based research projects).

Priority areas for research-based knowledge generation range from clinical efficacy to system performance, and include:

- evaluating the adequacy of systems, services and supports
- evaluating and developing behavioural and pharmacological interventions
- evaluating and developing screening and assessment tools, including brief measures of problem severity
- estimating population health needs and evaluating and developing population health interventions for those in greatest need
- evaluating and maximizing the capacity of knowledge exchange processes that will affect policy and practice.

Each of the areas of research identified above has a high potential to help guide policy formation, organizational change and community-based action. However, the value of the research in each area will depend on:

- communication and co-ordination between the research program and the proposed knowledge exchange network to support the implementation of the tiered model of services and supports
- openness to multiple forms of inquiry, including evaluation research, systems analysis, gender and cultural analysis, implementation studies, clinical investigations, and both qualitative and quantitative methods
- the research being informed by analyses of the determinants of health.

12. Examples include the Forum on Alcohol and Illicit Drugs Research in Canada (2003) and the National Research Agenda set out in the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005). A key report, prepared for the 2003 Forum is the background paper *Alcohol and Illicit Drugs Research Priorities for Canada.*

13. Examples include the Institute of Neuroscience, Mental Health and Addictions (INMHA) and other Canadian Institutes of Health Research (CIHR) institutes; the Canadian Health Services Research Foundation; and provincial bodies such as the Alberta Heritage Foundation for Medical Research and the Ontario Mental Health Foundation.

RECOMMENDATIONS

11. Develop mechanisms to increase the capacity for a targeted research program on substance use **(National Treatment Strategy Leadership Team)**, including:
    a. the initiation of competitive funding calls by CIHR and the Social Sciences and Humanities Research Council (SSHRC) to develop and support research teams to address priority areas (this will complement the anticipated call for proposals on substance abuse "treatment" from CIHR's Institute of Neuroscience, Mental Health and Addictions (INMHA), as well as the work of the Institute of Aboriginal Peoples' Health)
    b. proactive encouragement and resourcing by CIHR and SSHRC of cross-sectoral research on substance use services and supports; community-based research collaborations; and the development of junior researchers
    c. funding at the provincial and territorial level for focused, applied research to build capacity for knowledge generation beyond the academic community.
12. Promote opportunities (e.g., through symposiums and workshops at relevant events) to present and review new research in the priority areas, with an emphasis on increasing the engagement of the scientific community on research related to improving the quality, accessibility, and range of services and supports within the tiered model **(National Treatment Strategy Leadership Team)**.
13 Provide resources for research directly related to the implementation of the tiered model, for intersectoral collaborations and for knowledge exchange **(all jurisdictions and funding bodies)**.
14. Promote research partnerships and collaboration between the specialized addiction treatment system and others engaging in parallel efforts, including the Correctional Service of Canada and the Aboriginal Health and Human Resources Initiative **(National Treatment Strategy Leadership Team, research agencies)**.

MEASURING AND MONITORING SYSTEM PERFORMANCE

Optimally, data collection across Canada should be co-ordinated by means of a national information system. Realizing the potential of data collection requires a system developed in the context of a larger strategy for the epidemiological monitoring of substance-related risks and harms, and that operates hand-in-hand with a national research agenda and its priorities, each supporting and informing the other. While the quality and accuracy of a national data set may be limited by, among other things, the quality and accuracy of existing jurisdictional data, both jurisdictional and national efforts will have the potential to improve over time.[14]

Better and more consistently collected information is needed:

- to support the business case for investing in services and supports for people with substance use problems
- to better assess the capacity of the national "system" to respond to demand, and to determine what access barriers are experienced by certain populations
- to measure and monitor the impact of system changes based on the recommendations of this report.

