Alberta Health Services

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On April 1, 2009, AHS brought together 12 formerly separate health entities in the province: nine geographically based health authorities (Chinook Health, Palliser Health Region, Calgary Health Region, David Thompson Health Region, East Central Health, Capital Health, Aspen Regional Health, Peace Country Health and Northern Lights Health Region) and three provincial entities working specifically in the areas of mental health (Alberta Mental Health Board), addiction (Alberta Alcohol and Drug Abuse Commission) and cancer (Alberta Cancer Board).

Review of addiction services in Alberta

October 2008

Alberta Health Services
Alberta Alcohol and Drug Abuse Commission

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Prepared by Alberta Health Services–Alberta Alcohol and Drug Abuse Commission

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- the team of researchers and clinicians from British Columbia Mental Health and Addiction Services (BCMHAS) and the Centre for Addictions Research of BC (CARBC), who were commissioned by AADAC to carry out the review
- the members of the expert advisory panel, who provided guidance and commentary on the review

The expert advisory panel included the following members:

- Deborah Lloyd, board member and acting chair, AADAC
- Rita Notarandrea, deputy chief executive officer and director of research and policy, Canadian Centre on Substance Abuse, Ottawa, Ontario
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- Tom Payette, director of Addiction Prevention and Treatment Services, Capital Health Authority, Halifax, Nova Scotia
- Margaret Clarke, professor, Department of Paediatrics/Psychiatry, University of Calgary, Calgary, Alberta
- Wayne Skinner, deputy clinical director of the Addictions Program, Centre for Addiction and Mental Health; assistant professor, Department of Psychiatry, adjunct senior lecturer, Faculty of Social Work, University of Toronto, Toronto, Ontario

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Executive summary

Concerns about the harm associated with substance use and gambling occur at all levels of society within communities throughout the province. At some point in their lives, a significant number of Albertans will experience personal problems related to alcohol, other drugs or gambling. Others will face difficulties because of someone else's addiction.

In 2007, AADAC initiated an external review of addiction services in Alberta. An expert advisory panel was established, made up of leading experts in the addiction field from Alberta and across Canada. Based on the panel's recommendation, a team of researchers and clinicians was selected as the independent consultant to conduct the review: the British Columbia Centre for Mental Health and Addiction Services (BCMHAS), which worked in partnership with the Centre for Addictions Research of BC (CARBC) for the purposes of the review.

The review resulted in findings and recommendations, which were reviewed by the expert advisory panel. This report provides an overview of the key findings from the review and has incorporated comments and recommendations of the expert advisory panel.

Purpose and method

The purpose of the review was to objectively examine the existing system of addiction services in Alberta and to develop recommendations that will ensure Albertans are receiving the best possible care. To achieve this goal, the project team was tasked with

- identifying how best and promising practices may affect addiction service delivery in Alberta
- providing evidence-based recommendations to close gaps and minimize duplications in service
- providing recommendations and strategies to enhance the delivery of services in Alberta

A multi-method approach was used to address these objectives, including (1) conducting a literature review of best and promising practices and reviewing related statistical reports and documentation, (2) undertaking consultations with stakeholders, and (3) analyzing data for themes. The contractor collected data for the review between October 2007 and January 2008.

Highlights from the literature

A broad range of literature was accessed, including published systematic reviews of relevant research findings and recent best practice and policy reports. The latter included recent national policy efforts in both Canada and several other countries with comparable health systems; these also

were used to inform the development of the National Treatment Strategy.[1] As the National Treatment Strategy was developed based on a recent review of the best practices literature, it was well suited to fulfilling the objectives of this review.

The strategy recommends the adoption of a "tiered model" framework for understanding, organizing and better linking services and supports along the continuum of care. The model is a tool for making decisions about the continuum of services and supports within a given jurisdiction (e.g., province, region or community). Each tier represents a set of services and supports that are similar in terms of their availability and the level of intensity of the treatment services provided. Lower tiers are foundational to the system, and include services and supports that are broadly accessible and available, such as community groups and primary health care. These are generally intended to meet the needs of large segments of the population. Upper tiers include services and supports that are more resource intensive (for example, services that are typically offered within structured residential treatment settings). These services are designed to meet a higher level of need among a smaller number of people.

This review examined to what extent the system of addiction services in Alberta provides, distributes, and manages services and supports for problematic substance use and gambling in a manner consistent with the tiered model described above.

