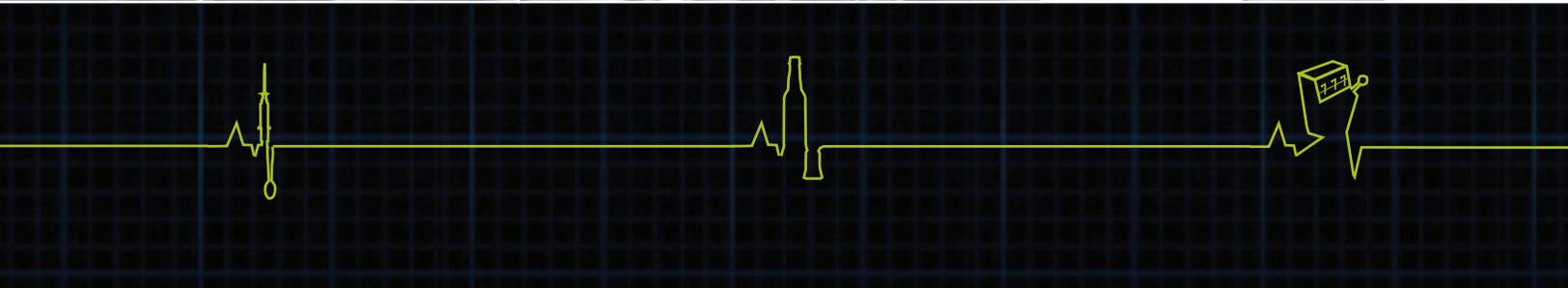
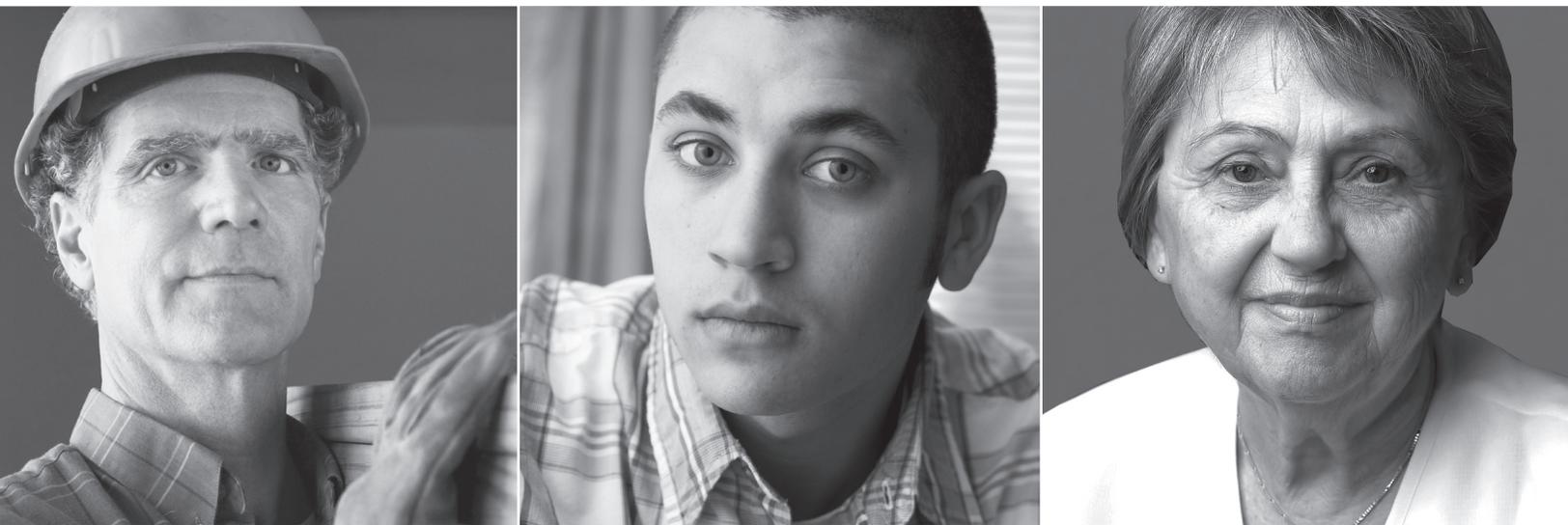


STEPPING FORWARD

Improving Addiction Care in British Columbia



A POLICY PAPER BY BC'S PHYSICIANS | MARCH 2009



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Improving Addiction Care in British Columbia

A Policy Paper by BC's Physicians

March 2009

The Addiction Strategy Group is part of the British Columbia Medical Association's (BCMA's) Council on Health Promotion, a voice for health advocacy calling for changes to improve the overall health of British Columbians.

The project group for this paper includes:

Addiction Strategy Group

Dr Shao-Hua Lu, Chair – Addiction Psychiatry, Vancouver

Dr Douglas Coleman – Addiction Medicine, New Westminster/Coquitlam

Dr Donald Hedges – Addiction Medicine, New Westminster/Coquitlam

Dr Veronic Ouellette – Family Practice and Community Medicine Specialist, Vancouver/Surrey

Dr Larina Reyes-Smith – Addiction Medicine, Richmond/Surrey

Dr Paul Sobey – Addiction Medicine, New Westminster

Staff support was provided by Mr Robert Hulyk, MHA, Senior Public Affairs Specialist,

Ms Matilda Dray and Ms Susanne Carlon, Administrative Assistants

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“As long as there is one individual who is out on the street, who is homeless, who is wanting to deal with a mental health issue and is not getting the support or has an addiction issue and is not getting the support, then I’m not going to be satisfied.”

The Honourable George Abbott, BC Minister of Health
Committee of Supply, Ministry of Health
21 May 2008

“In light of the public input on this topic, the Finance Committee agrees that both mental health and addictions services are priority areas for investment.”

Legislative Assembly of British Columbia
Select Standing Committee on Finance and Government Services
Report on the Budget 2009 Consultations

AN OPEN LETTER FROM THE BC MEDICAL ASSOCIATION PRESIDENT

Addiction is a disease that touches every British Columbian in one way or another. Today it is estimated that almost 400,000 British Columbians suffer from some form of addiction or substance misuse.* These people come from every socioeconomic, geographic, cultural, and age demographic within our province. The impact of addiction on British Columbia is immense. In 2006, it was estimated that substance abuse cost BC over \$6 billion, or \$1,500 per year for every British Columbian. Although we often see the tragedy of addiction on our streets, the majority of suffering occurs in people's homes, at school, and at work across all parts of our province. While we tend to think of addiction in terms of illicit drugs, addiction to alcohol and gambling in BC are far more prevalent.

Despite the significant impact of addiction on our province, there are clear gaps in our system that result in people not getting the appropriate levels of care they need where they need it. Too often, emergency departments, law enforcement, and the workplace bear the brunt of addiction—and that is before we consider the impact on the addicted individuals and their families in their homes. Consider that in our health system:

- A recent study showed that as many as 1 in 10 visits to Vancouver General Hospital's emergency room was for substance abuse.¹
- Each year, BC uses enough hospital beds for substance abuse care to fill Kelowna General Hospital every day for a year.²

To create a system where those pressures can be reduced and those resources can be allocated to other problems requires that we change our thinking in a fundamental way. We must begin to think of addiction as a chronic disease and invest our health care dollars accordingly, much in the same way as we have begun to do for diabetes and heart disease.

Therefore, the BC Medical Association (BCMA) is calling on the Premier and the Minister of Health to formally recognize addiction as a chronic disease and increase resources for addiction treatment and care in BC over the next 5 years. Addiction care infrastructure must be a priority in 2009, and the province must create 240 new detoxification spaces and 600 new addiction treatment beds by 2012.

The news is not all bad. The provincial government has significantly reinvested in mental health, addiction, and housing, particularly in recent years. Health Authorities have worked hard to develop services and long-term plans to expand and improve services. The Ministry of Health Services is also set to release a new 10-year mental health and addiction plan. However, new resources must be targeted to key areas of need. In particular, we need to ensure that we improve access to care at the early stages in an addicted person's search for recovery. Access to primary and intervention levels of care can provide immediate benefits and help reduce the stress and costs on the system further down the line.

British Columbia bears the cost of addiction, no matter where it occurs or, more importantly, whether we choose to act or not. We want to be proud to live in a society that chooses to do something.

Sincerely,

Dr Bill Mackie, MD
President, BCMA

* This figure includes 344,000 with indications for alcohol addiction (120,000 with a high probability of alcohol dependence and 224,000 with indications of alcohol dependence), 33,000 with a severe addiction to illicit drugs, and 159,000 British Columbians estimated to have a gambling addiction (31,000 with a severe addiction, 128,000 with a moderate gambling problem). Addiction to tobacco is excluded, but recent estimates show 700,000 British Columbians are active smokers. Addiction to prescription medications is not included in the total, but is also recognized as a serious problem. Full references for these figures are provided in Section III and Appendix A.

THE BCMA'S RECOMMENDATIONS

As some recommendations have several parts, see pages 59-61 for a full list.

The BCMA recommends that British Columbia:

1. Formally recognize addiction as a chronic, treatable disease under the BC Primary Care Charter and the BC Chronic Disease Management Program. This requires expanding the BCMA/Ministry of Health Community-based Mental Health Initiative launched in 2008 to include addiction.
2. Create and fund 240 new flexible medically supervised detoxification spaces across BC by 2012 (60 per year). BC needs to ensure that detoxification is available "on demand" when requested by the individual, health professional, or Vancouver's drug court by 2012. This flexibility must also include adapting to specific needs for youth and other populations. Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary.
3. Fund the development of 600 new addiction-treatment beds across the province by 2012 (150 per year). Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary. The creation of these new beds should also include expansion of existing capacity to treat concurrent disorders (mental health and addiction).
4. Expand existing community addiction programs, case management, and crisis support teams across all Health Authorities by 2012, including specific programs for rural communities, First Nations, minority populations, youth, pregnant women, and seniors. This expansion must include better integration with primary care.
5. Ensure that access to addiction care is accessible without financial and other barriers throughout BC; this includes the elimination of per diem fees, minimization of language barriers, and access to inpatient addiction care.
6. Establish standards of care for addiction medicine treatment. This includes clearly defined wait times for services across the continuum of care developed in conjunction with front-line practising health professionals, Health Authorities, and the Ministry of Health Services. This should also include the development of clinical guidelines and protocols for addiction care developed by the Ministry of Health Services and the BCMA through the Guidelines and Protocols Advisory Committee (GPAC).
7. Expand training and support for physicians in addiction medicine. This should include formal recognition of addiction medicine as a specialty in British Columbia by provincial and national medical, nursing, and other health profession education bodies.
8. Further expand BC's addiction-research capacity, enabling researchers to collect data, conduct utilization research, and evaluate programs.
9. Review and expand pharmacotherapy coverage for addiction treatment. Include the input of health professionals actively practising addiction medicine.
10. Expand the mandate of the Premier's Task Force on Homelessness, Mental Illness and Addiction to include the full continuum of addiction care. Its mandate should also include specific capacity and accessibility targets province-wide and require the task force to meet at least twice per year to review these targets and coordinate efforts.

I) BACKGROUND ON PROJECT

In 1997, the BCMA participated in the development of a joint report with the BC Ministry of Health entitled *No Further Harm*. The report focused on the epidemic of intravenous (IV) drug use and addiction in BC and the potential spread of the human immunodeficiency virus (HIV). The report made 43 recommendations for improving prevention, treatment, and the health care infrastructure for addiction in British Columbia.

Ten years after the release of this report, it is clear that the overall situation has deteriorated. While the use of IV drugs appears to be on the decline, the use of other drugs such as methamphetamine (crystal meth), crack cocaine, heroin, and ecstasy has increased.

British Columbia's physicians care for patients with addiction on a daily basis. Despite positive efforts on several fronts, British Columbia is failing to make significant headway in multiple areas of addiction care, with clear gaps in the continuum of care. Physicians and other health professionals see these struggles firsthand every day.

In 2008, through its Council on Health Promotion, the BCMA formed a project group comprising physicians with broad experience in the area of addiction medicine to prepare a report with recommendations to assist government and Health Authorities in dealing with the issue of addiction. This report is the result of that process.

This report is intended to facilitate a positive and balanced discussion on how to move forward. It is not meant as an exhaustive study; rather, it is intended to focus on priority issues facing addiction care in British Columbia today.

Addiction and mental health

Although this report focuses on the issues and challenges associated with addiction, the BCMA recognizes that considerable overlap exists between addiction and mental health. Many aspects of addiction care have implications for mental health care. A number of people also suffer from concurrent disorders, having both a mental illness as well as an addiction. Service delivery structures for addiction within Health Authorities are often provided by the same professionals and facilities that provide care for mental health. This report is only one part of the efforts to address this complex problem; more needs to be done. Improving mental health care in British Columbia continues to be a significant challenge for our province. As noted in the 2006 report from the Standing Senate Committee on Social Affairs:

Research has shown 30% of people diagnosed with a mental illness will also have a substance use disorder in their lifetime and 37% of people with an alcohol use disorder (53% who have a drug use disorder other than alcohol) also live with mental illness.³

Tobacco

Tobacco addiction continues to be a major problem in British Columbia. This report, however, focuses primarily on the prevention and treatment of other forms of addiction, such as illicit drugs, alcohol, and gambling. This is in no way meant to diminish the impact of tobacco on our society. As noted by the Ministry of Health in 2006, "tobacco



kills more people than all other psychoactive substances combined."⁴ In addition, the deaths of 5,972 people aged 35 and over were considered attributable to smoking in 2006.⁵

The BCMA has already made recommendations for addressing tobacco addiction in other documents such as *Physicians Speak Up*, the BCMA's submission to the BC government's Conversation on Health.⁶ In addition, several organizations (e.g., BC/Yukon Division of the Canadian Cancer Society) and government have clear recommendations and stop-smoking programs in place. However, many of the recommendations in this report regarding improving addiction care in primary care could easily be adapted for tobacco cessation, should other resources fall into place.



II) WHAT IS AN ADDICTION?

Addiction is a chronic, generally progressive, and treatable biological disease. Addiction has been recognized as a disease by the Canadian and American Medical Associations as far back as 1976.^{7,8} A person can be addicted to a substance (e.g., alcohol, illicit drugs, or prescription drugs) or an activity (e.g., gambling). The Australian Medical Association recently defined addiction as the following:

Addiction is a chronic pattern of behaviour that is characterised by the repeated use of substances or behaviours despite significant and ongoing harms associated with use, where the harms outweigh the benefits. It is difficult to control or cease the use of the substances or behaviour due to physical or psychological dependence. Addictions generally take a period of time to develop and follow a chronic and relapsing course and therefore require ongoing support and treatment.⁹



Nancy's story

"Nancy" is a 20-year-old woman living in a suburban community in Vancouver. She graduated from high school and works in the food service industry. She is bright, popular, in a relationship, and appears to be a happy young woman. Nancy's real story is not so positive.

By the age of 11, Nancy was diagnosed with depression and anxiety and treated by a child psychiatrist. She has been off and on antidepressants but refuses counseling. At age 13, Nancy began smoking cigarettes and marijuana. She started drinking alcohol occasionally at age 15 and experimented with other drugs, such as ecstasy. By age 18, she was drinking daily. Nancy was exposed to painkillers as a child and she continues to attempt to get prescriptions for them. However, it is her drinking that is getting more and more out of control. She occasionally misses work, fights with her partner about her drinking, and also routinely drinks and drives.

Nancy feels constant guilt and would like to stop drinking in order to have a healthy child. She has tried to stop drinking on her own many times. However, when she is upset or stressed or simply wants to go out with her friends, she relapses. Nancy has attempted detoxification several times, but she never stays more than 2 days.

Her alcohol consumption and prescription drug use have been increasing in regularity and severity, but she has finally said she is ready for treatment. However, there are few resources for youth outside of the Downtown Eastside, and she refuses to return to local treatment centres, where she feels out of place. Her parents can help with funding but do not want her to leave the province or go to the Downtown Eastside.

In a full continuum of care, Nancy would be able to immediately access a youth-focused detoxification and then seamlessly transfer to an intensive outpatient or residential treatment centre in her community, with ongoing primary care services provided in support. The Aurora Centre at BC Women's Hospital & Health Centre is an example of a centre focused specifically on women.

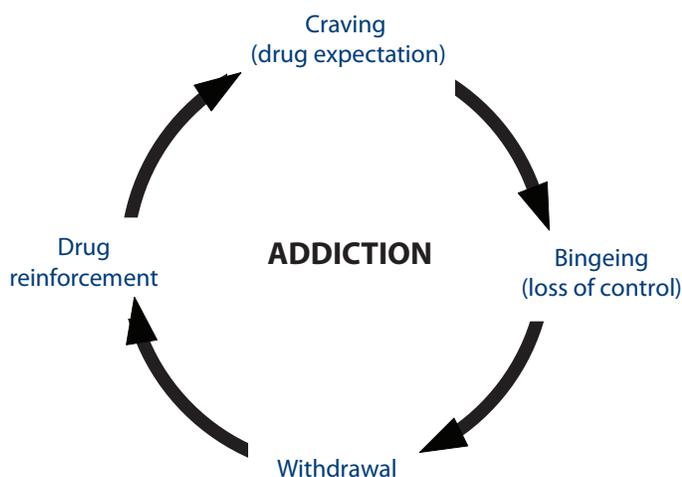
The terms “abuse” and “dependence” are often used to clinically describe a person’s behavior caused by the use or misuse of a substance. Definitions of these terms are provided in Appendix B. This BCMA report focuses on problematic substance use, especially addiction. Although this report often uses the word “addiction,” the BCMA fully recognizes that there can be a range of harms associated with substance use. This spectrum includes episodic intensely heavy use (“bingeing”) that can lead to severe acute health problems or using while pregnant or drinking and driving. It also includes consumption over time that counts as hazardous use due to the risk it poses for chronic physical and mental disorders. Finally, the spectrum includes addiction, which is itself a chronic disorder characterized by an inability to control use (e.g., *Diagnostic and Statistical Manual of Mental Disorders*-defined substance use disorders: abuse and dependence). Within the population, these three forms of problematic substance use may occur independently or in combination. Each makes its own substantial contribution to the burden on the health care system.