In order to capture the full scope, trajectories, costs and outcomes of people's use of services and supports, there must be a strong emphasis within and between all systems and tiers on linking not only aggregated data but also data at the individual level. Given the broad range of sectors addressing substance use problems, and the corresponding breadth of existing information structures and processes, a phased approach to improving data collection is the most feasible way forward. Initial efforts should be directed at the specialized addiction treatment system (i.e., services and supports located mostly in the upper tiers), and should build on recent jurisdiction-level data collection efforts, and on recent national efforts by the National Treatment Indicators Working Group (NTIWG) to increase the comparability of data and to develop a set of national data elements. A second area of effort should focus on services and supports delivered by the broader health care and social service system (i.e., services and supports located mostly in the lower tiers).

The specialized addiction treatment system. Cross-jurisdictional variations in information systems within the specialized addiction treatment system present a major challenge to creating a viable national information system. While the delivery of health care is largely a provincial and territorial responsibility, the compilation of national treatment data will bring a range of benefits. It will, for example:

- facilitate the evaluation of specific national strategies or programs
- help identify trends in the characteristics of people seeking services, as an indicator of emerging patterns of substance use and associated problems
- contribute pan-Canadian information to existing international data on services and supports for people with substance use problems
- permit jurisdictions' planning and quality improvement activities to be informed by valid comparisons between their own indicators[15] and those at regional and national levels.

14. The present limitations in gap analysis at the system level are increasingly at odds with the broader health care landscape in Canada and elsewhere, in which accountability and performance monitoring are fast becoming the norm.

15. Indicators for comparison might include clients' ages; the ratio of male to female clients; the proportion of clients presenting with alcohol problems versus problems with other specific drugs; the ratio of new to repeat admissions; the ratio of clients in residential versus outpatient treatment; and the proportion of clients with dependent children.

The possible approaches to a national information system range from the relatively straightforward—a set of merged statistical tables submitted by each jurisdiction, conforming to a common set of definitions to ensure comparability—to the complex—a national **client-level database** integrating the **episode databases** compiled by each jurisdiction. In reviewing the range of options, the NTIWG supported a process for the first of these approaches, at least as a feasible starting point. Additional data at the client level (e.g., treatment retention) and the program level (e.g., waiting time and unit-of-service cost) could be added after the system were established, along with data from private sector services and supports.[16] In addition, it will be essential to incorporate measures of client outcome into future enhancements of the national information system.

Based on a review of international best practices for large-scale treatment information systems, as well as analysis of key features of existing jurisdiction-specific information systems, the NTSWG selected a variety of national indicators feasible for development over the next two to three years. These indicators are listed in the text box below. Other indicators were identified for possible medium- to long-term development if found to be feasible.

The broader health and social service system: In order to measure and monitor system performance across the full continuum of services and supports, a second phase of effort should include sectors other than the specialized addiction treatment system (e.g., primary care, emergency services, social welfare, corrections). While strong information systems do exist (e.g., the Canadian Institute for Health Information), there have been few efforts to link data between sectors to provide a more comprehensive understanding of the overall system response to substance use problems. However, there are a number of national and jurisdiction-level activities to build on, and other relevant initiatives on the horizon.

DATA ELEMENTS COMMON TO THE PROVINCIAL JURISDICTIONS

- number of service episodes in public specialized services for substance use problems by categories of withdrawal management, residential service, non-residential service and total
- number of unique individuals served in public specialized services for substance use problems by categories of withdrawal management, residential service, non-residential service and total
- number of episodes and unique individuals served in public specialized services by gender, age and marital status (broken down if possible within categories of withdrawal management, residential services and non-residential services)
- total number of individuals in methadone services in both public specialized treatment services and specialized methadone clinics
- total number of individuals served within driving-while-impaired education programs

16. Private sector services and supports for people with substance use problems are a small part of the overall system in most jurisdictions in Canada, Quebec being the notable exception.

System-level case study

A regional health authority responsible for an urban centre is looking at where to invest additional money to improve substance use treatment. Local program managers share data indicating that while funding for needle exchange and methadone maintenance services has remained static over the past several years, the number of people accessing these services has increased substantially. The data also indicate that the number of older adults accessing withdrawal management services has increased. The health authority is able to use this information to justify increased investment in needle exchange and methadone services, and in the development of a withdrawal management program targeting the needs of older adults.