Key findings

Key findings are organized in the report into three core areas: enhancing the continuum of care, strengthening relationships along the continuum, and improving AADAC services by organizing for success. Integrated within each section is relevant information including stakeholder input, best practices and other information gathered.

Key recommendations

Based on careful consideration of the findings and recommendations prepared by the review team from BCMHAS and CARBC, the expert advisory panel provided a commentary outlining key recommendations. The panel acknowledged AADAC's commitment to undertake this review process. From the panel's perspective, the review presents an opportunity to improve and redesign the system of addiction services in Alberta in a thoughtful, co-ordinated and congruent way. The panel's recommendations are as follows.

1. Adopt the tiered model as a tool to plan and design addiction services in Alberta. For instance, complete a mapping of addiction

[1] The final report of the National Treatment Strategy Working Group is slated for release in 2008.

services by settings and demographics to identify duplications and gaps in services by region. Identify existing strengths of Alberta's health-care and social service system along the five tiers as described in the National Treatment Strategy, and identify strategic partnerships across government departments and community organizations, and within the health-care system and social service system.

2. Put in place a provincial mechanism to oversee the redesign of addiction services in Alberta. Establish a Provincial Addiction Steering Committee with a provincewide focus. The committee would be accountable to the Minister of Health and Wellness and chaired by someone who will champion addiction services in the province, is knowledgeable and experienced in the addiction field and possesses a passion about creating a vision for integrated addiction services in Alberta.

3. AADAC review its role and focus on its strengths. AADAC is both a provider of direct service and a funder of services across the province. This can produce role confusion and service disparities. It is important that there be clarity regarding these two roles, and that strengths in each be recognized. In addition, AADAC might be best suited to play a hub role in co-ordinating, facilitating and supporting a wider set of services that include addiction in their work.

4. AADAC take a lead role in setting the standards for addiction practice for the system, and more broadly, in getting tools to partners in the addiction system. The review noted issues of philosophy and inconsistencies in standards, and also noted differences in service delivery. As a funder and provider of services, AADAC has an opportunity to ensure consistency in standards and practice.

AADAC accepts the recommendations put forward by the expert advisory panel and sees the review as an important step in setting future direction for addiction services in the province. These recommendations are congruent with the direction emerging from AADAC's strategic planning process. Further, the recommendations are consistent with the current direction of the Ministry of Health and Wellness in taking a broader system view of health services, and with the Alberta Government priority to increase access to quality health care and improve the efficiency and effectiveness of health delivery.

Introduction

Concerns about the harm associated with substance use and gambling occur at all levels of society and within communities throughout the province. A significant number of Albertans will experience personal problems related to alcohol, other drugs or gambling at some point in their lives. Others will face difficulties because of someone else's addiction.

The burden of harm associated with abuse of alcohol, tobacco, illicit drugs and gambling underscores the importance of developing and maintaining a comprehensive and effective continuum of services and supports to address both prevention and treatment of related problems. According to a national study by the Canadian Centre on Substance Abuse, substance abuse is estimated to cost the province of Alberta $4.4 billion annually, the bulk of which can be attributed to indirect costs associated with lost productivity (AADAC, 2006b).

This report provides a summary of a review of the system of services and supports for people with substance use or gambling problems in Alberta, with particular emphasis on the role of the Alberta Alcohol and Drug Abuse Commission (AADAC) within this system. The purpose of the review was to objectively examine the existing system of services and to develop recommendations that will ensure Albertans receive the best possible addiction services. This report provides background along with a summary of key findings and recommendations.

Background

In 2007, the board of directors of AADAC initiated an external review of addiction services in Alberta. An expert advisory panel was established to oversee the completion of the review, and was made up of leading experts in the addiction field from Alberta and across Canada. The panel's role was to provide advice and comment, sharing their collective knowledge and experience in the area of addiction.

Using a competitive process, AADAC posted a request for proposals in June 2007. The purpose of the proposal was to develop a strategy to review addiction services in Alberta, which would inform future development of the addiction service system in the province. The expert advisory panel recommended the selection of a team of researchers and clinicians from the British Columbia Centre for Mental Health and Addiction Services (BCMHAS) as the independent consultant to complete the review. BCMHAS worked in partnership with the Centre for Addictions Research of BC (CARBC) for the purposes of the review. The review team consisted of service, program, research and academic specialists with national and international experience in the addiction and mental health fields. (Refer to Appendix A for a listing of project team members.)