From a clinical perspective, each form of problematic substance use may call for a distinct treatment approach. For example, research evidence has clearly shown that brief interventions delivered by primary care providers can significantly reduce the incidence of intensely heavy use as well as excessive use over time. But more intensive and specialized treatment approaches are generally required for patients with addiction. In these cases, primary care providers can play a vital role in screening for substance use problems, including addictions. It is critical, however, that family physicians and other medical practitioners have adequate tools, training, and support. In particular, physicians must have the knowledge and means to refer patients to specialists in addiction medicine or other addiction treatment providers.

The cycle of addiction and accumulation of loss

Research has shown that a person with an addiction follows a relatively consistent pattern. Over time, addiction has been shown not only to affect all parts of the brain but to alter it.¹⁰ As described in Goldstein and Volkow (2002), the four common stages of an addiction include:

- 1) Craving (drug expectation)
- 2) Bingeing (loss of control)
- 3) Withdrawal
- 4) Drug reinforcement



The “three C’s” of addiction

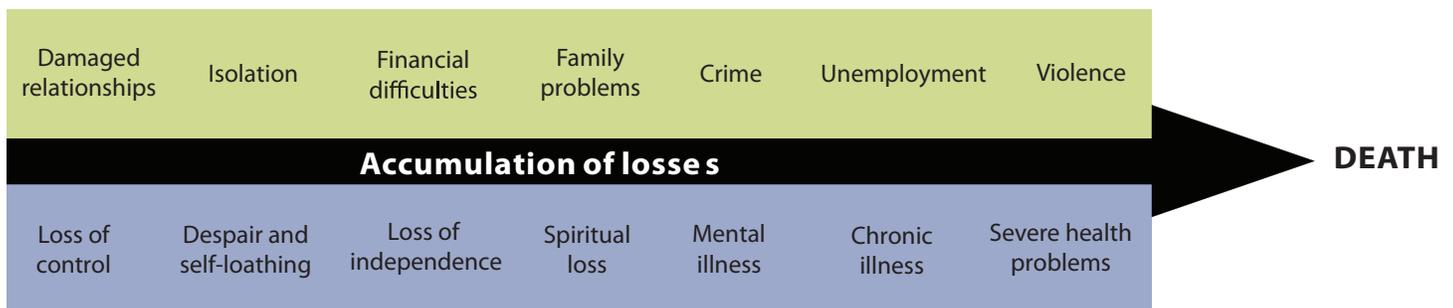
Health professionals describe the characteristics of an addiction as the “three C’s,” as follows:

1) Loss of <u>C</u>ontrol:	The inability to stop using a substance despite a desire or attempt to stop.
2) Use despite the <u>C</u>onsequences:	The ongoing use of a substance despite negative impact on family, job, finances, or health.
3) Increased <u>C</u>ompulsion:	The persistent and often overwhelming urge or impulse to use a substance that increases over time.

The accumulation of losses

As the disease of addiction progresses, a person will often undergo an “accumulation of losses.” The following chart is intended to provide a simple summary of the kinds of losses that a person with an addiction may suffer over time.

External



Internal

Items listed above do not represent a chronological sequence of events.

Examples of loss include withdrawal from social activities, financial difficulties, problems at work, and medical complications. However, not everyone with an addiction will necessarily suffer all of these losses or go through these stages in this sequence. For some people, this cycle may take years to occur. In some cases (e.g., cocaine or crystal meth addiction), the entire spectrum of loss can be experienced in a matter of weeks. Too often, patients with an addiction are aware of their situation; however, this progression continues despite their personal efforts to reverse the accumulation of losses.



Why do people develop an addiction?

The science of addiction continues to evolve, but there are three basic factors that influence the likelihood of addiction:

- 1) **Individual:** includes genetics, physical and mental health, age of first use.
- 2) **Environment:** neighborhood, social network, family history, social policy and regulations (e.g., legal ages for purchasing alcohol).
- 3) **Substance or behavior:** cocaine, alcohol, gambling, or prescription medications.

While no one is completely immune, most people do not develop an addiction. For example, many people are able to enjoy a glass of wine or buy a lottery ticket without becoming clinically addicted. For some, however, these activities become overwhelming. According to the Canadian Centre for Addiction and Mental Health:

- A person usually perceives the behaviour itself as being strongly rewarding in some way. The nature of the reward, however, may vary from person to person and may change over time. Some individuals may be rewarded by the energizing, exciting, or pleasurable effects of a substance or of a behaviour, such as gambling.
- Some people may engage in addictive behaviours because the physiological or psychological effects relieve physical or emotional suffering.
- Addictive behaviours may divert attention from distressing or overwhelming life circumstances. For example, some substances may temporarily lessen the symptoms associated with anxiety, depression, or chronic frustration.¹¹

In 2006, the BC Ministry of Health defined the spectrum of use in terms of the intensity of harms that occurs from increasing use:

Substance use can occur along a spectrum from beneficial use through non-problematic to problematic and dependent use. Problematic substance use includes episodic use having negative health consequences and chronic use that can lead to substance use disorders (e. g., dependence) or other serious illnesses... Substance use may begin at one point on the above spectrum and remain stable or move gradually or rapidly to another point. For some people, their use of one substance may be beneficial or non-problematic, while their use of other substances may be problematic.¹²

The stigma of addiction

One of the greatest challenges of addiction is the significant stigma attached to it. The truly unfortunate



consequence of this stigma is that it reinforces a sense of this issue being a lower priority than other health challenges.

Not unlike mental illness, there exists a negative view and stigma around addiction, that these members of society are somehow weaker than others, that it is acceptable for us to turn a blind eye to their suffering. It's time to clear the air—addiction is a disease, and those who suffer with it need medical assistance just as those who suffer from heart disease or cancer.¹³

Dr Brian Day, President
Canadian Medical Association, 2007/2008

In its eighth Annual National Report Card on Health Care 2008, the Canadian Medical Association (CMA) revealed startling information on the perception of mental illness and addiction among Canadians. The survey showed that:

Only about half of Canadians say drug addiction (51%), alcoholism (49%)...or gambling (53%) are either serious mental illnesses or mental illnesses.

The survey also showed that:

- Only one-third of Canadians or fewer say they would be likely to socialize with a friend who has an alcohol (32%) or other drug addiction (26%).
- Only 21% of Canadians would socialize with a co-worker who has either an alcohol or drug addiction.
- Only 4% of Canadians would hire someone to work for them who has an alcohol addiction, and only 2% of Canadians would hire someone with a known drug addiction.
- Only 5% of Canadians would have a family doctor who has an alcohol problem, and only 2% would have one who has a known drug addiction.¹⁴

These survey results help demonstrate the social stigma attached to mental health and addiction. This stigma is one of the first barriers individuals with this illness must face. One of the worst tragedies of this disease is that, invariably, those suffering from it try hard to conceal it or deny it exists. For example, among friends or strangers an individual may be quick to identify himself or herself as a cancer survivor; the same cannot be said for a person with an addiction.

Many people with an addiction will deny that they have a problem—this denial is part of the illness. The stigma of addiction may be reinforced by an addicted individual's belief that nothing can be done to help him or her or by misinformation about the characteristics of the disease. Addressing this stigma, this element of shame, must be a critical consideration of any approach to improving addiction care and involves research, education, and treatment to help overcome it. These same efforts were critical in helping to overcome stigmas that once existed around other illnesses, such as cancer in the 1950s and HIV in the 1990s.



Recent mental health and addiction legislation in the United States

In October 2008, the United States government took a significant step forward in treating mental illness and addiction the same as other diseases when it passed the *Mental Health Parity and Addiction Equity Act*. With support from the house and senate, the bill ended unfair discrimination by health plans toward individuals with mental illness or addiction, removing limitations on such things as deductibles, hospital stays, and doctor visits. The mandated that mental health and addiction be treated on the same terms and conditions as other illnesses:

The financial requirements...and treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan.¹⁵

Position of the Canadian Medical Association

The Canadian Medical Association called for the same approach to be undertaken as far back as 2000, adopting the following resolution:

That the Canadian Medical Association engage in a formal dialogue with the insurance industry and worker compensation organizations to discuss the burden on patients and health care providers of restrictive policy underwriting, enhanced claims scrutinizing, and onerous assessment processes for mental, nervous, and addictive disorders and seek solutions equitable to all parties.¹⁶



Trevor's story

"Trevor" is a 33-year-old skilled laborer who started drinking when he was 13. His father was a heavy drinker and died of cirrhosis of the liver at 55. Trevor experimented with marijuana at 14 and was smoking it daily by 16. He first snorted cocaine at 19 and tried crack at 31. Initially the depressive after-effects of crack scared him off it, but 2 years later he tried it again at a party. Within 3 months, he was using crack daily. Beer and marijuana fell by the wayside. In the last year, Trevor has spent \$40,000 on crack. His relationship with his girlfriend ended and she moved out with their two children.

Trevor missed nearly a month of work and eventually stopped calling in with excuses when he lost his cell phone. His parents contacted his union representative after they found him living in his car near their home. He had lost his apartment 2 weeks earlier. Within 11 days, Trevor had seen an addiction specialist and left for a treatment centre, where a 2-year monitoring agreement was recommended. The cost was split between his union, his employer, and an interest-free loan his employer gave him.

Trevor had a good outcome. This example illustrates how Trevor's employer recognized both the benefit and cost to the company in assisting his recovery and the benefits of expedited access to care and early intervention for its employee. However, Trevor could also have been helped sooner had intervention been available or provided earlier on.

III) ADDICTION IN BRITISH COLUMBIA—THE “ICEBERG”

If you asked an average British Columbian, it is unlikely that he or she could tell you how many people in British Columbia suffer from an addiction. Many people would point out the problems in Vancouver’s Downtown Eastside, or some might know of someone in their family, workplace, or school who has had some type of addiction but would not know the number of people with addictions in the province. This is BC’s addiction “iceberg”—many see the tip of addiction in the Downtown Eastside, but the number of addicted people in other parts of the province is significantly larger and largely unknown.

The reality is that today almost **1 in 10 British Columbians** may suffer from some form of addiction or dependence. **This means almost 400,000 British Columbians may have some form of addiction or dependence problem today (not including tobacco¹⁷).**

For 40,000 to 50,000 people, that addiction is severe, and these addicted people are spread across the province. For example:

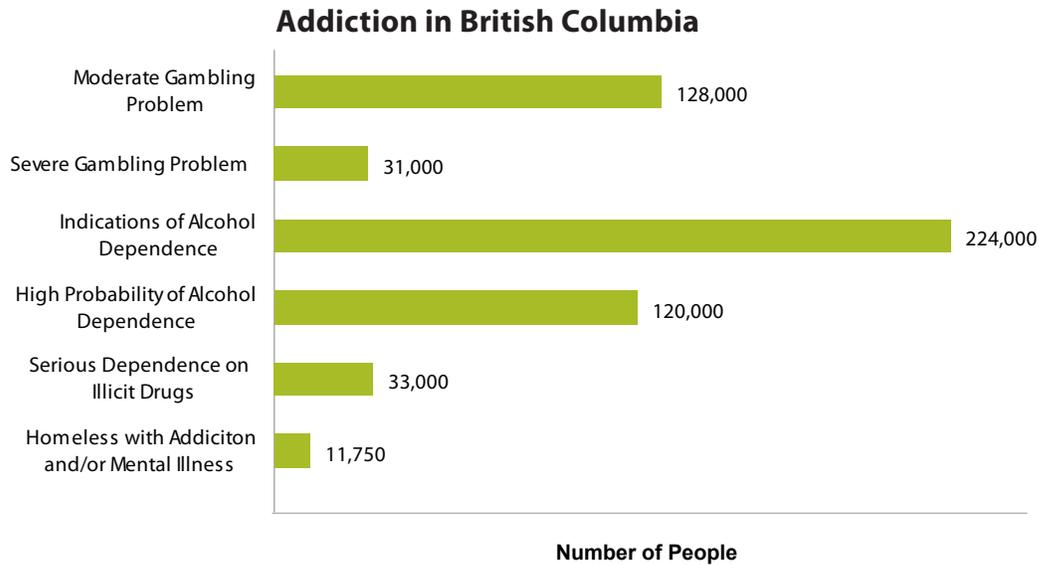
- 1) The Vancouver Island Health Authority (VIHA) estimates that “there are over 150,000 people across Vancouver Island coping with mental health and addiction issues.”¹⁸
- 2) The Fraser Health Authority (FHA) estimates that “by 2010 approximately 192,000 to 240,000 people will be in need of withdrawal management and/or treatment services for substance misuse.”¹⁹

Among British Columbians:

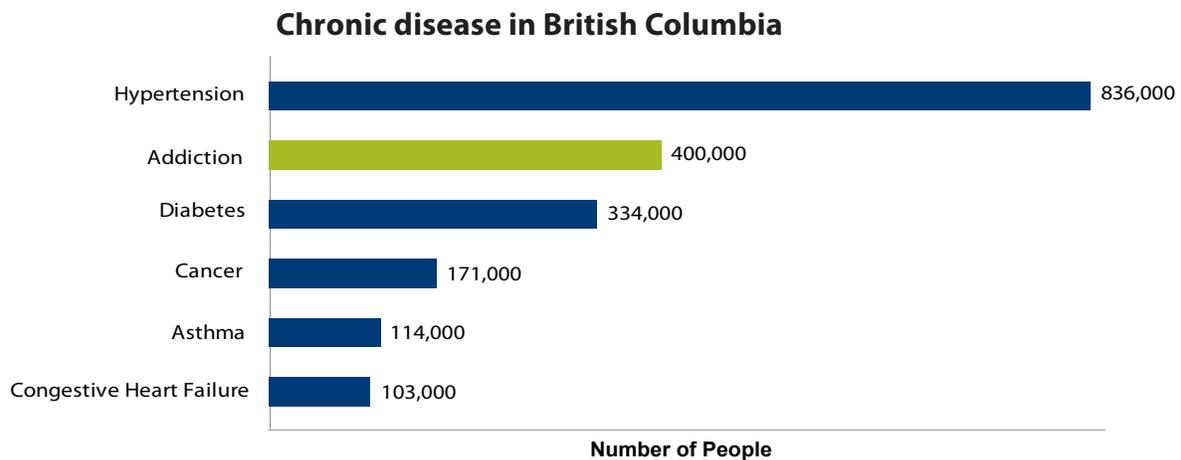
- **11,750** are homeless and have a severe addiction and/or mental illness. Between 2,000 and 4,000 of these people are in Vancouver’s Downtown Eastside.²⁰
- **33,000** have a serious dependence on illicit drugs.²¹
- **120,000** have a high probability of alcohol dependence, with an additional **224,000** with indications of alcohol dependence.²²
- **31,000** have a severe gambling problem. The number of people in BC with a severe gambling problem has increased since 2002 from 0.4% of the population to 0.9% in 2007.²³
- **128,000** additional British Columbians have a moderate gambling problem.²⁴



The following graph depicts these statistics.



Consider the number of British Columbians with an addiction compared with other chronic diseases:^{25,26}



The impact from this challenge is widespread. For example, BC's Provincial Health Officer recently commented on the impact of alcohol consumption in British Columbia in a December 2008 report:

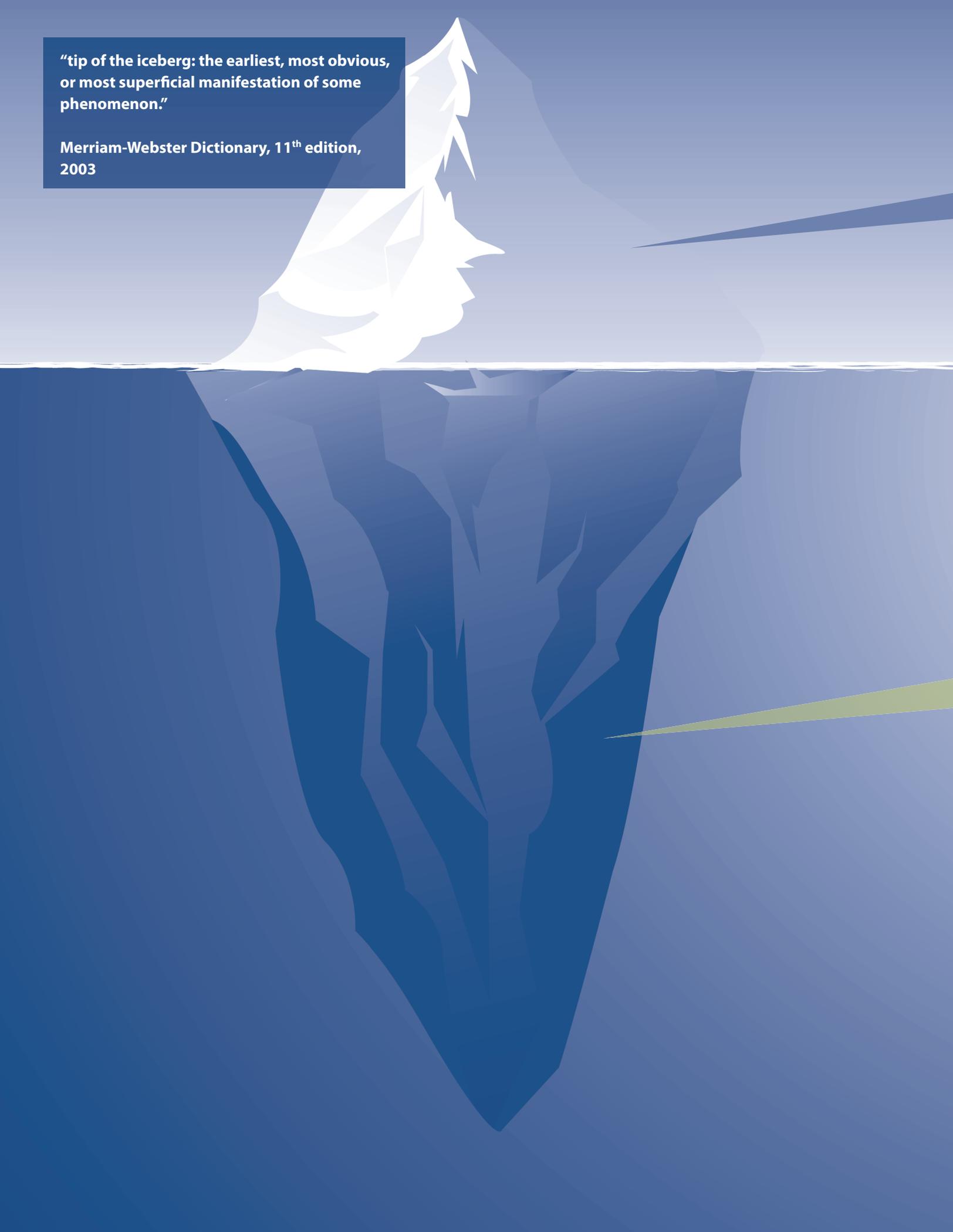
Overall, alcohol is confirmed as a major source of health and social harms and costs, and it appears as though the concerns expressed in the 2002 PHO report about the effects of increased access leading to greater consumption have been confirmed. The evidence also suggests that the growth in consumption has translated into concomitant increase in some health and social harms, notably indicated of alcohol-related road trauma and, to a lesser extent, hospitalizations attributable to alcohol use.