Efforts within both the specialized and broader systems will permit specific projects to share relevant expertise, knowledge and tools related to performance measurement and monitoring, both within and between all jurisdictions. Areas should be identified in which there is a need for collaboration aimed at increasing jurisdictions' ability to build and improve models and indicators for performance monitoring. Such efforts might include collaboration on:

- conducting environmental scans to identify existing sources of data and data collection activities
- assessing the factors related to meaningful measurement and monitoring of system performance, based on identified existing and potential indicators.
- developing a culturally appropriate method to collect data on cultural, philosophical and traditional indicators relevant to First Nations people, Inuit and Métis, respecting the principles of **ownership, control, access and possession (OCAP)**.

Jurisdictions will need help to work together to develop common tools and build capacity in areas of common interest. Toolkits to support these efforts should be aimed at monitoring consumers' *outcomes* to validate program effectiveness; building on work already done in some Canadian jurisdictions and elsewhere; and developing estimates of the cost of various types of services and supports.

RECOMMENDATIONS

15. Identify a national lead and establish a process for reporting and sharing data on the capacity and use of services and supports, based on the tiered model, and guide the ongoing development of national treatment indicators, beginning with those listed in this Strategy **(National Treatment Strategy Leadership Team, Health Canada)**.
16. Co-ordinate projects to improve measurement and monitoring of the performance of services and supports in each of the five tiers **(National Treatment Strategy Leadership Team)**.
17. Develop the capacity to collect and report information from all sectors in each of the five tiers, including the capacity to report on the national treatment indicators **(all jurisdictions)**.

Moving the Strategy forward

LEADERSHIP AND CO-ORDINATION

While it is important that individual jurisdictions recognize substance use problems as a priority area, the implementation of the recommendations in this report will require the collaboration of many jurisdictions, sectors and organizations across Canada. Sustaining this collaboration will in turn depend on effective leadership.

Strong leadership will also provide a starting point for advancing strategic policy change, by facilitating communication between service and support providers, researchers, policy-makers and program administrators. Some examples of the work required are to prioritize issues and problem areas; co-ordinate communication on identifying sources of support and developing proposals for specific work; and co-ordinate and support activities that keep substance use problems on the political agenda. Leadership will be drawn from three appropriately positioned organizations: the Federal-Provincial-Territorial (FPT) Liaison Committee on Problematic Substance Use, the Canadian Executive Council on Addictions, and the Canadian Centre on Substance Abuse. This leadership will also be linked to the leadership and co-ordination of the National Framework for Action.

The FPT Liaison Committee on Problematic Substance Use is designed to share information, enhance capacity to address issues related to problematic substance use, and provide advice for the co-ordination, among various levels of government and organizations, of action at the national level. The Committee advises the federal government on problematic substance use matters of national scope and acts as a liaison committee to the Pan-Canadian Public Health Network (PCPHN). It also supports the federal government and the PCPHN on policy, regulatory and program issues related to the impact of substance use on the health of Canadians.

The Canadian Executive Council on Addictions (CECA) is a national, non-governmental organization of senior executives of addiction agencies in Canada. CECA provides a forum for discussion and collaborative efforts to reduce the harms associated with substance use, strengthens the knowledge of Canadian addiction organizations with the aim of improving services across Canada, and provides proactive advice on substance use issues to all levels of government in Canada.[17]

The Canadian Centre on Substance Abuse (CCSA) has a legislated mandate to provide national leadership and evidence-informed analysis and advice, in order to mobilize collaborative efforts to reduce risks and harms related to substance use. This mandate places CCSA in a unique position to assume a leadership role in moving forward the recommendations in this report and monitoring their implementation. This role should be twofold:

- co-ordinating and monitoring the range of actions recommended in this Strategy
- encouraging jurisdictional leadership in adopting and carrying out the recommendations.