The review conducted by BCMHAS and CARBC resulted in findings and recommendations, which were reviewed by the expert advisory panel. This report provides an overview of the key findings from the review and has incorporated comments and recommendations of the expert advisory panel.

Methods

The review team was tasked with three objectives:

- to identify how best and promising practices may affect addiction service delivery in Alberta
- to provide evidence-based recommendations to close gaps and minimize duplications in service
- to provide recommendations and strategies to enhance the delivery of services in Alberta

A multi-method approach was used to address these objectives, including (1) conducting a literature review of best and promising practices and reviewing related statistical reports and documentation, (2) undertaking consultations with stakeholders, and (3) analyzing data for themes. The contractor collected data for the review between October 2007 and January 2008.

Review of literature and background documents

A broad literature review was conducted to identify relevant and up-to-date evidence and insights concerning best and promising practices in addiction service systems. This phase involved reviewing the relevant published literature, including research articles and public health or professional guidelines. The review team also reviewed recent national policy efforts in Canada and several other countries with comparable health systems, which were used to inform the development of the National Treatment Strategy.[2]

In addition, background material was gathered on the nature, scope (i.e., what services are offered), availability and accessibility (e.g., wait times, geography) of existing services in the province. The primary source for these documents was AADAC; others were located and accessed online.[3] Excluded from this component were services and supports provided by the broader health and social service systems.

As well, publicly available sources of information on the use of psychoactive substances and service use by Albertans were obtained to provide context on substance use prevalence and patterns of use, associated health and social costs, perceptions regarding harm, and reasons for using treatment services.

[2] The final report of the National Treatment Strategy Working Group is slated for release in 2008.
[3] This review component included information about AADAC services and initiatives, AADAC-funded services and initiatives, and non-AADAC community agencies and providers of addiction services and supports in the province.

Stakeholder consultations

Stakeholders participated through participation in focus groups, key informant interviews, and an online survey. Three broad groups were targeted for stakeholder consultations:

- clients, families and interested members of the public
- non-AADAC service providers across a variety of service sectors, including addiction service providers in AADAC-funded agencies
- AADAC managers, staff and service providers

There was broad representation from AADAC and non-AADAC stakeholder groups in each region and from both rural/remote and urban settings. The client/family/public stakeholder group was underrepresented, despite considerable efforts to build awareness of and encourage participation in the consultation process. (See Appendix B for a summary of the 173 stakeholders who participated in the consultations.)

Review team members were assigned to conduct in-person focus groups as well as one-on-one telephone interviews with stakeholders in communities within each of three regions of the province: southern (Calgary/Lethbridge), central (Edmonton/St. Paul-Bonnyville) and northern (Grande Prairie/ Athabasca). (See Appendix B for additional information regarding the types of information gathered through the consultation.)

To encourage participation in the stakeholder consultations, particularly among clients and families, facilitators informed focus group participants that an online survey was available. The survey featured the same questions presented during the focus group sessions and telephone interviews, and the link was provided by e-mail within one week. Participants were encouraged to share this link with colleagues, clients or members of the public who were unable to participate in the focus group but who might be interested in providing feedback. Forty-three people completed the online survey; of those, 33 had not previously attended a focus group or had other contact with the review team.

Thematic analyses

Following completion of the stakeholder consultation process, the three facilitator teams conducted a thorough review and content analysis of all stakeholder input for their region, first individually and then as a pair, to identify themes emerging within and across stakeholder groups in their region. This allowed for comparison, refinement and synthesis of the themes identified by the facilitators. Themes were consensus driven, in that they were considered themes only if consistently expressed either within regions or stakeholder groups, or across either or both. Particular attention was paid to themes that emerged not only among multiple people, but also across regions or groups.

Themes that emerged consistently across regions were synthesized with the information gathered through the literature review, data review and background information. These themes served as the primary focus for the discussion and recommendations.