Dr Perry Kendall, BC Provincial Health Officer
December 2008

Public Approach to Alcohol Policy

"tip of the iceberg: the earliest, most obvious, or most superficial manifestation of some phenomenon."

Merriam-Webster Dictionary, 11th edition, 2003



The addiction iceberg in British Columbia

Deaths

- 213 British Columbians died from unintentional illicit or illegal overdose in 2006.²⁷
- 1,986 British Columbians died from alcohol-related deaths in British Columbia in 2006; 46% (or 914 of them) were seniors.²⁸
- 77 British Columbians committed suicide from alcohol or drug poisoning in 2006.²⁹

Homelessness

- 11,750 British Columbians with severe addiction and/or mental illness are homeless. Between 2,000 and 4,000 of them are in Vancouver's Downtown Eastside.³⁰
- 18,759 additional adults with severe addiction and/or mental illness are at imminent risk of homelessness.³¹

Hospital and ER use

- 48,082 hospital days in BC in 2004/2005 were utilized for substance abuse.³² That is enough hospital days to fill Kelowna General Hospital every day for a year.
- 1 in 10 patients in Vancouver General Hospital's emergency department was there due to a substance abuse problem, shown in a 6-week study conducted in 2008.³³
- The number of patients staying at Vancouver General and UBC Hospitals due to substance abuse increased by 44% between 2005 and 2008 (from 1,317 to 1,896).³⁴
- In 2007, hospitalizations attributed to alcohol use in BC Health Authorities ranged from a low of 315 per 100,000 in Vancouver Coastal to 657 per 100,000 in the Northern Health Authority—more than double the rate in Vancouver (the BC average was 404).³⁵
- Hospitalizations in BC Health Authorities due to illicit drug use in 2007 ranged from 79 per 100,000 in Vancouver Coastal to 160 per 100,000 in the Northern Health Authority (again, more than double the rate in Vancouver). The BC average was 112 per 100,000.³⁶

Police and crime

- 49% of Vancouver Police Department (VPD) calls in the Downtown Eastside involved contact with an individual who was mentally ill.³⁷
- 379 chronic offenders in Vancouver have an average of 71 police encounters and 33 charges each.³⁸ Their offences are often committed to support their addiction.
- A 2002 study of federal inmates showed 49% of violent crimes (assault, murder) and 30% of gainful crimes (theft, break and enter) were associated with alcohol and/or illicit drugs.³⁹

Cost

- The total financial burden of substance abuse in British Columbia in 2002 was **\$6 billion** — averaging almost \$1,500 per capita.
- 40% of this \$6 billion is attributed to direct health costs (\$1.32 billion) and law enforcement costs (\$810 million). The biggest component of those health costs is hospitalization, estimated at \$670 million, and 60% is attributed to indirect costs, such as disability, time away from work, and insurance costs.
- A December 2008 report from BC's Provincial Health Officer estimated health and enforcement costs exceeded government revenue from alcohol sales by \$61 million in 2002/2003. The report also showed that alcohol consumption increased 8% since 2002, with rates of consumption growing in all areas of BC, particularly in the Vancouver Island and Interior Health Authorities.⁴⁰
- According to WorkSafeBC, people who abuse alcohol or drugs are five times as likely as their peers to file a workers' compensation claim. They are also three times as likely to be absent from work or late to work.⁴¹

IV) THE CONTINUUM OF CARE FOR ADDICTION

By definition, a continuum of care is:

An integrated and seamless system of settings, services, service providers, and service levels to meet the needs of clients or defined populations.⁴²

A continuum ranges from prevention activities to community services, primary care, and hospital services. The continuum of treatment care for addiction is a complex system. Unlike treatment for other diseases, addiction treatment often involves several health and social agencies, ranging from housing and community agencies to primary care and law enforcement. It can also cross over from public to extended health and privately paid care, depending on the circumstances of the individual.

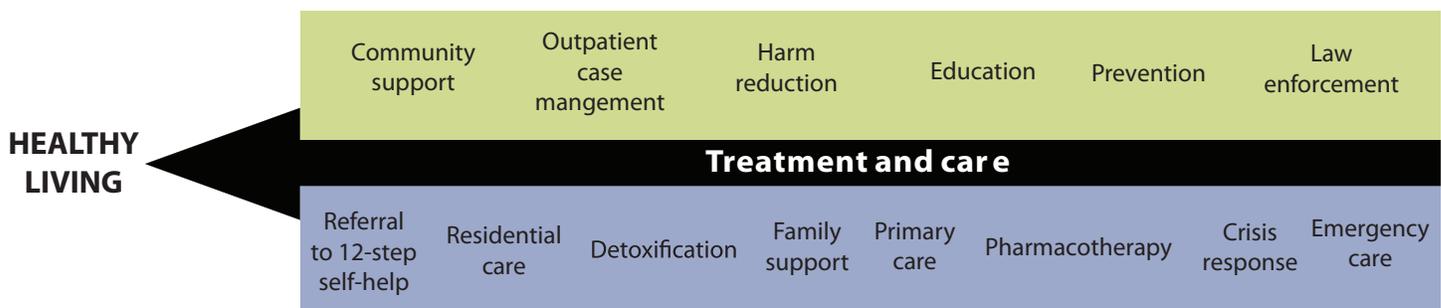
This can lead to problems with:

- Communication
- Fragmentation of care
- Duplication of services
- Conflicting advice

and, hence, poor outcomes.

Without guidance, navigating through the continuum of care can be a bewildering experience for both addicted individuals and their family members. There is also no guarantee that individuals can access services when needed.

An addicted individual may require (or encounter) only select parts of the continuum; i.e., he or she may not encounter them all. However, to be truly effective, the full continuum needs to be available, seamless, and—most importantly—accessible. The following chart provides a simple example of the addiction care continuum.



Items listed above do not represent a chronological sequence of events.

The following chart provides brief definitions of some of the elements of this continuum.

Prevention	Programs aimed at preventing or delaying the onset of use of a substance or attempts to reduce the burden of disease associated with use. Different types of prevention can occur along every stage of the continuum and at every developmental or life stage of the individual and encompass a range of policies, programs, or interventions.
Community support	Programs or resources provided by either the health authority, non-profit society, or volunteers dealing with a wide scope of activities ranging from assistance with finding employment and housing, to providing meals, clothing, transportation, and family support.
Primary care	Comprehensive care provided by a family physician with assistance from other health professionals as required. Primary care is essential to coordinate care and help reduce fragmentation and duplication of services. As a chronic disease, addiction benefits from continuous primary care and shared care with other professionals.
Outpatient case management	Care in which a health professional such as a counselor regularly meets and monitors the progress of a person receiving addiction care. This care can be provided across the continuum. However, consultation and collaboration with the primary care physician and other health professionals is critical.
Residential care (short- and long-term)	Care in which an individual stays full-time in a residence or facility specifically designed to provide addiction care and treatment. This treatment can last from weeks to months and include transition back into the community.
Pharmacotherapy	The use of a prescribed withdrawal-management medication to assist in the treatment of addiction. The prescription drug can be used to reduce the craving, block the effect, or act as a substitute of the addictive substance. An example is methadone used to treat opioid (e.g., heroin) dependency. This must involve ongoing monitoring and follow-up care in consultation and collaboration with primary care physicians through the stages of recovery.
Law enforcement (and court system)	Any interaction with the police, ranging from community response, to arrests, custody, and appearance before the courts or drug court. This is often a severely addicted person's first contact with treatment.
Detoxification	The process of withdrawal from a psychoactive substance in a safe and effective manner. ⁴³ This process allows the body to rid itself of the chemical effects of the drug. The detoxification process can take several days (e. g., withdrawal from heroin or alcohol) or months (for benzodiazepine taper), and withdrawal symptoms can be very demanding on the individual. Medical or personal care and support are often provided during withdrawal.
Harm reduction	Programs designed to decrease the negative consequences and health risks associated with severe addictive, destructive behaviors. "Harm reduction" is a general term used to describe a wide variety of programs.
Crisis response	Instances when an agency goes to the individual when a crisis or emergency occurs. This includes services such as ambulances and community outreach teams.
Hospital/Emergency care	Acute care provided for people with major medical or psychiatric conditions resulting from substance use (e. g., overdose, severe trauma, psychosis, intoxication). This process can range in time from hours to several days.
Referral to after-care or 12-step self-help programs	Community-based recovery programs. A 12-step program is an example of a program with a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems. This program is widely used by Alcoholics Anonymous, Narcotics Anonymous, and Gamblers Anonymous.



Two notable reports have also outlined the need for a continuum of care.

1) National Treatment Strategy Working Group

There have been several efforts made to enhance the existing continuum of care for addiction. One of the most comprehensive of these was the National Treatment Strategy Working Group's report, *A Systems Approach to Substance Use in Canada*, released in October 2008. The report contains a number of recommendations to improve the continuum based on input from across Canada. This comprehensive and well-researched report also provides an analysis of the continuum of care and gaps in existing treatment of substance abuse from a national perspective. The report noted:

The attention paid to problematic substance abuse is inadequate, and the services devoted to addressing the associated risks and harms are inadequately funded and co-ordinated.⁴⁴

The report also concluded that there are significant benefits from a full continuum of care:

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.⁴⁵

A central component of this report is the recommendation to develop a tiered continuum of services meant to address the spectrum of harms from substance use. The BCMA supports the work of the National Treatment Strategy Working Group and its recommendations. Although there are some differences in the task force's depiction of the continuum of care, its overall approach contains many similarities with the BCMA's vision of the continuum. Though many of the recommendations from this BCMA report are more specific to British Columbia, they are consistent with the work of this national task force.

2) Association of Substance Abuse Programs of British Columbia (ASAP-BC)

In 2006, the ASAP-BC released its report *Focusing the Effort: A Stronger Role for Addictions in the BC Mental Health and Addictions System*. The intent of this report was to foster collaborative efforts and strengthen the role of addiction services in an integrated system.

The report identified a range of challenges within addiction services, in particular addiction treatment's low priority relative to other services:

In many health authorities in British Columbia, addiction services are seriously under-funded relative to mental health services. This creates a "poor cousin" situation and, in some jurisdictions, has resulted in demoralization of staff and reduced quality programming for clients with a substance dependency issue.⁴⁶



This report also highlighted the need for a continuum of services, noting that:

A comprehensive continuum of services provides easy access and seamless transition to highly integrated and mutually reinforcing services for people at risk for and struggling with substance use, mental illness and/or concurrent disorder. In British Columbia, the continuum of services for mental health and addictions includes health promotion, prevention, harm reduction, assessment, diagnosis, early intervention, treatment, supported self management, long-term rehabilitation, community support (including drug courts) and supportive housing.⁴⁷



V) LEVELS OF ACCESS TO ADDICTION CARE IN BRITISH COLUMBIA

Before looking at specific gaps in the continuum of care for addiction in British Columbia, it is important to point out the levels of access that exist in our system. While some overlap, services can generally be divided into four categories:

- 1) **Public**
- 2) **Extended health/Employer programs**
- 3) **Private**
- 4) **Non-profit and volunteer organizations**

Although not unique to addiction care, the scope of services available to British Columbians as well as how fast they can be utilized varies according to which of these levels a person can access. The following is a brief overview of the services provided in each of these levels.

1) Public

By far, the largest component of addiction services in British Columbia is publicly funded. The provincial government reports that:

Since 2001, government has spent more than \$1.1 billion to support mental health and addiction services in British Columbia, an increase of 30 percent. In that same time period, housing supports, including community mental health beds for people with serious mental and substance use disorders, have increased by 44 percent.⁴⁸

Funded services for people with an addiction include:

- Primary care
- Specialty care (e.g., psychiatry)
- Emergency and inpatient hospital care
- Outpatient and day services
- Counseling
- Detoxification
- Residential care (short- and long-term)
- Harm reduction
- Prevention

However, it is important to note that even within these public programs, the costs of some services are not completely covered by the public health care system. For example, at BC Women's Hospital, the Aurora program provides both residential and day program beds for addiction treatment. While some of the program is covered



under the Medical Services Plan, the 6-week intensive residential treatment program is not and costs \$2,730 (\$65 per day). It is not unusual for some programs (particularly residential or day programs and methadone programs) to have a per diem or monthly cost associated with them that can be as much as \$60 to \$90 per day. For example, the Pacifica Treatment Centre,⁴⁹ a non-profit society that is partly funded through the Vancouver Coastal Health Authority, has a per diem cost of \$90. The BCMA notes that these per diem costs are somewhat unique to addiction treatment, in contrast with other diseases. They are also different than facility fees charged in hospital (i.e., upgraded costs for a single instead of shared room). There are provisions by Health Authorities and other agencies to provide subsidies to assist some low-income clients with these fees. However, physicians report that coverage is sporadic, with applications being denied or Health Authority funds being used up very early in the year. It is also usual for many methadone treatment programs to have monthly fees for non-physician services not entirely covered by public funding.

A key consideration for the public system is access to services. While emergency care is reasonably accessible, access to primary care and community-based counseling can be challenging, and other areas such as detoxification and residential care often face long waiting lists. An unfortunate consequence is that in more severe cases, individuals often wind up in emergency departments and/or acute hospital beds.

Health professionals, bed capacity, and other resources can vary considerably between urban and rural communities. Gaps in the current capacity within the public system are outlined later in this document.

2) Extended health/Employer programs

Many individuals in BC have access to another level of funded or semi-funded addiction care as part of their extended health benefit plans. Access to these programs is often included in the conditions of collective agreements and contracts for union and non-union workers or as an employee benefit. WorkSafeBC (formerly the WCB) is one example of a provider of these services. Other providers include insurance companies, such as Great-West Life, Sun Life, and Manulife. A significant amount of care for addiction in BC is provided at this level. However, the range of services is not as broad as the public system, focusing primarily on treatment and counseling services, and can include:

- Detoxification
- Short-/long-term residential care
- Follow-up care, case management, and psychological services
- Pharmacotherapy

Examples of people in BC who can access these systems include:

- Health professionals (e.g., physicians, nurses, paramedics, etc.)
- Airline pilots
- Construction workers
- Civic, provincial, and federal employees
- Many unionized workers
- RCMP and police, sheriffs, and firefighters
- Lawyers

Should an individual be able to access services in the public system as outlined earlier in this section, the per diem or monthly costs are often covered by his or her extended health programs in full or in part. In many of these programs, a return to work is conditional on the person no longer being impaired by an addiction. For example, the College of Physicians and Surgeons of BC expressly states that with regard to a physician licence to practise:

The College expects that no physician will provide patient care when impaired by illness, whether that be due to physical or mental reasons, emotional disturbance, cognitive concerns, or addiction to alcohol or drugs.⁵⁰

3) Private

Privately delivered addiction care is widely used today in British Columbia. In some cases, these resources are contracted to provide services to both the public and extended health systems. In other cases, they are exclusively provided through private payment. Examples of services offered privately include:

- Detoxification
- Short-/long-term residential care
- Follow-up care
- Pharmacotherapy
- Psychotherapy

The actual costs can vary depending on the service and location. Costs may range from \$250 per day for short-term stays, to between \$10,000 to \$12,700 per month for longer stays.^{51,52}

As noted earlier, payment for these programs may be facilitated by the patient's employer or through extended benefits programs. In other cases, patients may have to pay the full amount themselves. However, it is important to remember that without the private facilities that provide programs such as these, many of these services would simply not be available in BC. Other advantages of these facilities can include on-site withdrawal programs, rapid intake, medical and psychiatric care and treatment, and individualized flexible treatment. Many of these components should be emulated in public services, as the services these facilities provide often meet or exceed the standards of services of non-profit and volunteer organizations.

4) Non-profit and volunteer organizations

Non-profit organizations provide critical addiction support and care. In some cases, these agencies receive partial or full funding from government or other agencies. In other cases, they are fully funded by donation. These organizations may also have agreements with Health Authorities to provide services. The services they provide range from community meal support, to counseling, to residential treatment and cover most of the continuum of care. Without the help of many of these agencies and dedicated volunteers, many addicted people would simply go without resources or care.



Examples of organizations in BC are:

- Kettle Society
- Alcoholics/Narcotics/Cocaine Anonymous Canada
- Public alcohol and drug programs, e.g., "Share Society," Langley Family Services
- Recovery houses (which form the largest proportion of residential treatment beds in the province)
- Salvation Army
- Coast Foundation
- Phoenix House
- Highway House
- Last Door



Mary's story

"Mary" is a 35-year-old First Nations woman from Vancouver Island. She has been living in Vancouver's Downtown Eastside for 8 years, and she has been homeless for several periods during that time. She is known to local mental health teams, neighborhood soup kitchens, and Vancouver Police for numerous misdemeanors, prostitution, possession charges, and as a victim of physical and sexual assault. She is addicted to cocaine and heroin. Mary also has hepatitis C and a history of mild traumatic brain injury.

Mary has persistent anxiety and depressive symptoms. She can't tell if this is caused by her past abuse, her addiction, or her life circumstances. Using drugs is her only "escape." Over the past year, she has been in and out of Vancouver General Hospital 20 times. She has tried to get clean a few times but has been "kicked out" of treatment centres on several occasions. Relapse is almost instantaneous when she returns to the Downtown Eastside.