Effective leadership will require the involvement and insights of people who have experienced substance use problems themselves or among family members or other loved ones. Mechanisms must therefore be established to ensure representation of a cross-section of people in an advisory capacity, including in particular those with relevant lived experience.

17. CECA members include British Columbia Mental Health and Addiction Services; Centre for Addictions Research of British Columbia; Alberta Alcohol and Drug Abuse Commission; Saskatchewan Mental Health and Addictions Services; Addictions Foundation of Manitoba; Centre for Addiction and Mental Health; Addictions Services of Newfoundland and Labrador; Addiction Prevention and Treatment Services of Nova Scotia; and the Canadian Centre on Substance Abuse.

RECOMMENDATIONS

18. With regard to implementing the National Treatment Strategy:
    a. Allocate and align resources to implement the Strategy in a way that maximizes individual and collective efforts **(all jurisdictions, CCSA, FPT Liaison Committee on Problematic Substance Use, CECA)**
    b. Co-ordinate the implementation of the Strategy through:
        i. developing a multisectoral National Treatment Strategy Leadership Team including representation from Health Canada, the FPT Liaison Committee on Problematic Substance Use, the Correctional Service of Canada, national Aboriginal organizations, clients and carers, the Canadian Executive Council on Addictions, and the Canadian Centre on Substance Abuse **(CCSA, CECA, Health Canada, FPT Liaison Committee on Problematic Substance Use)**
        ii. identifying and monitoring benchmarks, and service-level and jurisdictional responsibility, for implementing the Strategy **(National Treatment Strategy Leadership Team)**
        iii. co-ordinating communication and partnerships among services and jurisdictions to facilitate the implementation of the Strategy **(National Treatment Strategy Leadership Team)**
        iv. applying gender- and diversity-based analyses throughout the implementation process **(National Treatment Strategy Leadership Team)**
    c. Work with the provinces and territories to develop mechanisms to engage stakeholders and identify opportunities to support implementation of the National Treatment Strategy recommendations **(National Treatment Strategy Leadership Team)**.

IMPLEMENTATION AND EVALUATION

Adequate funding will be needed in order to translate the recommendations in this Strategy into a reality. As noted earlier, estimated funding needs for services and supports within the tiered model must be grounded in needs-based planning models that incorporate population-level data on the prevalence of substance use problems, estimated demand for services and supports, and other factors. In addition, a plan should be developed to evaluate the implementation and ongoing improvement of the many initiatives generated by this Strategy. Such a plan will require the development of success indicators in several areas (e.g., progress toward a tiered model of services and supports; knowledge exchange activities and the adoption of evidence-informed practice and related policy; development of a national research agenda).

RECOMMENDATIONS

19. Develop methodology to articulate the investments that will be needed to implement this Strategy, and encourage stakeholders to allocate resources toward this suite of investments **(National Treatment Strategy Leadership Team)**.
20. Establish a plan to evaluate the implementation of this Strategy **(National Treatment Strategy Leadership Team)**.

4. CONCLUSION

Substance use problems affect Canadians in all walks of life. Yet the services and supports devoted to addressing these problems are inadequately funded and not optimally distributed. This National Treatment Strategy was developed to improve the quality, accessibility and range of services and supports for people with substance use problems. Based on research, consultations and feedback from experts in the field, the Strategy includes 20 recommendations within three areas of focus: building capacity along the full continuum of services and supports; supporting the continuum of services and supports; and moving the Strategy's recommendations forward. The Strategy also proposes that the Canadian Centre on Substance Abuse, in collaboration with CECA and the FPT Liaison Committee on Problematic Substance Use, take a leadership role in co-ordinating the implementation and monitoring of recommendations, supported by a National Treatment Strategy Leadership Team that reflects the broad representation and expertise of the working group that drafted the Strategy.