She avoids mental health programs because she doesn't want people to think she is crazy, but she goes to Native Health occasionally. She knows her life is killing her and wants to try and get clean, but she doesn't know how or where to start to change.

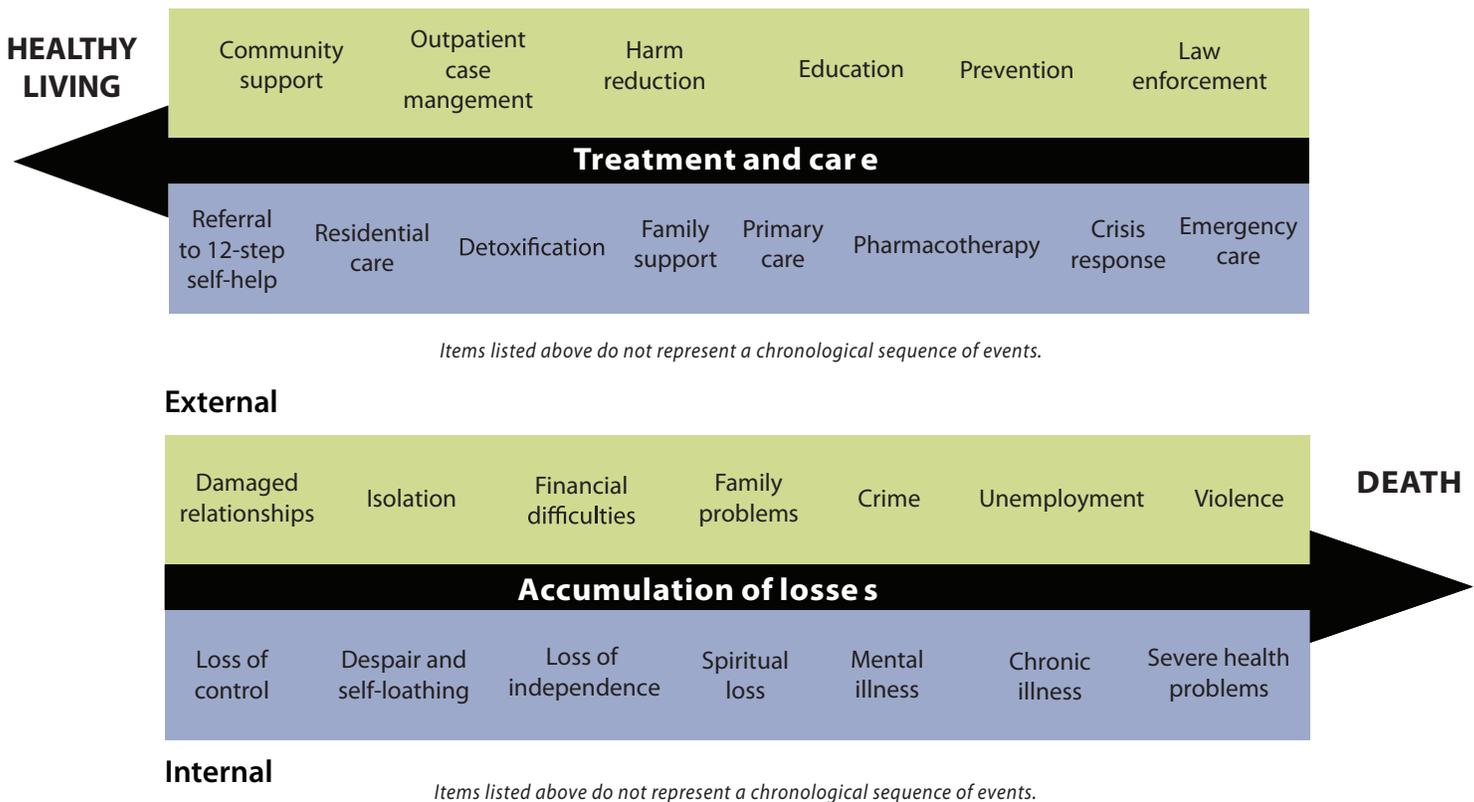
Although she currently has a roof over her head, it is in an extremely unhealthy building. She has tried to get better housing and move to a different surrounding but has never been able to secure affordable rent in another area. She has tried to access detox beds and treatment beds but has had tremendous difficulties even complying with the steps required to get into a detox bed.

A stable, safe, and secure housing environment would improve Mary's situation. It would provide the basis for her to begin addressing her mental illness as well as her addiction. Access to treatment for her concurrent disorders may require a stay in a residential facility for a short period of time, but the majority of her care should be provided by community-based support, in conjunction with treatment by a primary care physician with training in addiction care.

VI) THE CONTINUUM OF CARE FOR ADDICTION AND EXISTING GAPS

The importance of the continuum of care is best understood when the continuum of care chart is viewed alongside the accumulation of losses chart shown earlier. Putting the two charts together helps illustrate how important it is for services to be both accessible and specific to the needs of the person.

When a person does not or cannot access care, his or her risk of moving even further down the path of loss increases. As a result, he or she often requires more intensive and costly care. The sooner care can be provided, the greater the likelihood of stopping this downward cycle and the more likely it is that a person can return to health.



This section of the report examines priority gaps within the current continuum of care in British Columbia and provides recommendations to address those gaps. These priorities reflect areas of need cited by practising physicians, the Ministry of Health Services, BC Health Authorities, and the Cities of Vancouver and Victoria. A list of references for this section is contained in Appendix C. The BCMA recognizes that neither the list of gaps nor the recommendations address all of the challenges in the current system.

Based on this review, two themes emerged:

First, it is encouraging to see the increased level of planning and effort being made by many groups, including Health Authorities, municipalities, the Ministry of Health Services, and the Ministry of Healthy Living and Sport, in an attempt to address this critical issue.



They are to be commended for this work.

Second, despite these efforts, Health Authorities, municipalities, and the primary care system are not able to meet the demands for addiction services due to a significant lack of capacity and funding at virtually every level of care.

Consider the following statements from BC's Health Authorities:

Fraser Health Authority: The FHA "estimates that by 2010, approximately 192,000 to 240,000 people will be in need of withdrawal management and/or treatment services for substance misuse. Of those, between 29,000 and 36,000 individuals will seek assistance....FHA service capacity does not meet current demand along many points in the continuum: housing, community services, withdrawal management, special populations, acute care, and urgent and crisis response services."⁵³

Vancouver Island Health Authority: "There are over 150,000 people across Vancouver Island coping with mental health and addiction issues." VIHA's total service population is reported to be 752,000.⁵⁴ The City of Victoria in its Task Force Report indicated that "the picture emerging from the gap analysis of addictions services underscores public perceptions that this is a significantly underfunded service area."⁵⁵

Vancouver Coastal Health Authority: "The number of users of illicit drugs, aside from marijuana, is estimated to be over 14,000 in Vancouver....More than 15,000 people have a high probability of dependence on alcohol, with the city reporting 1,348 alcohol-related deaths in 2003."⁵⁶

Northern Health Authority: "Post-treatment recovery, and specifically local recovery support, seems to be one of the most significant gaps in a continuum that has many gaps."⁵⁷

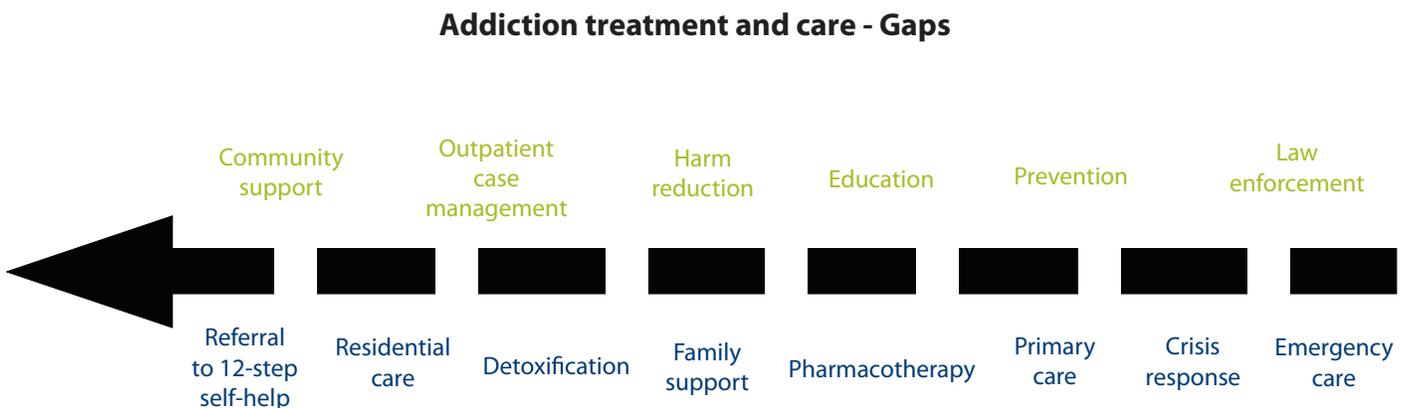
Interior Health Authority: "While there are significant strengths in the work which IH has undertaken to date, we acknowledge that there are areas for improvement. These include...promoting a coordinated continuum of care of clients with mental health and addictions needs."⁵⁸ Alcohol-related deaths were the fourth-leading cause of death in the IHA from 2001 to 2005, and Interior Health residents have higher rates of self-reported heavy drinking (25.4%) than the BC average 21.3%.⁵⁹

Provincial Health Services Authority: "Timely access to services and wait times are on both the public and the provincial and federal agendas. There has been an increasing demand for inpatient beds at BCMHAS (BC Mental Health and Addiction Services), leading to increased wait times and service pressure."⁶⁰



Gaps in addiction care

This section identifies what the BCMA sees as priority gaps in the continuum of care and provides recommendations to begin to address those gaps. This list is not exhaustive and is not meant to address all of the challenges in the system. The following chart is a simple illustration of how the continuum likely feels to the patient and health professionals in the system.



GAP #1 – THE NEED TO DESIGNATE ADDICTION AS A CHRONIC DISEASE

Despite the significant number of people in British Columbia suffering from addiction and its impact on our province, addiction care has not received the priority status it deserves. This section looks at the need to recognize addiction as a chronic disease. This designation is a critical first step in improving care, particularly in primary and community-based care.

The number of British Columbians personally impacted by addiction is outlined earlier in this report. Addiction is often related to significant increases in risk for many physical and mental illnesses (e.g., cardiac disease, liver disease, cancer). Family members also tend to suffer physical, financial, and emotional harm.

The use of addictive substances has also been clearly identified as a significant cause of preventable illness and death. For example, a report for the BC Ministry of Health in 2006 noted that "recent estimates in 2000 indicate that approximately 7 million deaths globally were associated with the use of psychoactive substances."⁶¹ Addiction is therefore both a primary chronic disease itself as well as a precursor to other medical disorders. It also impacts the health of others.

In a recent article, Saitz and colleagues called for the inclusion of addiction in the chronic disease model, noting that:

- 1) Substance dependence is a chronic disease requiring longitudinal care, although most patients receive no treatment (e.g., detoxification only) or short-term interventions.



- 2) For other chronic diseases requiring longitudinal care (e.g., diabetes, congestive heart failure), chronic disease management (CDM) has been proven effective.⁶²

The article also noted that elements of CDM in addiction have already proven effective, for example:

- “Patients with addiction who receive both regular addiction and medical care were less likely to be hospitalized than those who received one or neither service.”
- “On-site primary care at addiction programs has been associated with reduced addiction severity.”

In the past few years, increasing attention has been directed at the care of chronic illness in British Columbia. Both the provincial government and the BCMA cited chronic disease management as one of eight priorities in their 2006 Agreement. Subsequently, through the General Practices Services Committee (GPSC), the BCMA and the Ministry of Health collaborated to improve three areas: diabetes, congestive heart failure, and hypertension. This collaboration has demonstrated success in improving care for these chronic conditions.

Including addiction in BC’s current efforts to treat chronic disease would allow addiction-care health professionals to more efficiently utilize systems and structures already in place. These services range from existing collaborative care teams to education sessions for health professions, web sites, and data collection. This inclusion would also provide another opportunity to enhance care for other chronic diseases, such as hypertension and diabetes. Most importantly, it would send a strong message that BC is prepared to take a significant step to overcome the stigma attached to this pervasive medical disorder.

Although there are more people in BC suffering from addiction than from most other chronic illnesses, addiction is not yet formally classified as a “chronic illness.” The BCMA believes that this needs to change if we are to improve care, particularly in primary care. The Vancouver Coastal Health Authority recognized these limitations in its recent service plan:

We have a clear consensus that mental health and addiction services are generally underfunded and that the most significant gaps are at the “upstream” end of the continuum that would provide support and services related to health promotion, prevention, and primary care.⁶³

As referenced in the table below, a significant number of BC physicians participated in GPSC programs, which in turn benefited thousands of people with these chronic conditions.⁶⁴

Chronic illness	GP participation	Patients receiving evidence-based care
Diabetes	3,021	142,454
Congestive heart failure	1,963	18,073
Hypertension	2,768	228,264



The results of this program show considerable levels of success in its early stages. Patients with diabetes are receiving better monitoring and care, and hospitals are seeing a lower number of acute and rehabilitative care days. Under the congestive heart failure (CHF) program, the age-standardized mortality rate among patients with CHF has gone down since the program came online.⁶⁵

Fortunately, efforts to include addictions are already underway in BC in this area. In May 2007, the BC Ministry of Health and the BCMA established the Primary Health Care Charter.⁶⁶ That document mentioned several target areas for system change, with addiction cited as one:

These priority areas knit together with a focus on priority populations: maternity patients, people at risk for or living with chronic conditions, the frail elderly, people living with mental ill health and addictions, aboriginal people, and people approaching end of life.⁶⁷

Now that addiction has been identified as a priority in the Primary Health Care Charter, BC simply needs to take the next step and officially include it as part of the CDM program. By integrating addiction into the CDM structure, addiction-care health professionals can utilize existing systems already in place to improve care as well as increase uptake among physicians and other health professionals. In 2008, the GPSC embarked on a plan to expand British Columbia's Chronic Disease Management program to include mental health. In January 2008, the Community-based Mental Health Initiative was introduced to.⁶⁸

- 1) Support the provision of an accurate diagnosis.
- 2) Require the development of a patient plan.
- 3) Support longitudinal follow-up of the patient in the community.

By March 2008, 1,122 general practitioners had participated and mental health plans were developed for 17,367 patients. Given the success in other areas of chronic disease management, the BCMA recommends that the GPSC be expanded to include addiction care in 2009.

Fortunately, a substantial amount of clinical resources are available for use in British Columbia to ease the transition. The following is a brief list of examples. While much of this section focuses on moving education and training forward for physicians, it is recognized that the same types of support need to be provided for other health professionals as well.



Clinical addiction resources

Agency	Resource
Centre for Applied Research and Mental Health and Addiction, Simon Fraser University ⁶⁹ (British Columbia)	<i>Family Physician Guide: For Depression, Anxiety Disorders, Early Psychosis, and Substance Use Disorders</i> , also several research studies.
Centre for Addiction and Mental Health (CAMH) (Ontario)	Clinical journals, CME events, patient resources.
Centre for Addictions Research of BC, University of Victoria ⁷⁰ (British Columbia)	Research-focused efforts to improve evidence-based understanding of addiction and possible policy responses.
National Institute on Alcohol Abuse and Alcoholism (NIAAA) (United States)	Clinical guidelines, patient information pieces, and information for training and support for health professionals.
National Institute on Drug Abuse (NIDA) ⁷¹ (United States)	Teaching information, clinical trial resources, prevention and treatment information, patient information pieces.
Substance Abuse and Mental Health Services Administration (SAMHSA) ⁷² (United States)	<i>SAMHSA/CSAT Treatment Improvement Protocols</i> . The Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse.
American Society of Addiction Medicine (ASAM) ⁷³ (United States)	Continuing medical education courses and events offered in addition to other materials provided by ASAM, such as the clinical <i>Journal of Addiction Medicine</i> , its clinical textbook <i>Principles of Addiction Medicine</i> , and the ASAM certification process.
Canadian Society of Addiction Medicine (CSAM) ⁷⁴	Resource for physicians and the public. CSAM offers Canadian certification for physicians, addiction information for the public, bulletins, physician conferences, policy statements, and other research.

There are many examples of the usefulness and applicability of these resources for primary care. One such area is the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). The three elements of this approach include:

- Screening quickly—assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention—focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment—provides those identified as needing more extensive treatment with access to specialty care.

Research conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the US has shown that brief intervention is a successful means of providing early treatment for patients with addiction. As noted in the treatment improvement protocol developed by SAMHSA:

Brief interventions can be used as a method of providing more immediate attention to clients on waiting lists for specialized programs, as an initial treatment



for nondependent at-risk and hazardous substance users, and as adjuncts to more extensive treatment for substance-dependent persons....Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment. A brief intervention, however, is only one of many tools available to clinicians. It is not a substitute for care for clients with a high level of dependency.⁷⁵

As part of this review, SAMHSA developed a comprehensive treatment protocol to assist physicians in conducting these interventions. For example, they have identified six elements that are critical for effective brief interventions:

- 1) Feedback is given to the individual about personal risk or impairment.
- 2) Responsibility for change is placed on the participant.
- 3) Advice to change is given by the clinician.
- 4) Menu of alternative self-help or treatment options is offered to the participant.
- 5) Empathic style is used by the counselor.
- 6) Self-efficacy or optimistic empowerment is engendered in the participant.⁷⁶

Based on screenings of over 536,000 individuals as of August 2007, SAMHSA has noted that interventions such as SBIRT have been found to:

- Decrease the frequency and severity of drug and alcohol use.
- Reduce the risk of trauma.
- Increase the percentage of patients who enter specialized substance abuse treatment.⁷⁷

A more recent study of 459,599 patients completed in 2008 concluded that:

SBIRT was feasible to implement and the self-reported patient status at 6 months indicated significant improvements over baseline, for illicit drug use and heavy alcohol use, with functional domains improved, across a range of health care settings and a range of patients.⁷⁸

Given the clear benefits both in terms of cost-effectiveness and clinical outcomes, it is time for BC to take the next step in recognizing addiction as a chronic disease. In doing so, BC will be able to better provide care and services upstream in the earlier stages of the continuum as well as provide better support and training for front-line health professionals helping these patients.