In summary, the National Treatment Strategy recommends that:

- a continuum of services and supports be developed and implemented that is based on a tiered model
- needs-based planning be undertaken and resources allocated to develop this model across Canada's many jurisdictions
- a comprehensive strategy be developed to address the stigma and discrimination that prevent many people from accessing services and supports for substance use problems
- Canada's knowledge exchange and research capacity be developed to ensure that evidence-informed practices are identified and adopted
- national data on substance use services and supports be improved, and other resources to support planning and evaluation activities be enhanced.

The recommendations in this Strategy are the outcome of collaboration between partners from many sectors; provinces and territories, relevant federal departments; First Nations and Inuit organizations; non-governmental organizations; academic institutions; substance use agencies and service providers; people who use substance use services and supports, family members; and community members. These partnerships will need to continue and be expanded in order to implement the recommendations. By working together toward the common goal of improving the quality, accessibility and range of services and supports for people with substance use problems, we can reduce the risks and harms associated with substance use in Canada.

5. GLOSSARY OF KEY TERMS

Aboriginal: An umbrella term that includes Inuit, First Nations and Métis.

Carers: All family, friends and others involved in providing care and support to those with substance use problems.

Client-level database: A database containing data relating to an individual, client-specific identifier that extends across different services.

Episode database: A database containing data relating to a particular treatment episode within a given service.

First Nations: Indigenous people in Canada who are not Inuit or Métis. This term has generally replaced the term "Indian" as a more respectful reference.

Gender- and diversity-based analysis: A method of analysis applied to research, policy and service provision that makes visible the ways in which exposure to risk, disease courses and outcomes are affected by health determinants such as gender, ethnicity, socioeconomic status, disability, sexual orientation, migration status, age and geography.

Harm reduction: An approach that aims to minimize risks and harms associated with substance use and related behaviours (e.g., sharing needles and other drug paraphernalia, unsafe sexual practices), and reaches out to encourage engagement in services and supports without requiring an immediate commitment to abstinence. Abstinence may, however, remain a longer-term goal for many people.

Inuit: A term meaning "the people" in Inuktitut, referring to the indigenous people of Arctic Canada, as well as of Greenland and Alaska.

Knowledge exchange: The sharing of information and ideas between those who generate knowledge (e.g., the research community) and those who influence service provision and shape policy. The goals of knowledge exchange activities include more evidence-informed decision making, and research that is better informed by the needs of decision makers.

Métis: A term used to describe people with mixed First Nations and European ancestry who identify themselves as such.

Ownership, control, access and possession (OCAP): The principles of OCAP outline First Nations' governance over research, data and information activities related to First Nations communities, as follows: Ownership: First Nations' collective right to manage community information; Control: the inherent right to control the management of First Nations' information; Access: the right to manage and make decisions about collective access to First Nations' information; Possession: the capacity to manage, assert and protect the ownership of information. For more information, see www.rhs-ers.ca/english/ocap.asp.

Population-informed: Taking gender and all other forms of diversity into account and integrating them into all aspects of service delivery.

Population-specific: Addressing the needs of specific subgroups (e.g., a service for young men who have experienced trauma and substance use problems).

Primary care: The front-line delivery of health services, which in Canada includes family medicine (general practice) physicians, nurses and nurse practitioners.

Specialized addiction treatment system: The part of the health system that specializes in treating and caring for people with serious and persistent substance use problems. It includes both publicly and privately funded services.

Wraparound services: The provision of substance use treatment along with services targeted to a person's other health and social needs, such as access to housing and food, as well as employment and education supports.