Recommendations

See pages 59-61 for a full list of recommendations.

NOTE: THE BCMA HAS PRIORITIZED ITS RECOMMENDATIONS BY CARE GAP SO THE RECOMMENDATION NUMBERING IS NOT SEQUENTIAL

1. Formally recognize addiction as a chronic, treatable disease under the BC Primary Care Charter and the BC Chronic Disease Management Program. This requires expanding the BCMA/Ministry of Health Community-based Mental Health Initiative launched in 2008 to include addiction.

This includes:

- A. Providing \$4 million to expand the existing BCMA/Ministry of Health Community-based Mental Health Initiative (January 2008) to include addiction. This will support development of flowsheets, guidelines, and protocols for care for patients with addiction.
 - B. Developing Physician Support Program modules to provide additional community-based training opportunities and resources to primary care physicians.
 - C. Expanding online tools for physicians from existing resources and making use of existing resources to develop guidelines under the Guidelines and Protocols Advisory Committee (GPAC). This would help identify addiction disorders and provide resources for physicians on how to discuss the issue with patients, e.g., *Family Physician Guide*.
6. Establish standards of care for addiction medicine treatment. This includes clearly defined wait times for services across the continuum of care developed in conjunction with front-line practising health professionals, Health Authorities, and the Ministry of Health Services. This should also include the development of clinical guidelines and protocols for addiction care developed by the Ministry of Health Services and the BCMA through the Guidelines and Protocols Advisory Committee (GPAC).
 10. Expand the mandate of the Premier’s Task Force on Homelessness, Mental Illness and Addiction to include the full continuum of addiction care. Its mandate should also include specific capacity and accessibility targets province-wide and require the task force to meet at least twice per year to review these targets and coordinate efforts.

GAP #2 – THE NEED TO CREATE MORE RESIDENTIAL TREATMENT CAPACITY

The need to formally classify addiction as a chronic disease is the first major step in improving addiction care, particularly at the early parts of the continuum. That being said, BC must do a better job of providing care and treatment to addicted British Columbians immediately. There is a very urgent need to increase residential treatment capacity across the province. A recent CKNW radio program on addiction on the *Bill Good Show* crystallized the severity of this problem when it featured a mother (Holly) struggling to find treatment for her daughter.

The following is an excerpt from that CKNW-AM program, hosted by Michael Smyth with reporting by Rebecca Scott, that aired on 15 April 2008:⁷⁹

HOLLY: I am right now sitting out in front of...excuse me...Royal Jubilee Hospital because I've got to pick up my daughter [Laura]...and I don't know where to go, what to do. There's no safe houses, there's nothing. There's no place to put her.

BILL GOOD (CKNW-AM): How old's your daughter, Holly?

HOLLY: She's 26 and I'm really nobody; I can't really do anything. She has to do it on her own, but I'm losing her. I've been told by the doctors that if I can get a chance for her, she's saveable. But if she goes on the streets, I'm going to lose her.

SCOTT: So over the past month or so, we have been trying to get Laura through the detox process and Mike, as I was telling you earlier this morning, when you and I were discussing this segment, this is an impossible task and I think that most of our panelists will agree that the bureaucratic hurdles that an addict needs to jump through in order to get help are mind-boggling.

And we are in the process of trying to get Laura help; we've managed to get her into a detox program but now, and this is the part that really gets me, there's nowhere for her to go. We have her registered for rehab, but we have to wait for a bed to open up.

SMYTH: Well, it's amazing to think that here you have a 26-year-old woman, a recovering heroin addict, and she's getting the profile...I mean, she's got a family who's got the guts to go public and tell their story publicly, on the radio. And so, here we are giving her all this profile, and you...we still can't get her help.

SCOTT: And we still can't get her help, I mean, this is as high profile as it gets, and it's helped out a lot. Let's not make any illusions about it. It's helped out a lot. Our help is making a difference, but it's not making as big a difference as we thought it might.

While tragic to hear, this scene occurs daily in our province. Whether in a detoxification centre, an emergency room, or their own homes, individuals often make the choice to seek treatment only to be confronted with obstacles, a lack of space, a wait list with no certain date of entry, and even unanswered phone calls. Despite the proven success of addiction care services, a lack of access to them continues to frustrate patients and health professionals. For example, the Aurora Centre at BC Women's Hospital in Vancouver has provided addiction services to women for over



30 years. Their success is well-documented and they report that:

We know our treatment works: Studies conducted 3 to 6 months post-treatment consistently show that **over 90 percent** of former clients contacted report either complete abstinence, or abstinence following a brief relapse. As well, our clients report improved physical and emotional health and improved relationships, vocational status, and spiritual awareness.⁸⁰

In addition to the benefit to the individual, research has also suggested there is an economic benefit to residential treatment. One study found that “the benefits of residential drug abuse treatment exceed costs by a factor of 4 to 1 in five programs in Washington state, when they used a benefit-cost analysis that considers societal costs.” The study further reported that “the average economic cost of treatment for this sample of residential clients in Washington state was \$4,912. The average economic benefit was \$21,329. The average net benefit of treatment was \$16,418, and the benefit-cost ratio was 4.34.”⁸¹

Other studies have also outlined the cost-benefit and characteristics of successful residential treatment.⁸²⁻⁸⁷

The term “residential bed” is used to reflect a spectrum of treatment beds, and the BCMA recognizes that individual needs vary. Therefore, any examination of capacity must include flexibility in any planning. The following is a simplified list of the types of treatment “beds” that exist within the addiction continuum, excluding emergency or acute care in hospital.

- 1) **Stabilization beds:** Short-term stay of up to 1 month after completing detoxification process. Also included are acute-crisis beds used for either short-term homelessness or for detoxed individuals waiting for a treatment placement.
- 2) **Day beds:** Individual sleeps in his or her home but comes to a centre for care during the day.
- 3) **Long-term treatment beds:** 24/7 addiction treatment care provided in a residential facility. Care can be provided for up to 1 year or longer but also incorporates return-to-work programs and reintegration back into the community.
- 4) **Support recovery homes:** Provide housing and varying levels of addiction counseling and treatment.
- 5) **Centres for the treatment of concurrent disorders:** Stays for up to 1 year for care and treatment of mental illness and addiction.

Addiction beds ≠ Long-term care beds

It is important to point out that “residential treatment beds” in addiction treatment cannot, and should not, be confused or compared with long-term or residential beds used for services such as seniors care or Riverview-type beds for long-term mental health.

Residential beds in addiction treatment provide specific treatment and support services (for example, it is common for them to provide 28-day programs), with the usual objective of returning patients to the community as active members of society.



These beds encompass an intensive phase of treatment, and a more accurate comparison of service would be rehabilitative therapy treatment stays following a severe injury or cancer treatment. At the same time, they can also provide services while individuals are integrating themselves back into their normal lives (such as return-to-work programs).

These residential treatment beds must also be matched with transitional and longer-term community based programs, including capacity for day treatment, addiction counseling, and assertive community support teams.

Scale of the challenge

In 2007, the Fraser Health Authority (FHA) estimated it had a **shortfall of 226 residential addiction beds** (108 short-term and 118 long-term residential beds) in 2006-2007. The FHA's capacity was 273 beds (126 short-term and 147 long-term) but it estimated a further need for 499 beds (234 short-term and 265 long-term) to meet its service benchmarks.⁸⁸ This means the FHA's current residential care capacity is only 55% of what it needs to be based on its service benchmarks.

In 2006, the Vancouver Coastal Health Authority (VCHA) released a report entitled *Vancouver: Building on Strength* as a regional plan for mental health and addiction services. The comprehensive report revealed that the VCHA's residential treatment capacity at that time was a total of 42 beds (22 for intensive treatment, 12 for stabilization, and 8 for youth), not including support recovery beds at the Aurora Centre and the Pacifica Treatment Centre.⁸⁹ As of 2008, this number appears to have increased to 64 beds. However, the Vancouver Health Authority clearly felt capacity was not sufficient, reporting that:

Residential programs need to expand their capacity to meet the requirements for the service. Outreach follow-up services should be expanded for individuals completing residential programs. Clients completing these programs need better options for safe housing upon discharge.⁹⁰

This is not to say that investments have not been made. The provincial government and Health Authorities are on the right track in several areas. According to Health Minister George Abbott:

In addictions beds, there were 874 [in 2001]; today, 2,102 addictions beds across British Columbia.⁹¹

However, the description, breakdown, and distribution of this figure, with particular reference to levels of care, are not currently available. Regardless, this increase signifies an average increase of 175 addiction beds per year. Therefore, the BCMA recommendations in this section are not out of line with that scale of expansion and should be readily accommodated.

Given the scale of the problem and the need, it is no wonder that Health Authorities are struggling to make headway against it. The challenge is that the response must be equal to the scale of the problem. Consider the impact of substance abuse on the acute care system in the Vancouver Island Health Authority (VIHA):

Within VIHA's service area, drug and alcohol use has a significant impact on the



health care system. At any given time, close to 7% of VIHA's acute care beds are occupied by clients whose presenting medical problems are related to their substance abuse or chemical dependence. Over the course of 3 years, 25% of those individuals reappeared in acute care at least once.⁹²

Despite these significant challenges, there are examples in British Columbia where investments and capacity are being expanded. While not sufficient to solve all of the province's problems, they are encouraging. Two examples are the Phoenix Centre for drug and alcohol recovery in Surrey and the Burnaby Centre for Mental Health and Addiction.

1) Phoenix Centre

The Phoenix Centre was originally founded in 1992. Fifteen years later, this facility went through an upgrade and expansion and was announced in its current form by Premier Gordon Campbell on 20 April 2007. This \$10.9-million facility was developed and funded in part by both the federal (\$5.55 million) and provincial (\$2.48 million) government. Funding was also obtained from business and community agencies, including Vancity who provided a \$1-million award to the Centre. As described by Premier Campbell at its opening:

The Phoenix Centre is the first development of its kind in BC to combine clinical addiction services with transitional housing, employment and education services. The Centre will provide 28 early stabilization addiction-services beds and 36 transitional housing units. The combination of care levels and services provided ensures residents will have support in a stable environment at all stages of their treatment and recovery.⁹³

Services at the Phoenix Centre include:

- Integrated case management
- Substance misuse awareness and education
- Individual and group counseling
- Relapse prevention skills
- Health promotion skills
- Personal health care coaching
- Personal management skills
- Stress management
- Cognitive restructuring
- Emotional management training
- Additional addiction services provided by a concurrent disorder therapist⁹⁴

A critical element in the development of the Centre was the level of community engagement and the partnerships that developed to support it. Partners included federal and provincial agencies, universities, and small and larger businesses.* These collaborations and their success provide examples of the new roles that universities, financial

* Kwantlen Polytechnic University, Service Canada, Vancity Savings Credit Union, Ministry of Housing and Social Development, Just Beginnings Florist, BC Housing.



institutions, and government departments can play and demonstrate that housing, justice, education, income supports, and employment can be envisioned as part of a community problem-solving of this issue. As noted by the Phoenix Centre's Director, Michael Wilson:

Central to the development of the Centre's services that are the key building blocks necessary for people affected by addiction and homelessness to move out of the cycle of poverty to achieve a sustainable livelihood, are these community partnerships.⁹⁵

Perhaps the most encouraging aspect of the Phoenix Centre is the portability of the model to other Health Authorities. This Centre applies a relatively full continuum of care while maintaining a manageable size that can be community based. Given the size and cost relative to other services, this model should be given due consideration for duplication.

2) Burnaby Centre for Mental Health and Addiction⁹⁶

Announced in February 2008, the Burnaby Centre for Mental Health and Addiction is the first facility of its kind in British Columbia. As outlined by Premier Gordon Campbell:

The new Burnaby Centre for Mental Health and Addiction will help people with a complex range of mental health and addiction challenges by providing a stable environment with on-site medical, nursing, and psychiatric care as well as addiction care, counseling, and trauma support.⁹⁷

The Centre will serve patients with complex mental health and addiction problems. Patients may stay at the Centre from 1 month to an average of 9 months or longer. The annual operating cost of the Centre is \$14 million, with an additional one-time capital cost of \$3.5 million to retrofit the Willingdon facility where the Centre is located. The current facility is temporary in nature (approximately 5 years) and a replacement facility is in the planning stages.

The need for services for specific populations

As noted above, there are a range of residential care treatment beds necessary for addiction care. There is also a need to expand residential treatment services for specific populations, including youth, seniors, and First Nations. We also need to remove language barriers. Underlying these needs is the particular challenge for rural communities to facilitate access to these services.

It is also recognized that due to their specialized nature, some of these residential facilities may not always be available in the communities where people live. Our goal should be to provide a range of residential facilities that are reasonably available in a variety of geographic areas.

The BCMA recognizes that for some individuals who suffer serious consequences of addiction, long-term treatment may be necessary (e.g., forensic psychiatric services). There are also patients who, due to the ravages of long-term or



severe addiction, will require long-term residential care.

We recognize that the effort to connect patients with community residential services has not met with compensatory community services. For example, a plan was developed to facilitate this gap (Riverview Hospital Redevelopment Project) by expanding Health Authority capacity for these types of services, but delays and challenges have occurred to slow this process.⁹⁸

For these services to succeed, the Health Authorities must work with each other to share access to services, and the Ministry of Health Services must continue to monitor the capacity of these services in relation to the provincial need.

The challenge of bricks and mortar

The BCMA believes that our province needs to significantly expand its residential addiction treatment capacity. The challenge with an increase in residential treatment beds is the expense compared with other components of the continuum. It is also recognized by the Ministry of Health Services and the Health Authorities that it is often hard to determine how many and where new beds should go, due to poor data and estimation models. The data challenge is discussed further on in this paper.

Investment in residential treatment requires both capital and ongoing operations funding. It is often a challenge to prioritize funds when other areas, particularly acute care, need resources as well. However, an increase in residential treatment facilities could reduce the stress and workload on existing emergency departments and hospitals, though it is recognized that expansion can also include staffing challenges.

Work must also be done to improve standards of care and accountability among existing resources. A significant portion of residential treatment capacity is provided by recovery houses that, although not funded by the province, need to demonstrate that they meet consistent quality and service levels across the province. However this must be done in a flexible and seamless manner so as not to overburden existing resources with unnecessary regulations. Even within residential care there is a continuum of services that may be offered, and facilities may develop some or all of these services. Standards of care and accountability are meant to ensure that services offered are consistent with the best evidence on how to address an individual's need within that continuum.

The BCMA also believes there is an opportunity to link these facilities with the provincial government's plan to keep construction and infrastructure projects going in these tough economic times. As noted in the *Province* newspaper:

Premier Gordon Campbell says he's hammering out a New Deal-style building program to keep construction workers on the job and off EI. "There is going to be a supply of construction workers that we want to keep at work on the ground," Campbell told the *Province* editorial board yesterday. "Our goal is to get those folks to work now. It's possible, I think, to take short-term actions that provide long-term benefit to the economy, to the province, and to the people who live here." Campbell said he wants to use BC wood to build wood-frame condos, homeless shelters, schools, and hospitals—and he plans to fast-track the projects over the next 90 days.⁹⁹



The BCMA recommends that the Premier add the construction of residential addiction treatment facilities (which can often resemble two- to three-story condominiums) to the list of construction projects. For example, the province could immediately commit to building at least one comparable version of the Phoenix Centre (noted above) in every Health Authority as a first step to adding capacity.

In moving forward, there are three options for adding capacity:

- 1) Build new facilities.
- 2) Refurbish or adapt existing facilities, including short-term use of existing beds.
- 3) Contract services with non-profit or private facilities.

The BCMA believes that in most cases Health Authorities, with input from local health professionals, are in the best position to determine which option may work in the short- or long-term. Therefore, the BCMA recommends that the province, in conjunction with Health Authorities, do the following.

Recommendations

See pages 59-61 for a full list of recommendations.

3. Fund the development of 600 new addiction-treatment beds across the province by 2012 (150 per year). Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary. The creation of these new beds should also include expansion of existing capacity to treat concurrent disorders (mental health and addiction).

This ongoing assessment must include:

- A. Adopting a minimum standard of accessibility and availability. Health Authorities should maintain an appropriate number of treatment beds per capita based on their need and should also adopt maximum wait-time criteria for admission to these beds.
 - B. Working to improve standards in all public, private, and non-profit facilities in British Columbia by improving service, quality, and accountability standards based on the best available evidence.
 - C. Ensuring that new facilities target acute demand for residential treatment services among particular populations, such as rural, First Nations, youth, and seniors.
5. Ensure that access to addiction care is accessible without financial and other barriers throughout BC; this includes the elimination of per diem fees, minimization of language barriers, and access to inpatient addiction care.

GAP #3 – THE NEED TO EXPAND FLEXIBLE DETOXIFICATION SERVICE CAPACITY

British Columbia must also take steps to expand its detoxification (often referred to as “withdrawal services”) capacity. Detoxification is the treatment process for withdrawal in the substance discontinuation process, and it allows the body to rid itself of the effects of a drug. This process can take several days to months, and it can have significant psychiatric and physical symptoms and impacts. Medical care and other forms of personal care and support are often needed during withdrawal to avoid significant morbidity. For example, withdrawal from severe alcohol or benzodiazepine abuse often requires ongoing medical care to deal with the severe symptoms of withdrawal, such as gastrointestinal problems (nausea) and hallucinations.

Once individuals have made the choice to address their addiction, detoxification services are often a first step in their treatment path. However, they are only a first step in this part of the continuum. But evidence has shown these services to be a significant link to successful treatment, as noted by the National Institute on Drug Abuse in its document *Principles of Drug Addiction Treatment: A Research-Based Guide* (see Appendix E).