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APPENDIX A: LIST OF RECOMMENDATIONS

Building capacity across a continuum of services and supports

1. Build capacity along the full continuum of services and supports by adopting and implementing the principles and elements of the tiered model. This includes:
   a. assessing the extent to which existing services and supports reflect the principles and elements of the tiered model
   b. investing sufficient resources and developing infrastructure to ensure that:
      i. the services and supports required within each tier are available in all jurisdictions
      ii. people have universal and timely access to a minimum standard of services and supports, in all sectors and in each tier
   c. ensuring intersectoral collaboration and co-ordination in planning and delivering services and supports, including the development of shared service protocols, agreed service and support pathways, and interdisciplinary, collaborative models of service delivery **(all jurisdictions)**.
2. Involve consumers, advocates, families, friends and other carers in designing, delivering and continually evaluating services and supports, and include people with experience as consumers in all policy, planning and regulatory bodies **(all jurisdictions)**.
3. Co-ordinate the preparation of a toolkit to help jurisdictions to estimate the optimal level of services and supports across the continuum of care **(National Treatment Strategy Leadership Team)**.
4. Review inter-jurisdictional cost-sharing mechanisms to facilitate access to service across jurisdictional boundaries **(Health Canada and the FPT Liaison Committee on Problematic Substance Use)**.

Supporting the continuum of services and supports

KNOWLEDGE EXCHANGE

5. Develop and co-ordinate a national knowledge exchange network to ensure linkage and exchange between knowledge producers and knowledge users, and to promote the implementation of each phase of the proposed knowledge exchange strategy **(National Treatment Strategy Leadership Team)**. The network's efforts should:
   a. build on and enhance existing collaborations at the jurisdictional level, such as the National Workforce Development initiative
   b. identify and address knowledge needs; collect and synthesize existing knowledge; identify factors that respectively facilitate and impede the effective use of knowledge; make this knowledge accessible across the full continuum of services and supports, to policy-makers, service providers, and to the public; and determine how best to support the implementation of knowledge
   c. be directed as a priority at lower-tier services and supports, in order to address the existing gaps in knowledge and practice regarding substance use problems and co-ordinated responses to them
   d. be grounded in the needs of diverse populations and acknowledge culturally appropriate healing practices.
6. Develop and implement clear knowledge exchange strategies to:
   a. improve the effectiveness of services and supports
   b. ensure that decisions regarding policies on the design and funding of the various health care systems that address substance use problems are informed by evidence
   c. improve the public's knowledge and skills to make healthy choices regarding substance use, leading to better self-management and the reduction of stigma and discrimination
   d. ensure a two-way flow of information between those producing research and those using it, including service providers and political decision makers **(all jurisdictions)**.
7. Make funding available to support activities consistent with the proposed knowledge exchange strategy **(all jurisdictions and research funding bodies)**. This should include an annual call for proposals for the development of inter-jurisdictional and intra-jurisdictional mechanisms to:
   a. collect and synthesize knowledge
   b. ensure its implementation across the full continuum of services and supports.

   Specific priorities for each call for proposals should be recommended by the National Treatment Strategy Leadership Team in consultation with the national knowledge exchange network.
8. Fund the development of a best practices toolkit (or toolkits) to build capacity and to support the development of proactive, targeted knowledge exchange activities at all jurisdictional levels, the system level and the agency level. The toolkit(s) should be updated periodically, given the evolving nature of new interventions and technologies **(Health Canada)**.

REDUCING STIGMA AND DISCRIMINATION

9. Develop, implement and evaluate an evidence-based, comprehensive strategy, involving the specialized addiction treatment system, broader health and social service systems, people with substance use problems and others affected by substance use, to increase awareness and understanding and thereby reduce stigma and discrimination related to problematic substance use **(National Treatment Strategy Leadership Team)**.
10. Identify the range of potential partners and develop collaborative workplans with individuals and organizations already engaging in anti-stigma and anti-discrimination initiatives (e.g., Mental Health Commission of Canada, First Nations and Inuit Mental Wellness Advisory Committee) **(National Treatment Strategy Leadership Team)**.

DEVELOPING A RESEARCH PROGRAM

11. Develop mechanisms to increase the capacity for a targeted research program on substance use **(National Treatment Strategy Leadership Team)**, including:
    a. the initiation of competitive funding calls by CIHR and the Social Sciences and Humanities Research Council (SSHRC) to develop and support research teams to address priority areas (this will complement the anticipated call for proposals on substance abuse "treatment" from CIHR's Institute of Neuroscience, Mental Health and Addictions (INMHA), as well as the work of the Institute for Aboriginal Peoples' Health)
    b. proactive encouragement and resourcing by CIHR and SSHRC of cross-sectoral research on substance use services and supports; community-based research collaborations; and the development of junior researchers
    c. funding at the provincial and territorial level for focused, applied research to build capacity for knowledge generation beyond the academic community.
12. Promote opportunities (e.g., through symposiums and workshops at relevant events) to present and review new research in the priority areas, with an emphasis on increasing the engagement of the scientific community on research related to improving the quality, accessibility, and range of services and supports within the tiered model **(National Treatment Strategy Leadership Team)**.
13. Provide resources for research directly related to the implementation of the tiered model, for intersectoral collaborations and for knowledge exchange **(all jurisdictions and funding bodies)**.
14. Promote research partnerships and collaboration between the specialized addiction treatment system and others engaging in parallel efforts, including the Correctional Service of Canada and the Aboriginal Health and Human Resources Initiative **(National Treatment Strategy Leadership Team, research agencies)**.

MEASURING AND MONITORING SYSTEM PERFORMANCE

15. Identify a national lead and establish a process for reporting and sharing data on the capacity and use of services and supports, based on the tiered model, and guide the ongoing development of national treatment indicators, beginning with those listed in this Strategy **(National Treatment Strategy Leadership Team, Health Canada)**.
16. Co-ordinate projects to improve measurement and monitoring of the performance of services and supports in each of the five tiers **(National Treatment Strategy Leadership Team)**.
17. Develop the capacity to collect and report information from all sectors in each of the five tiers, including the capacity to report on the national treatment indicators **(all jurisdictions)**.

Moving the Strategy forward

LEADERSHIP AND CO-ORDINATION

18. With regard to implementing the National Treatment Strategy:
    a. Allocate and align resources to implement the Strategy in a way that maximizes individual and collective efforts **(all jurisdictions, CCSA, FPT Liaison Committee on Problematic Substance Use, CECA)**.
    b. Co-ordinate the implementation of the Strategy through:
        i. developing a multisectoral National Treatment Strategy Leadership Team including representation from Health Canada, the FPT Liaison Committee on Problematic Substance Use, the Correctional Service of Canada, national Aboriginal organizations, clients and carers, the Canadian Executive Council on Addictions, and the Canadian Centre on Substance Abuse **(CCSA, CECA, Health Canada, FPT Liaison Committee on Problematic Substance Use)**.
        ii. identifying and monitoring benchmarks, and service-level and jurisdictional responsibility, for implementing the Strategy **(National Treatment Strategy Leadership Team)**
        iii. co-ordinating communication and partnerships among services and jurisdictions to facilitate the implementation of the Strategy **(National Treatment Strategy Leadership Team)**
        iv. applying gender- and diversity-based analyses throughout the implementation process **(National Treatment Strategy Leadership Team)**.
    c. Work with the provinces and territories to develop mechanisms to engage stakeholders and identify opportunities to support implementation of the National Treatment Strategy recommendations **(National Treatment Strategy Leadership Team)**.

IMPLEMENTATION AND EVALUATION

19. Develop methodology to articulate the investments that will be needed to implement this Strategy, and encourage stakeholders to allocate resources toward this suite of investments **(National Treatment Strategy Leadership Team)**.
20. Establish a plan to evaluate the implementation of this Strategy **(National Treatment Strategy Leadership Team)**.