While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

Without subsequent supports, detoxification is generally not successful. Health Authorities and municipalities across BC have recognized not only their shortage of detoxification capacity but also the impact of not having these services:

Fraser Health Authority: Fraser Health estimated its service gap for withdrawal management and detoxification was 7,617 clients in 2006-2007, projected to increase to 8,538 clients by 2010.¹⁰⁰ In 2006-2007, FHA provided services to 2,017 clients. (This translates into a 79% shortfall in capacity, although FHA did not use this figure.)

Vancouver Coastal Health Authority: “While the intake system for detoxification facilities has been significantly streamlined in recent years, immediate access to withdrawal management services is still an unmet need among highly marginalized individuals, many of whom are homeless and have no safe place in which to wait for access to services. The result of missing or insufficient services is people not receiving treatment, inappropriately accessing emergency care, or staying for extended periods in more costly acute care.”¹⁰¹

Northern Health Authority: “Adequate capacity to provide detoxification is essential as the first stage in the recovery journey. Currently detoxification is seen as not being available when needed, or as being ineffective.”¹⁰²

City of Victoria: “Continuity of care—with seamless and continuous access to withdrawal management, residential treatment services, and long-term support—is not currently available.”¹⁰³

BC needs to ensure that it not only has sufficient capacity but also flexible capacity. There are several levels of detoxification services, yet most people tend to think of it as an inpatient delivered service. According to the American Society of Addiction Medicine, there are four main categories:



- 1) **Level I-D: Ambulatory detoxification without extended on-site monitoring** (e.g., physician office practice/home health care with regular visits and phone help).
- 2) **Level II-D: Ambulatory detoxification with extended on-site monitoring** (e.g., detoxification in a partial hospitalization program where patient may spend the day).
- 3) **Level III-D: Residential/Inpatient detoxification** (e.g., residential or health-facility based stays to manage withdrawal).
- 4) **Level IV-D: Medically managed inpatient detoxification** (e.g., hospital-based inpatient stay for acute and severe withdrawal management).¹⁰⁴

When discussing detoxification services, most people tend to think in terms of levels III or IV, which involve staying in a facility (for a few days, a month, or longer). These spaces are often needed for patients suffering from severe withdrawal, whose conditions may also include complicating medical and/or social factors.

Flexibility is important, as an inpatient detoxification bed may not be appropriate in all circumstances, and the patient may be better served receiving detoxification in another setting. Likewise, an outpatient detoxification setting may not meet the needs of an individual who should really be cared for in an inpatient setting. Fortunately, there are criteria in development to assist in easing the stratification process developed by the American Society of Addiction Medicine through its Patient Placement Criteria.¹⁰⁵ The key is that this determination is a collaborative process between the patient and the physician.

Upon review, there appear to be three critical factors for improving detoxification and withdrawal services in British Columbia.

First, it is critical that the most appropriate level of detoxification services is accessible when requested by the individual or a health professional. The decision by an individual to seek treatment provides what is often a short window of opportunity for change, and it is crucial that the health system is capable of delivering that service, or the patient may simply return to his or her regular behavior of abuse.

Despite data being limited, the BCMA estimates that BC requires an additional 240 flexible detoxification spaces or “beds” to address existing service shortfalls. While expansion of some inpatient facilities is needed, capacity must also be expanded in community daytox and home detoxification as well. Particular innovation must occur to accommodate detoxification capacity for First Nations,* youth, and seniors, as a traditional detoxification facility may not meet the cultural or demographic needs of those populations.

Second, aside from the decision to seek care, the most important part of the detoxification process is what happens to the person upon completion of that process. As noted in the Gap #2 section of this report, there is a critical shortage of treatment beds in BC. The reality today is that often patients completing detoxification are, at best, sent home or, at worst and in the most extreme cases, sent to a temporary shelter while they are on a wait list for a residential treatment bed. Therefore, BC’s detoxification capacity must be matched to long-term support recovery capacity, whether facility or community based.

* One example of a detoxification and treatment centre that serves First Nations is the Round Lake Treatment Centre located on the Okanagan Reserve near Vernon, British Columbia. www.roundlake.bc.ca/.

Third, the BCMA believes that while BC needs to expand its residential and inpatient detoxification capacity, there is also an opportunity and need to expand primary care and/or outpatient level detoxification. However, the historical challenge has been that many physicians and other health care providers do not feel they are appropriately trained to handle this level of detoxification. In part, the recognition of addiction as a chronic disease will help to build this element of primary care over time. This expansion of care must also include the participation of other health care providers (nurses, counselors, etc.) in the provision of care.

It is important that while detoxification is being offered, care is provided for the patient's other primary health care needs through coordination with a family physician or other health care provider. In many cases, there are other underlying illnesses and conditions (such as diabetes, arthritis, hepatitis, and mental illness).

Recommendations

See pages 59-61 for a full list of recommendations.

2. Create and fund 240 new flexible medically supervised detoxification spaces across BC by 2012 (60 per year). BC needs to ensure that detoxification is available "on demand" when requested by the individual, health professional, or Vancouver's drug court by 2012. This flexibility must also include adapting to specific needs for youth and other populations. Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary.

GAP #4 – THE NEED TO EXPAND COMMUNITY SUPPORT

Community support is an integral part of the continuum of care and has a role throughout the continuum of care for addiction. There are a wide range of services provided in this portion of the continuum, including nursing support, counseling, after-treatment care, and assistance finding housing or employment.* While care is provided at this level by our primary care system and by Health Authorities, volunteer and charitable organizations contribute significantly as well. In BC's current system of community support, services are provided by many agencies, depending on the community. For example, in its mental health and addiction strategy *Building on Strength*, Vancouver Coastal Health noted that:

Addiction services are now delivered through a combination of direct and contracted services. Vancouver Coastal Health provides services directly through numerous facilities and interdisciplinary teams of professionals. Its contracted addiction services are provided through more than 20 contracts with over 15 community agencies.¹⁰⁶

Community support is also important because it may be the only way to maintain engagement with many of the hardest-to-reach individuals suffering from addiction. This is also where many innovative and creative solutions emerge.

* For example, the Fraser Health Authority has "Addictions outpatient clinics providing screening, assessing, treatment planning, group education, group support recovery and relapse prevention, intensive therapeutic groups, intensive one to one therapy, consultations, referrals and case management activities. Some communities have specialized clinics or clinicians providing services exclusively to seniors, youth, hard-of-hearing clients or to clients from diverse cultural groups." Source: www.fraserhealth.ca/Services/MentalHealthandAddictions/AddictionServices/Pages/Outpatient.aspx

Community support is key, as it is often the service a person with an addiction receives just before or after treatment. It is important to continue to engage those who are currently not ready to stop or to seek treatment. For example, within the spectrum of loss, particularly for those people with severe social dysfunction, addiction may have led to such loss that active community management is necessary. Active case-management teams in the community serve as the “firefighters” of community care, providing support to people in dire situations, and they are an encouraging innovation within the addiction continuum that warrants further expansion and evaluation.

Unfortunately, this sector also suffers from challenges in terms of the availability of resources relative to the demand. One example from Vancouver of the current gap in community care resides in community outreach and counseling services, where Vancouver Coastal Health:

currently funds 17 adult Aboriginal addiction counselors with a total capacity to serve 430 adults per year. Given a conservative estimate of 1,000 Aboriginal people experiencing significant addiction issues in Vancouver, there should be an additional 570 adult client spaces to meet the demand.¹⁰⁷

Essentially, Vancouver Coastal Health believes it needs to literally double the number of counselors it has in place today. Turning to the Fraser Health Authority, it noted with regard to outpatient outreach services that:

The Fraser Health Authority provided 8,273 clients with Outpatient Outreach services for their addiction in 2006-2007. Unfortunately their service benchmark identified 26,184 possible clients for services, meaning a gap of 17,911 clients. This gap is expected to rise to 19,978 by 2010.¹⁰⁸

Based on those projections, Fraser Health would have to *triple* its outreach capacity to meet current demand, let alone the demand in 2010.

Although there are clearly gaps within this sector, there are also emerging opportunities for improvement. One example of an innovation in community care comes from joint efforts of the Canadian Mental Health Association’s Bounce Back program. Now functioning in several Health Authorities, this program provides resources and telephone-based coaching to individuals with chronic conditions who also suffer from anxiety and depression. This project was cited in the recent announcement of the 25 Integrated Health Networks (IHNs), from the BC Ministry of Health Services with the support of the BCMA in November 2008.

An IHN is a partnership between a patient and a team of health professionals. Led by the patient’s family physician, the health network team may consist of nurses, dieticians, pharmacists, specialist physicians, and community agencies.¹⁰⁹

Adapting the IHNs for addiction is a logical and welcome next step. IHNs throughout BC contain many of the same elements (e.g., counseling, after-care, etc.), but Health Authorities also recognize that these support structures must be adapted to fit local community needs. For example, services for First Nations must be developed in conjunction with the First Nations community to ensure that the services provided will be meaningful and accessible. This means Health Authorities need the flexibility to do something as simple as ensuring that a community support worker is able to visit the community or reserve to provide help, as opposed to patients only going to a centralized office.



Many physicians tell of their frustrations in not being able to easily access or hear reports back from a variety of community-based services. Currently, many community services in addiction care do not involve physicians or regularly communicate with them. Through the IHNs, there are opportunities to better coordinate care, access services, and improve the flow of information among health professionals. As noted by the Fraser Health Authority, the primary care sector is the best place to initially manage these needs:

Research indicates that about a third of people who consult their family physician have mental health and/or addiction problems, with up to 25% having a diagnosable disorder. Research suggests that the primary care sector is the most efficient and effective place to meet the management needs of the majority of individuals experiencing mild-moderate mental health and addiction problems.*

Recommendations

See pages 59-61 for a full list of recommendations.

4. Expand existing community addiction programs, case management, and crisis support teams across all Health Authorities by 2012, including specific programs for rural communities, First Nations, minority populations, youth, pregnant women, and seniors. This expansion must include better integration with primary care.

This expansion should:

- A. Address the clear gaps in service identified by Health Authorities.
- B. Ensure that all Health Authorities adopt a similar standard of care for access and delivery of community-based services. In particular, this should focus on wait times and availability of services when deemed necessary by a physician or other health professional.
- C. Improve coordination of these community agencies with the primary care system. This includes improving the integration of counseling and other services with primary care physicians and their offices and improving the information available to primary care physicians and patients on how to access these services through a single resource directory.

GAP #5 – THE NEED TO RECOGNIZE AND EXPAND ADDICTION TRAINING

This section looks at two important gaps regarding addiction training of physicians:

- 1) **Addiction as a recognized specialty**
- 2) **The need to expand addiction training in BC medical schools**

* Reference cited in quote: Jenkins R, Strathdee G. The integration of mental health care with primary care. *Int J Law Psychiatry* 2000;23:277-291.

1) Addiction as a recognized specialty

The majority of addiction medical care in British Columbia is provided by medical practitioners who have developed an interest and/or have had extra training in the field. A considerable amount of care is also provided by front-line family physicians, nurses, counselors, and volunteers (some of whom are in recovery from an addiction themselves or have family members who were). However, this section will deal specifically with care provided by physicians.

Currently, the practice of addiction medicine in all fields, including specialty and family medicine, is not formally recognized in BC. It is also not included by the Royal College of Physicians and Surgeons of Canada as a specialty or subspecialty.¹¹⁰ Certifications in addiction medicine are available from several societies (listed below) but are not recognized by the Royal College and do not bestow any particular status on a physician who holds one (unlike, for example, the status held by a specialist practising cardiology, neurology, or general surgery). However, there is a process in place within the Royal College to pursue this, and the onus is now upon the respective bodies to make this case. Presently, the BCMA does not have a section of addiction medicine, although one existed in the 1990s. This issue will be revisited shortly, given the need.

Given the importance of this area of study and its impact in our society, it is long past due for this area to be formally recognized. The importance of recognizing addiction medicine was outlined in a 2005 editorial in the *British Columbia Medical Journal (BCMJ)*:

Addiction medicine is an orphaned “specialty” and the time has come for Canada to develop and recognize a training program that would lift the field from *interest* to *fellowship*. . . . Recognizing addiction medicine as a specialty would formalize and standardize the skill and knowledge required to be granted such fellowship. Likewise, the use of “Addiction Medicine” as a professional title would be restricted to those who had achieved such certification.¹¹¹

Dr Heidi Oetter, *BCMJ* Editorial Board, 2005

In contrast, Australia recognizes addiction medicine as a specialty. In New Zealand, the Medical Council of New Zealand recently took the first steps to recognize addiction medicine as a specialty in May 2007.¹¹²

In the United States, a certification in addiction medicine is available from the American Society of Addiction Medicine (ASAM). A certification from ASAM is valid for 10 years. The requirements to achieve certification include:

- A recognized medical degree in the US or Canada.
- A valid licence to practise.
- Three letters of recommendation from physicians in an applicant’s community.
- Completion of a residency training program in any recognized specialty.
- 1 year full-time providing care in the field of alcoholism and other drug dependencies.
- 50 hours of continuing medical education (CME) with the American Medical Association.
- Completion of written examination conducted by ASAM.¹¹³

In Canada, the Canadian Society of Addiction Medicine (CSAM) also offers a certification process, albeit based on exams from other jurisdictions. Its requirements include:



- Member of the CSAM for minimum of 2 years.
- Completed practice review by a team from CSAM.
- Passed the ASAM or International Society of Addiction Medicine (ISAM) exam within 2 years of the practice review.
- Attended the CSAM Annual Meeting for 2 years prior to certification.
- Completed 50 hours of CME in the 2 years prior to presentation for credentialing.

CSAM will grant certification to physicians who already have been certified by ASAM or ISAM.¹¹⁴

The ISAM also has a certification process, but the majority of physicians in Canada pursue either the CSAM or ASAM certification. However, the certifications from any of these three societies are not formally recognized in Canada by the Royal College of Physicians and Surgeons of Canada¹¹⁵ or the College of Family Physicians of Canada.¹¹⁶

Should any changes be considered in this area, a critical factor would be to include a grandfathering process to ensure that physicians currently practising in this area can be included. The change process cannot drive these physicians out of the system.

2) The need to expand addiction training in BC medical schools

While it is important to expand addiction training and certification for currently practising physicians, BC also needs to expand training for future physicians. Given that (as noted in a report by the Fraser Health Authority) "about a third of people who consult their family physician have mental health and/or addiction problems,"* it may be time to give this area a higher priority. Addiction training may currently be inadequate, given the burden of disease and the fact that physicians from all fields of medicine will encounter patients with addiction throughout their careers.

The BCMA also recognizes that additional education and resources need to be developed around prescription practices for sedatives, narcotics, and stimulants for patients who have a personal risk or family history of addiction. Prescription addiction is a leading trend of addiction in the US¹¹⁷ and should not be lost in our discussions in British Columbia.

That being said, the BCMA recognizes that the medical school curriculum is under constant pressure for adaptation and, therefore, the actual manner in which BC medical schools choose to address this is best left up to them. In the past, the UBC Faculty of Medicine offered the Addiction Medicine and Intercollegial Responsibility (AMIR) program. For reference, the five goals of the program were:

- 1) To explore individual and societal consequences of alcohol and other drug use and abuse, and one's own attitude toward patients.
- 2) To explore the roles physicians and dentists may play in prevention, identification, and treatment of substance use disorders.**
- 3) To identify expectations and recommendations which patients and service providers have for physicians and dentists in the health care system.
- 4) To identify the role that scientific research, economics, social policy, and public opinion have in the categorization of drugs as medications, recreational drugs, or drugs of abuse.

* Reference cited in quote: Jenkins R, Strathdee G. The integration of mental health care with primary care. *Int J Law Psychiatry* 2000;23:277-291.

** At the time, this course was offered to both students from the Faculty of Medicine and Faculty of Dentistry.



- 5) To use personal encounters and community visits to appreciate positive and negative experiences that patients with substance use disorders experience with the health care system.¹¹⁸

These goals provide a reference for consideration for any new programs, whether for medical students or for currently practising physicians. The BCMA would also strongly support the inclusion of the UBC Faculty of Medicine in any discussion of physician training.

Recommendations

See pages 59-61 for a full list of recommendations.

7. Expand training and support for physicians in addiction medicine. This should include formal recognition of addiction medicine as a specialty in British Columbia by provincial and national medical, nursing, and other health profession education bodies.
 - A. That the Ministry of Health Services support additional addiction training and resources for urban and particularly rural physicians through existing CME and the BCMA/Ministry of Health Rural Education Action Plan, in conjunction with the Physician Support Program.
 - B. That the Faculty of Medicine be included in discussions regarding expansion of addiction training both for new and currently practising physicians.

GAP #6 – THE NEED TO FOCUS ON EVIDENCE-BASED PREVENTION AND EDUCATION

Prevention is an important, albeit broad topic. Although placed at the beginning of the continuum in this paper, prevention efforts can be applied at virtually every part of the continuum for multiple purposes. Health promotion and prevention covers a wide range of areas and activities, as noted by the Provincial Health Officer:

Over the last three decades it has become increasingly apparent that good health depends on much more than health services. Good jobs, access to education, a stable economy, a supportive and well functioning family, and a clean and safe environment impact the health of individuals and the population as a whole. These social determinants of health are clearly reflected in B.C.'s health goals.¹¹⁹

Prevention programs should be well informed by research evidence and based on a thorough understanding of all the factors that have an impact on the development of harms from substance use. In recent years, significant knowledge about effective prevention has been collected and is available to program planners. Properly implemented, these programs have significant potential to reduce harms and improve the ability for people to access services.



In March 2006, the BC Ministry of Health completed and published a thorough evidence review entitled *Following the Evidence: Preventing Harms from Substance Use in BC*.¹²⁰ This report covered a wide range of prevention initiatives, particularly reducing harms associated with the use of legal substances (alcohol and tobacco). That report concluded that:

The greatest return from investment in prevention strategies will come from a comprehensive approach, which tackles cultural norms and regulatory models that determine the price and availability of psychoactive substance used by all people of all ages in modern society, as well as working towards healthy psychosocial and brain development throughout pregnancy, infancy, and childhood.

This report identified five strategic directions for government consideration when looking at reducing harms:

- 1) Influencing developmental pathways.
- 2) Preventing, delaying, and reducing use of alcohol, cannabis, and tobacco by teens.
- 3) Reducing risky patterns of use.
- 4) Creating safe contexts.
- 5) Influencing economic availability.

In December 2008, BC's Provincial Health Officer released a report on alcohol entitled *Public Health Approach to Alcohol Policy* to follow up on its 2002 report.¹²¹ The strength of these reports is that they take a multi-factorial approach to prevention, examining a broad range of issues from taxation policy, to access to substances, to enforcement.

Prevention programs need to be well planned and evaluated. A balanced approach that combines universal and targeted strategies is critical in preventing and reducing harms associated with substance use. There are a wide range of prevention programs, and Appendix D (Drug awareness campaign evaluation profiles) profiles two government awareness campaigns that, despite significant financial investment and a strong belief in their foundations, simply did not meet their objectives. Mass generalized advertising campaigns are unlikely to be the most effective or best use of resources for British Columbia. Existing programs in BC, such as the Here to Help web site (www.heretohelp.bc.ca), show considerable promise in terms of the scope and usefulness of the information provided to the public.

What these reports and experiences demonstrate is that properly implemented prevention programs and campaigns have the potential to reduce harms and improve the ability for people to access services. However, as with investments in any program in the addiction continuum, investments in prevention must be routinely evaluated to ensure that resources are spent effectively.

The BCMA fully supports the idea that prevention requires an evidence-based multi-pronged approach that encompasses a number of initiatives across various age groups and stages of the addiction continuum. These efforts must be independently evaluated to ensure that resources are being directed effectively. The recent report from the Provincial Health Officer on alcohol is another example of a broad-based strategy that incorporates multiple prevention efforts to reduce the scope of harms from alcohol abuse.

It is also recognized that many jurisdictions are also focusing considerable efforts in this area that BC can learn from.



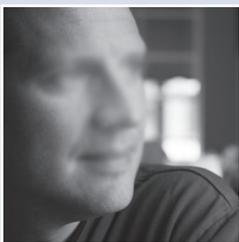
For example, the government of Australia completed an extensive review of the evidence around prevention in 2004 in its report *The Prevention of Substance Use, Risk and Harm in Australia*.¹²² This 315-page report is an exhaustive look at the evidence and experience across the continuum of care and substances. The Australian Department of Health and Ageing summarized the report as an examination of “international and national data, literature, and programs that provide evidence of good practice in preventing or delaying the onset of drug use and that address the risk and harm known to be associated with drug use.”¹²³

Recommendations

See pages 59-61 for a full list of recommendations.

Included under recommendation 8.

- B. That any prevention campaigns or programs considered for implementation in British Columbia be evidenced-based and designed and evaluated in collaboration with appropriate practising health professionals, Health Authorities, and other stakeholders as required.
- C. That the province and Health Authorities ensure that prevention or public education programs are appropriately piloted and evaluated prior to, and after, a move toward large-scale implementation.
- D. Ensure systematic funding, implementation, and evaluation of prevention programs that have the best evidence that they prevent the harm caused by substance use in BC.



John's story

“John” is a 33-year-old physician working in emergency medicine. His father is a recovering alcoholic, and since his early teens John drank regularly. His family, wife, and some friends expressed concerns. In his teens he used marijuana, LSD, and mushrooms but stopped using all drugs except alcohol until 3 years ago when he was given morphine and Demerol during knee surgery. The drugs made him feel calm and confident. When his doctor stopped prescribing them, he used the pain to justify taking a few Demerol pills from work. Within 3 months he was stealing and injecting Demerol three or four times daily. When confronted about the missing Demerol, he initially denied and then confessed everything. After 10 days of inpatient detoxification, he spent 7 weeks in a treatment centre for addicted health care professionals. This was followed by intensive outpatient counseling and Narcotics Anonymous, Alcoholics Anonymous, and Caduceus meetings (addiction meetings for physicians only). He returned to work in the emergency room in 6 months, with zero access to narcotics and sedatives and a rigorous monitoring program for 5 years. Like over 90 percent of addicted physicians in Canada, he achieved a stable drug-free recovery and learned how to deal with the stress of work without using drugs.

John's story is a success largely due to the quick access to treatment he had and the continuous monitoring and support provided during his return to work and the support of his colleagues.

GAP #7 – THE NEED TO IMPROVE ACCESS TO HOUSING PROGRAMS

Although not specifically a medical issue, we cannot discuss the addiction continuum without considering the impact and need for housing. For most people, the homeless addict is the most visible face of BC's addiction problem. Often the problems associated with addiction or mental health impact the ability of a person to find or keep housing.

The current lack of appropriate housing programs for the range of addiction and mental health problems in BC undermines the effectiveness of and the ability to provide medical care and treatment. Housing needs vary, depending on the needs of the individual, which can range from programs facilitating return to work, to addiction-treatment monitoring, to supportive mental health services, to life skills assistance.

The importance of housing was identified by the Vancouver Coastal Health Authority as a cornerstone of the new Burnaby Centre for Addiction:

Housing is a starting point for clients who are homeless or living in unstable housing—ahead of any kind of treatment.¹²⁴

In October 2008, the *American Journal of Psychiatry* published a comment as part of its series on mental illness advocating the importance of housing in its policy statement *Putting Housing First, Making Housing Last*. The BCMA believes this strategy applies equally for addiction. The journal cited this three-pronged policy strategy necessary to effectively address the needs of those suffering from a mental illness:

- 1) Housing must be addressed first before you can begin to address their illness.
- 2) Ensure people with severe and persistent mental illness have access to housing.
- 3) If they are to remain housed, supportive services must be available when needed.¹²⁵

In 2008, the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University released a report looking at housing and supports in British Columbia. The results of that report were startling:

- **130,000** adults (in BC) meet the criteria for SAMI (severe addiction and/or mental illness).
- **39,000** adults in BC with SAMI are inadequately housed.
- **11,750** people are absolutely homeless.
- **18,759** adults with SAMI are at imminent risk of homelessness.¹²⁶

In September 2008, the Greater Vancouver Regional Steering Committee on Homelessness released its homeless count for Metro Vancouver. Based on a 24-hour point-in-time count of homeless people conducted on 11 March 2008, the report showed there were "at least 2,660 homeless individuals in Metro Vancouver on the day of the count."¹²⁷



Several Health Authorities have also commented on the lack of housing:

Fraser Health Authority: “Fraser Health lacks sufficient safe, affordable and suitable housing options for individuals coping with mental health and/or addiction problems. The total projected need for additional housing and residential resources is 915 by 2011.”¹²⁸

Northern Health Authority: There is a “lack of shelters providing basic safe housing for men awaiting detoxification and treatment programs” and a “lack of supportive recovery programs and settings to help the individual complete the recovery journey after detoxification and treatment.”¹²⁹

Vancouver Coastal Health Authority: Vancouver Coastal estimates that there are more than 800 people waiting for housing with health supports.¹³⁰

Any discussion of improving the continuum of care for addiction must include housing as a basic component, particularly for the most vulnerable individuals coping with homelessness, addiction, and mental illness. As the Vancouver Coastal Health Authority so aptly put it in 2008:

Clients need a home, a friend, a job.¹³¹

The provincial government has made significant investments in housing in recent years. For example, in 2007, as part of the Premier’s Task Force on Homelessness, Mental Illness and Addiction, the province “has funded 2,287 housing units under Initiative since 2004 and will allocate \$328 million this year to social housing—nearly triple 2001 spending.” As one example, in April 2007, the province purchased 10 single-room occupancy hotels in order to convert them to supportive housing. This “included 996 units of supportive housing, which was an \$80-million investment including the purchase of 15 buildings in Vancouver, Victoria, and Burnaby.”¹³²

For some individuals, particularly the chronically homeless, housing may need to be provided despite ongoing substance use. Some innovative but controversial efforts have looked at this issue with some success,¹³³ but ultimately it will be a decision for local or provincial government to pursue. Clearly, multiple factors come into play in terms of the mental and physical health of individuals, as well as their individual capacity and rights to make their own decisions.

Recommendations

See pages 59-61 for a full list of recommendations.

Included under recommendation 4.

- D. Continue to expand housing programs across the province to adequately address housing needs, given the severity of the problem of addiction and concurrent disorders in BC communities.

GAP #8 – THE NEED TO REVIEW ADDICTION PHARMACOTHERAPY

Another important component of the continuum of care is the use of medication to assist in the treatment of an addiction. Medications may be used to either mimic or block the effects of an addictive substance or assist with the reduction of withdrawal symptoms. The use of medication to assist in the treatment of an addiction is not new. For example, British Columbians may use medication (e.g., varenicline or bupropion) in order to treat their addictions to tobacco. They may also use nicotine replacement therapy (such as nicotine patches or gum).

In British Columbia, the most recognized form of pharmacotherapy for drug addiction is the use of methadone. Methadone has been a long-standing, and the only insured, treatment for opiate addiction. The use of methadone for an addiction (opiate dependence) in BC must be under the supervision of a physician trained in its use.¹³⁴

Since methadone is a banned substance, a special exemption must be obtained from the federal Minister of Health to write a prescription for methadone. Methadone can be used for analgesic purposes or for the treatment of opioid dependency. Physicians must obtain a separate exemption to prescribe methadone for either analgesia or opioid dependency or both.¹³⁵

Research has shown that pharmacotherapy for addiction can be effective in treating some forms of addiction, particularly alcohol.^{136,137} Research has also suggested pharmacotherapy can be a cost-effective means of treatment compared with other forms of treatment.¹³⁸ The current methadone program also requires ongoing evaluation and innovation to ensure that it matches the changing needs of patients and aspects of their care.

In some cases, these drugs are already available in BC but are not covered by Pharmacare. These medications may also be recognized as a primary form of treatment, for example, acamprosate and naltrexone for alcohol dependence in some individuals. The BCMA recognizes that the science and evidence in this area continue to evolve. It is also understood that as investigation continues, it may only be possible to proceed on an incremental basis.

The BCMA encourages government to monitor pharmacotherapy and consider coverage/review of the evidence, ensuring the participation of physicians trained in addiction care. This review needs to be evidence-based and conducted with considerations for best practices in combination with other forms of treatment. These decisions should not be made without the input of health professionals actively working with addiction patients.

Recommendations

See pages 59-61 for a full list of recommendations.

9. Review and expand pharmacotherapy coverage for addiction treatment. Include the input of health professionals actively practising addiction medicine.

This includes:

- A. Pharmacare actively seeking the input of practising physicians with training in addiction medicine when reviewing addiction medications.

- B. Examining financial or other barriers to addiction-related medications on an ongoing basis, including barriers to methadone treatment. This should include the option for special authority funding in cases where financial barriers are prohibitive.
- C. Ensuring that any research or evidence used as the basis for policy or coverage decisions is made available to health professionals and the public.

GAP #9 – THE NEED TO IMPROVE DATA COLLECTION AND EVALUATION

British Columbia needs to expand and improve its data collection and evaluation of addiction treatment. This includes not only improving how we estimate or monitor the number of people with an addiction but also tracking utilization of resources across the continuum and evaluating outcomes. This improvement needs to occur at virtually every level of the system, whether it is in primary care, acute care, or in the community, with the ultimate goal of improving quality of care.

While this would appear to be a lower priority when considered against the immediate need of access to care, it is no less of a critical gap. Information collected on utilization and diagnosis can impact planning for budgets and human resources across the system. Health Authorities and other agencies are often challenged in making their business cases and cannot move forward in providing treatment and care, due to the absence of concrete data.

The Interior Health Authority (IHA) highlighted this challenge in its 2007-2010 service plan as well as strategies to attempt to address it:

To date no provincial, national, or internationally accepted standards exist for the determination of service demand in Mental Health and Addictions Services. MoH funding has supported the engagement of the six HAs with the Centre for Applied Research in Mental Health and Addictions at Simon Fraser University in the development of a demand estimation process within mental health and addictions.¹³⁹

Data collection and evaluation for addiction in BC is evolving, particularly since the responsibility for managing addiction care has only been under the Ministry of Health since 2002. Since June 2008, part of this responsibility now also falls under the new Ministry of Healthy Living and Sport.

The waiting lists for a detoxification or treatment bed highlight the challenges caused by lack of data. Individuals who are on a wait list for a treatment bed for longer than 1 week will often give up or not call back, removing themselves from the wait list. They often come back a few months later, in effect "starting over." This is a common occurrence for people struggling with addiction. However, when data from those wait lists is collected, the wait list numbers appear falsely low.

Health Authorities and the Ministry of Health Services have been frustrated by the lack of data in this area. The



Vancouver Island Health Authority also cited this challenge in its strategic plan:

It is difficult to forecast how much service we will need to provide in this sector (Mental Health and Addictions Capacity Forecasts) primarily because we do not have comprehensive data to base such forecasts on. The Ministry of Health is exploring the development of benchmarks for a comprehensive range of mental health and addictions services.¹⁴⁰

A complicating factor is that information about a person's addiction history is extremely sensitive, and privacy must be protected. There are often implications for insurance, employment, and simply personal embarrassment when attempting to improve data collection in this area.

On the positive side, there are a number of agencies in British Columbia trying to improve research and evaluation in addiction. Examples include the Centre for Applied Research in Mental Health and Addiction, Simon Fraser University,¹⁴¹ the Centre for Addictions Research of BC, University of Victoria,¹⁴² the School of Population and Public Health, University of British Columbia,¹⁴³ and the BC Mental Health and Addiction Research Institute.¹⁴⁴

Their efforts deserve support through research funding and collaborative projects with Health Authorities and other agencies. At a minimum, we should strive to match the level of information collected and available on other chronic diseases, such as diabetes or hypertension. Efforts must also be undertaken at the front-line care level to improve data collection among health care providers and Health Authorities. The expertise and experience of physicians working in addiction care must also be incorporated into these discussions.

Recommendations

See pages 59-61 for a full list of recommendations.

8. Further expand BC's addiction-research capacity, enabling researchers to collect data, conduct utilization research, and evaluate programs.
 - A. That on an ongoing basis, the research and evaluation as well as the design and implementation of programs and initiatives include the participation of practising health professionals.

VII) CONCLUSION

From the workplace and people's homes to the homeless on our streets, addiction affects all British Columbians in some way, even if they do not realize it. Few other issues have as far-reaching implications for not only our health care system but also the health of our society as a whole.

The objective of this report is not to minimize the hard work that is already being done in British Columbia. Rather, it is to point out that there are steps that we as a province and a society can take to improve care for people suffering from this disease, for everyone's benefit.

It is time to give Health Authorities and health professionals the resources and infrastructure needed for a disease of this magnitude. It is also time governments, with the cooperation and support of health professionals and Health Authorities, move past the stigma of this disease and tackle the problem head-on.

In the past few years, the provincial government has significantly invested in housing and treatment and other resources, and it is to be commended for these efforts. Municipalities and Health Authorities have also worked hard to improve care and supports. However, addiction has not yet truly been addressed in our province.

This will take time, and the BCMA recognizes that change will not come overnight. However, there are major steps that can be taken immediately, even in these difficult economic times.

First, addiction needs to be recognized as the chronic disease it is. This will help our primary care system restructure itself to improve care across the continuum.

Second, British Columbia must invest in addiction care infrastructure. The Premier has indicated that the province will undertake public projects during these tough times, and the BCMA strongly supports community-based addiction infrastructure as a cost-effective area for capital investment.

The return on this investment is well worth it, and it is time for BC to step forward.

By far the most dangerous foe we have to fight is apathy—indifference from whatever cause, not from a lack of knowledge, but from carelessness, from absorption in other pursuits, from a contempt bred of self satisfaction.

Sir William Osler, Canadian physician (1849-1919)



THE BCMA'S RECOMMENDATIONS IN FULL

The BCMA recommends that British Columbia:

1. Formally recognize addiction as a chronic treatable disease under the BC Primary Care Charter and the BC Chronic Disease Management Program. This requires expanding the BCMA/Ministry of Health Community-based Mental Health Initiative launched in 2008 to include addiction.

This includes:

- A. Providing \$4 million to expand the existing BCMA/Ministry of Health Community-based Mental Health Initiative (January 2008) to include addiction. This will support development of flowsheets, guidelines, and protocols for care for patients with addiction.
 - B. Developing Physician Support Program modules to provide additional community-based training opportunities and resources to primary care physicians.
 - C. Expanding online tools for physicians from existing resources and making use of existing resources to develop guidelines under the Guidelines and Protocols Advisory Committee (GPAC). This would help identify addiction disorders and provide resources for physicians on how to discuss the issue with patients, e.g., *Family Physician Guide*.
2. Create and fund 240 new flexible medically supervised detoxification spaces across BC by 2012 (60 per year). BC needs to ensure that detoxification is available "on demand" when requested by the individual, health professional, or Vancouver's drug court by 2012. This flexibility must also include adapting to specific needs for youth and other populations. Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary.
 3. Fund the development of 600 new addiction-treatment beds across the province by 2012 (150 per year). Following the creation of these beds, a province-wide assessment should be made to determine if further expansion is necessary. The creation of these new beds should also include expansion of existing capacity to treat concurrent disorders (mental health and addiction).

This ongoing assessment must include:

- A. Adopting a minimum standard of accessibility and availability. Health Authorities should maintain an appropriate number of treatment beds per capita based on their need and should also adopt maximum wait-time criteria for admission to these beds.
- B. Working to improve standards in all public, private, and non-profit facilities in British Columbia by improving service, quality, and accountability standards based on the best available evidence.

- C. Ensuring that new facilities target acute demand for residential treatment services among particular populations, such as rural, First Nations, youth, and seniors.
4. Expand existing community addiction programs, case management, and crisis support teams across all Health Authorities by 2012, including specific programs for rural communities, First Nations, minority populations, youth, pregnant women, and seniors. This expansion must include better integration with primary care.