APPENDIX B: NATIONAL TREATMENT STRATEGY WORKING GROUP MEMBERS

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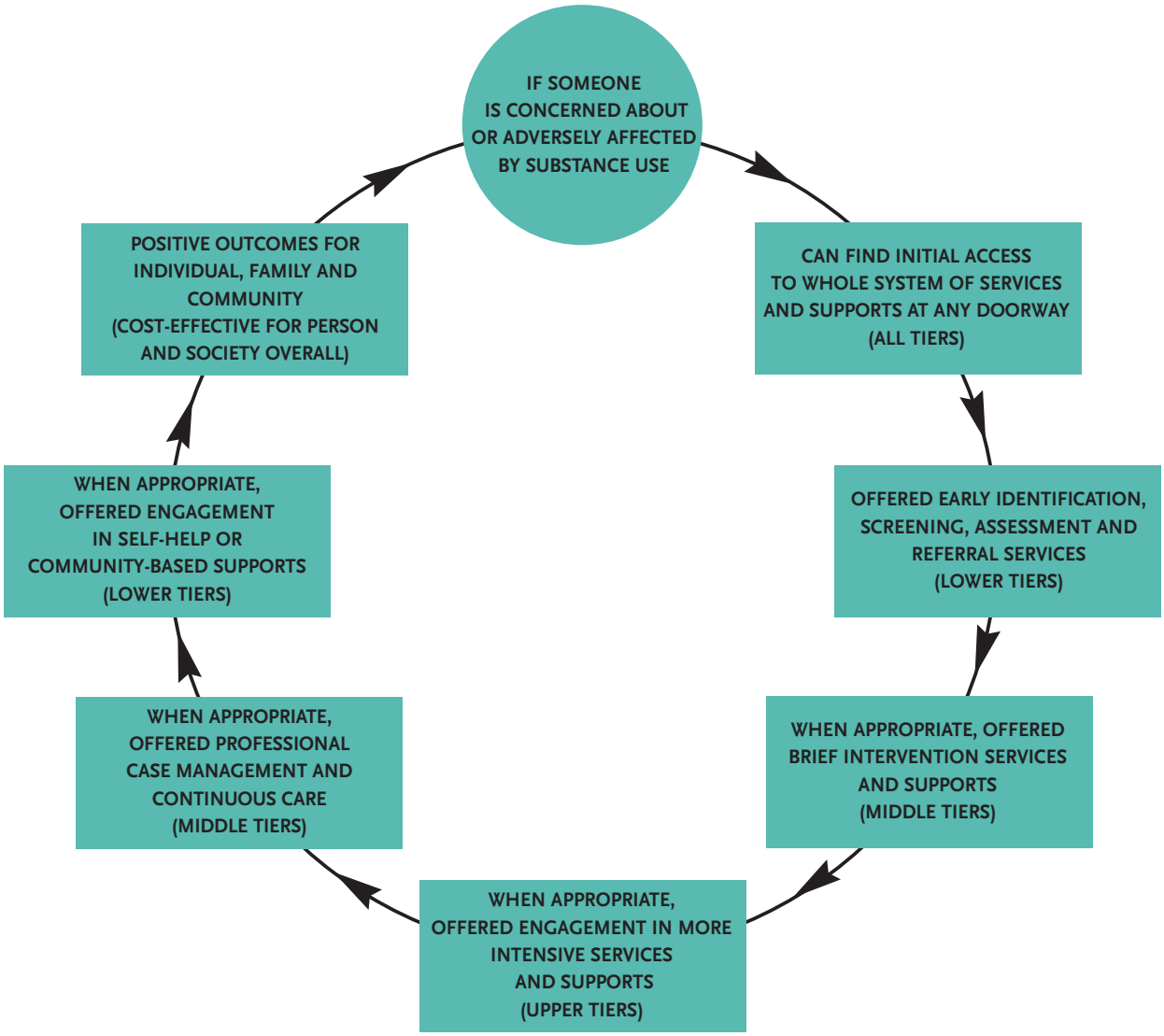
APPENDIX C: PERSON-CENTRED PATHWAYS THROUGH SERVICES AND SUPPORTS



BC Mental Health &
Addiction Services

An agency of the Provincial Health Services Authority

Canadian Executive Council on Addictions
Conseil exécutif canadien sur les toxicomanies

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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