This expansion should:

- A. Address the clear gaps in service identified by Health Authorities.
 - B. Ensure that all Health Authorities adopt a similar standard of care for access and delivery of community-based services. In particular, this should focus on wait times and availability of services when deemed necessary by a physician or other health professional.
 - C. Improve coordination of these community agencies with the primary care system. This includes improving the integration of counseling and other services with primary care physicians and their offices and improving the information available to primary care physicians and patients on how to access these services through a single resource directory.
 - D. Continue to expand housing programs across the province to adequately address housing needs, given the severity of the problem of addiction and concurrent disorders in BC communities.
5. Ensure that access to addiction medicine care is accessible without financial and other barriers throughout BC; this includes the elimination of per diem fees, minimization of language barriers, and access to inpatient addiction care.
6. Establish standards of care for addiction medicine treatment. This includes clearly defined wait times for services across the continuum of care developed in conjunction with front-line practising health professionals, Health Authorities, and the Ministry of Health Services. This should also include the development of clinical guidelines and protocols for addiction care developed by the Ministry of Health Services and the BCMA through the Guidelines and Protocols Advisory Committee (GPAC).
7. Expand training and support for physicians in addiction medicine. This should include formal recognition of addiction medicine as a specialty in British Columbia by provincial and national medical, nursing, and other health profession education bodies.
- A. That the Ministry of Health Services support additional addiction training and resources for urban and particularly rural physicians through existing CME and the BCMA/Ministry of Health Rural Education Action Plan, in conjunction with the Physician Support Program.
 - B. That the Faculty of Medicine be included in discussions regarding expansion of addiction training both for new and currently practising physicians.



8. Further expand BC's addiction-research capacity, enabling researchers to collect data, conduct utilization research, and evaluate programs.
 - A. That on an ongoing basis, the research and evaluation as well as the design and implementation of programs and initiatives include the participation of practising health professionals.
 - B. That any prevention campaigns or programs considered for implementation in British Columbia be evidence-based and designed and evaluated in collaboration with appropriate practising health professionals, Health Authorities, and other stakeholders as required.
 - C. That the province and Health Authorities ensure that prevention or public education programs are appropriately piloted and evaluated prior to, and after, a move toward large-scale implementation.
 - D. Ensure systematic funding, implementation, and evaluation of prevention programs that have the best evidence that they prevent the harm caused by substance use in BC.
9. Review and expand pharmacotherapy coverage for addiction treatment. Include the input of health professionals actively practising addiction medicine.

This includes:

- A. Pharmacare actively seeking the input of practising physicians with training in addiction medicine when reviewing addiction medications.
 - B. Examining financial or other barriers to addiction-related medications on an ongoing basis, including barriers to methadone treatment. This should include the option for special authority funding in cases where financial barriers are prohibitive.
 - C. Ensuring that any research or evidence used as the basis for policy or coverage decisions is made available to health professionals and the public.
10. Expand the mandate of the Premier's Task Force on Homelessness, Mental Illness and Addiction to include the full continuum of addiction care. Its mandate should also include specific capacity and accessibility targets province-wide and require the task force to meet at least twice per year to review these targets and coordinate efforts.

APPENDIX A

Addiction and substance abuse statistics for British Columbia

The resources on addiction in BC:

- 1) Health Canada
- 2) BC Ministry of Health Addiction Planning Framework
- 3) Vital Statistics BC
- 4) Centre for Applied Research in Mental Health and Addiction at Simon Fraser University

1) Health Canada – The Canadian Addiction Survey (CAS) (March 2005)

The CAS sample included 13,909 Canadians aged 15 and older who were interviewed by telephone between 16 December 2003 and 19 April 2004. Three thousand British Columbians completed the 400 unique questionnaire items, making it the most comprehensive survey of its kind on addiction. A limitation of the study is that it comprises self-report data, meaning it is likely that consumption data is underestimated, particularly for illegal substances.¹⁴⁵ The BC results are similar to the Canadian average.

Use of addictive substances:

- 22% of British Columbians who drank in the last year did so above Canadian guidelines.
- 17% of current drinkers reported problems with their drinking indicative of at least mild alcohol dependence.
- 16.8% reported using cannabis in the past year.
- 4% reported using any drug (excluding cannabis) in the past year.
- 2.6% reported using cocaine/crack in the past year.

Harm from use:

- 17.6% reported harm¹⁴⁶ to themselves occurred from drug use in the past year.
- 9.1% reported harm to themselves occurred from alcohol use in the past year.
- 35.4% reported harm from others in the past year as a result of alcohol use.

2) BC Ministry of Health Addiction Planning Framework – Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction (May 2004)

- 120,000 British Columbians have a high probability of alcohol dependence and another 224,000 have some indications of dependence (344,000 in total).
- Between 173,000 and 200,000 British Columbians are experiencing problems in some area of their life as a result of their consumption of alcohol.
- 33,000 British Columbians have dependence on illicit drugs.
- A 2004 study on injection drug use showed that almost 40% of drug-injecting youth overall and 60% of

female drug-injecting youth began injecting at age 16 or younger.

3) Vital Statistics BC – Trends in Vital Events (2006) and Death-related Statistics (2006)

- In 2006, there were 1,986 alcohol-related deaths in British Columbia, representing 6.5% of all deaths in the province for that year. Of these 1,986 deaths, 19% were directly related to alcohol and 81% were indirectly related.
- 46.3% of all alcohol-related deaths were among seniors (65 or older).
- Men accounted for 75.4% of alcohol-related deaths and women 24.6% of them.
- In 2006, 5,972 deaths of people aged 35+ were considered attributable to smoking.
- In 2006, 188 British Columbians died from unintentional illicit or illegal overdose. Of those deaths, 91 were from heroin/morphine and 55 from cocaine.

4) Centre for Applied Research in Mental Health and Addiction at Simon Fraser University – Housing and Supports for Adults with Severe Addiction and/or Mental Illness in BC (October 2007)

- In 2007, there were 130,000 British Columbians estimated to have a severe addiction and/or mental illness (SAMI).
- An estimated 11,750 of individuals with severe addiction and/or mental illness are absolutely homeless.
- 18,759 additional adults with SAMI are at imminent risk of homelessness.
- Approximately 50% to 70% of homeless people with severe mental illness also have substance abuse disorders.
- There are 39,722 people in BC with a severe substance abuse/dependence issue after a co-morbidity adjustment.

This section provides an overview of select studies examining the impact on British Columbians from five perspectives:

- 1) Deaths from addiction
- 2) Total financial costs
- 3) Impact on BC's health care system
- 4) Impact on law enforcement
- 5) Impact on the workplace

1) Deaths from addiction

In 2006, 220 people were identified by the BC Coroner's office as having died of illicit drug overdose. That report found:

220 deaths with available toxicology results; 5 were classified as suicide. 54 deaths (24.5%) occurred in Vancouver; of these, 53.3% were residents of the Downtown

Eastside (DTES). The mean age at death was 40.5 years; Vancouver deaths were older: 43.9 vs. 39.4 years outside Vancouver. Aboriginal ethnicity was reported in 19 deaths: 13 (30.2%) of 43 females and 6 (3.4%) of 177 males ($p < 0.001$).

In terms of the substances involved, the report found that:

Cocaine was identified in 79.5% of deaths, opiates in 60%, methadone in 14.1%, methamphetamine/amphetamine in 5.9%, alcohol in 22.7%, antidepressants in 10.5% and benzodiazepines in 3.6%. Poly-substance use was common; 2 or more substances were identified in 78.6% and 3 or more in 34.5% deaths. Opiates were more frequently identified in Vancouver: 74.1% vs. 55.4% ($p = 0.015$).*

2) Total financial costs

A 2006 report entitled *The Costs of Substance Abuse in Canada 2002*¹⁴⁷ estimated that the total financial burden of substance abuse in British Columbia in 2002 was over \$6 billion (and \$39.8 billion for all of Canada). This includes direct health and law enforcement costs as well as indirect costs from lost productivity and time away from work. This works out to \$1,463 per capita for British Columbians. The report broke down these costs by substance:

Illicit drugs =	\$1.507 billion (25%)
Alcohol =	\$2.219 billion (37%)
<u>Tobacco =</u>	<u>\$2.331 billion (38%)</u>

Total = **\$6.058 billion** (\$1,463 per capita)

The report also stated:

The biggest single direct cost associated with substance abuse is health care.
The second largest direct cost is law enforcement.

However, the report also found that indirect costs (such as long-term disability, lost productivity) accounted for 61% of the total national cost of substance abuse (\$24.3 billion of the \$39.8 billion), far surpassing health care and law enforcement costs.

3) Impact on BC's health care system

a) Vancouver Hospital Emergency Department Study

In May 2008, a comprehensive study was released detailing the visits that patients with substance-related problems make to Vancouver General Hospital.¹⁴⁸ Over a 6-week period, data was collected from Vancouver General Hospital's Emergency Department charts to compare patients with and without substance problems. The results are significant but, unfortunately, not surprising for physicians.

Of the 5,188 patients captured in the study, 600 had documentation of problematic substance use, and 521 visits (by 469

* Reference cited in quote: Buxton JA, Skutezky T, Tu AW, et al. The context of illicit drug overdose deaths in Vancouver and BC. 2006.



patients) were caused by substance problems.

People with substance-related visits:

- Were admitted to hospital at a rate of 25.3% compared with 17.6% for all other visits (7.7% higher).
- Stayed in the Emergency Department for an average of 232 minutes compared with 164 minutes for all other visits (41% longer).
- Revisited the Emergency Department within 1 year at a rate of 26.8% compared with 21.3% of all other visits (5.5% difference).

The study concluded:

A significant proportion of patients visiting a tertiary Emergency Department (ED) had documented evidence of a substance problem.

Patients with substance problems were younger but spent longer in the ED before discharge, were more likely to be admitted to hospital and were more likely to revisit the ED the following year.

Our findings suggest that programs targeting ED patients with substance problems could benefit a substantial portion of the ED patient population.

b) Hospital days in British Columbia

According to the Canadian Institute for Health Information (CIHI), substance abuse disorders accounted for 48,082 hospital days in British Columbia in 2004/2005.¹⁴⁹ This is enough days to fill Kelowna General Hospital every day for a year.

In 2005/2006 CIHI reported 26,721 separations¹⁵⁰ from general hospitals in British Columbia for mental illness. Of these, 22% (6,000 separations) had a primary diagnosis of substance-related disorders. Therefore, one in five patients seen in BC hospitals for mental health reasons does so because of substance abuse.

In addition, according to other CIHI data from 2003/2004, *one in five* patients hospitalized for mental illness in Canada also had a substance-related disorder.¹⁵¹ CIHI went on to report:

On average, these patients were younger than those without substance-related disorders and they were more likely to be male. Patients hospitalized with personality disorders made up almost one third (27.6%) of those psychiatric patients with a co-occurring substance-related disorder.

4) Impact on law enforcement

In January 2008, the Vancouver Police Department (VPD) released the report *Lost in Transition*. This report documented the VPD's interaction with the mentally ill in Vancouver over a 16-day period in 2007. The report revealed some startling information.

- 31% of the 1,154 calls tracked involved at least one mentally ill person.
- 49% of VPD calls in the Downtown Eastside involved contact with an individual who was mentally ill.



The report concluded:

VPD officers, along with the citizens with whom they come in contact, are bearing the burden of a mental health system that lacks resources and efficient information sharing practices, often with tragic consequences.

In June 2008, the VPD released another report detailing chronic offenders. The report tracked 379 chronic offenders with extensive records.¹⁵² The 379 offenders had:

- Averaged 71 police contacts each, with 26,755 total contacts.
- Averaged 33 charges each, with 12,418 total charges.
- Averaged 39 convictions each.

The most prolific offender had 305 police contacts and 154 charges since 2001.

5) Impact on the workplace

According to WorkSafeBC, people who abuse alcohol or drugs are:

- Five times as likely as their peers to file a workers' compensation claim.
- Three times as likely to be absent from work.
- Three times as likely to be late for work.¹⁵³

Suicide and substance abuse—A case from the United Kingdom

Substance abuse has long been linked as a risk factor for both suicide and suicide attempts. A 1999 report by the UK Department of Health clearly identified how strong the link is. For example, the report found that among suicides outside of a hospital:

- 38% had a history of alcohol misuse.
- 26% had a history of drug misuse.

As well, the report found that:

- 15% of people who misuse alcohol may eventually kill themselves.
- People who misuse drugs are 20 times more likely to kill themselves than the general population.
- Men are nine times more likely to misuse alcohol than women.
- Men who misuse alcohol are also six times more likely to die by suicide than the general population.¹⁵⁴

On a positive note, recent research has shown that suicide rates among young men have decreased and, in 2005, were at the lowest levels since 1968.¹⁵⁵



APPENDIX B

Dependence and abuse definitions

According to the *Diagnostic and Statistical Manual of Mental Disorders Text Revision #1* (DSM-IV-TR1), the clinical terms of “abuse” and “dependence” are defined as the following:

What is abuse? One (or more) of the following occurring in a 12-month period:

- 1) Recurrent substance use resulting in failure to meet major obligations at work, school, or home.
- 2) Recurrent substance use in situations where it is hazardous to do (e.g., driving or operating machinery).
- 3) Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
- 4) Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with family and friends).
- 5) Not met criteria for dependence.

What is dependence? Three (or more) of the following occurring in a 12-month period:

- 1) Tolerance: needs more to achieve desired effect.
- 2) Withdrawal: has a physical/mental reaction when substance not taken, or needs to take substance to avoid these reactions.
- 3) Larger amounts: requires larger amounts and/or over a longer period of time than intended.
- 4) Desire or unsuccessful attempts to cut down.
- 5) Significant time invested to obtain substance.
- 6) Important social, occupational, or recreational activities are given up because of substance use.
- 7) Use continues despite knowledge it is doing harm.



APPENDIX C

Strategic plan review

National Treatment Strategy Working Group

- A Systems Approach to Substance Use in Canada – Recommendations for a National Treatment Strategy, October 2008

Ministry of Health Services

- Service Plan – Balanced Budget 2007 – 2007/2008 to 2009/2010
- Every Door is the Right Door – May 2004

Health Authorities

- Fraser Health Operating Plan for the Four Years 2005-2006 to 2008-2009
- Fraser Health – Mental Health and Addiction Services Strategic Plan 2007-2012
- Interior Health Authority – Service Plan 2007/2008 – 2009/2010
- Northern Health – Strategic Plan 2004-2008
- Northern Health – Let’s Talk about Addiction and Mental Health – October 2007
- Provincial Health Services Authority – BC Mental Health and Addiction Services – Strategic Plan 2007
- Vancouver Coastal Health – Building on Strength: Building the Continuum of Care for Mental Health and Addiction, November 2006
- Vancouver Coastal Health Authority – Service Plan 2007/2008
- Vancouver Island Health Authority Five-Year Strategic Plan, originally approved April 2006, updated March 2007
- Vancouver Island Health Authority – A Year of Progress on VIHA’s Strategic Plan, August 2007

Municipal

- City of Vancouver – A Framework for Action – A Four-Pillar Approach to Drug Problems in Vancouver (2000 and 2007 update)
- City of Victoria – Mayor’s Task Force on Breaking the Cycle of Mental Illness, Addiction and Homelessness 2007



APPENDIX D

Drug awareness campaign evaluation profiles

Program	Description	Evaluation
Drug Abuse Resistance Education (DARE) - United States	<p>The Drug Abuse Resistance Education or DARE program in the United States is a police-officer-led series of classroom lessons that teaches children from kindergarten through 12th grade how to resist peer pressure and live productive drug- and violence-free lives.¹⁵⁶</p> <p>The total annual cost of this program was estimated at \$1.34 billion in 2001.¹⁵⁷</p>	<p>In 2001, the Surgeon General of the United States stated that the program “does not work,” concluding: “DARE is the most widely implemented youth drug prevention program in the United States. It receives substantial support from parents, teachers, police, and government funding agencies, and its popularity persists despite numerous well-designed evaluations and meta-analyses that consistently show little or no deterrent effects on substance use.”¹⁵⁸</p>
National Drugs Awareness Campaign - Ireland	<p>The National Drugs Awareness Campaign launched in 2003 and operated through 2005 used a wide array of tactics, such as television, radio, community road shows, and web sites to promote awareness of the harms of drug use. The objective of the program was to “increase awareness amongst the general population about current problem drug use and its consequences across society through the achievement of measurable change in the knowledge and attitude of targeted groups.”¹⁵⁹</p>	<p>In December 2007, an independent review of the campaign was conducted by the National University of Ireland. The report concluded that “The National Drug Awareness Campaign can be seen to have fallen short of the previously identified criteria for success that in turn may have reduced the latent effectiveness of the campaign.” Unfortunately, the impact of the program was limited.</p>



APPENDIX E

National Institute on Drug Abuse (NIDA) principles of drug addiction treatment

Principles of effective treatment

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs (see pages 11-49). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. ([Approaches to Drug Addiction Treatment section discusses details of different treatment components to accomplish these goals.](#))
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping



drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment ([see Drug Addiction Treatment Section](#)).

10. **Treatment does not need to be voluntary to be effective.** Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.¹⁶⁰



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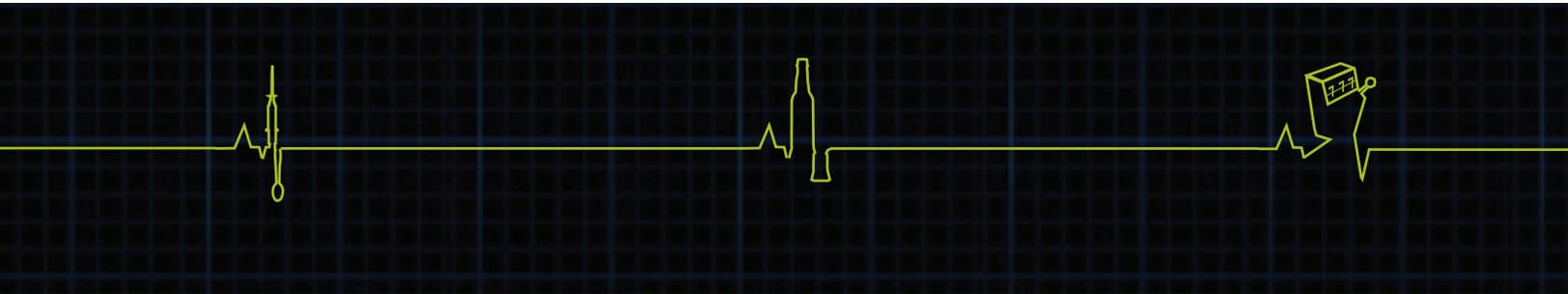


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