Limitations

As noted by the review team and expert advisory panel, the main limitations to keep in mind are as follows:

- The findings from the stakeholder consultations may not be reflective of the views and experiences of the general public in Alberta overall. Partly because of time constraints, the relatively small, non-random sample of participants, particularly clients, the general public and specific sub-populations (e.g., those living in rural areas), make it difficult to determine whether the views expressed are generally held. The largely self-selected sample, and the preponderance of replies from associated agencies that depend on AADAC for some of their funding, make conclusions drawn on the basis of these findings open to question.
- The above limitation applies even more so to the information from sub-populations such as women, Aboriginal people, and people living in rural areas. Although recommendations are made concerning these groups, and the recommendations may be sensible, they cannot be sustained on the basis of the minimal amount of information gathered as part of the report.
- AADAC commissioned the report and is the group that is most interested in the outcome. As a result, most of the information collected about addiction services relates to AADAC. The report lacks specific information about other, non-AADAC addiction services in Alberta.

The recommendations uniformly suggest action from AADAC, but it should be recognized that for the recommendations to be implemented, other groups must collaborate in a meaningful fashion. Although AADAC can and should initiate action related to several of the recommendations, the commission is in no position to act unilaterally.

Highlights from the literature

The intended outcomes of the review were to provide guidance to AADAC on two related aspects of the addiction services system: identification of service duplication and gaps, and program delivery implications of evidence-supported best or promising practices. A broad range of literature was accessed, including published systematic reviews of relevant research findings, and recent best practice and policy reports. The latter included recent national policy efforts in both Canada and several other countries with comparable health systems; these also were used to inform the development

of the National Treatment Strategy.[4] As the National Treatment Strategy was developed based on a recent review of the best practices literature, it was well suited to fulfilling the objectives of the review. The tiered model outlined in the strategy is described in further detail in this section. Additional findings from the literature are incorporated as they apply throughout the remainder of the report.

Recognizing the diversity of risks and harm associated with substance use and gambling, the review team took a comprehensive, systems-level approach to understand the continuum of responses to such risks and harm—an approach primarily organized around service delivery along the continuum of care, rather than around specific program content or clinical practices. The review sought to determine the extent to which the system in Alberta provides, distributes and manages services and support for problematic substance use and gambling in a manner that is consistent with the tiered model as it is described below.

Tiered model

Canada's emerging National Treatment Strategy recommends the adoption of a "tiered model" for understanding, organizing and better linking services and supports along the continuum of care. This model can be used at the system level for planning services and at the individual level to understand help-seeking and care pathways (National Treatment Strategy Working Group, 2008).

The tiered model is intended to be used as a tool for making decisions about the continuum of services and supports within a given jurisdiction (e.g., province, region or community). Each tier represents a set of services and supports that are similar in terms of their availability and the level of intensity of the treatment services in response to substance use problems.

A model with five tiers is described in the National Treatment Strategy; however, the number of tiers is less important than is the recognition of the difference between "lower" tiers relative to the "upper" tiers. Most important is the use of the model to design and manage linkages between lower-tier and upper-tier services and supports, and between services within a given tier.

Lower tiers are foundational to the system. They include services and supports that are broadly accessible and available, such as community groups and primary health care. These are generally intended to meet the needs of large segments of the population. They may not specialize in substance use problems, and typically provide relatively low-intensity responses. Lower tiers tend to be integrated into community-level services and should be available in most, if not all, communities.

[4] The final report of the National Treatment Strategy Working Group is slated for release in 2008.

It is important to note that the entire population has access to the lower-tier services and supports, regardless of their level of risk or severity of their problematic substance use. This population includes those who need to make use of services in the upper tiers at some point in their care pathways. For example, people with complex and highly problematic substance use also need to be continuously supported by community-based and primary care services and supports outside of specialized treatment settings. It is equally important to recognize that most people with substance use problems will need only lower-tier services and supports; they will not require the more intensive and expensive treatment included in the upper tiers.

Upper tiers include services and supports that are more resource intensive (for example, services that are typically offered within structured residential treatment settings). These services are designed to meet a higher level of need among a smaller number of people. They are generally organized and specialized for people with more severe substance use problems. Because of lower demand and higher need for specialization, these services will be less widely available than services and supports in the lower tiers, and should therefore be made accessible to people across a broad catchment area.

Figure 1 illustrates the general differences among tiers on a number of dimensions. The distinctions among tiers are relative; they are therefore most usefully considered in the context of the model as a whole rather than as standalone parts.

Figure 1: Differences among tiers

	Eligibility	Nature of Problems	Share of population in need	Cost per person	Degree of specialization and intensity	Degree of integration with community life
Tier 5	LIMITED	SEVERE	SMALLEST	HIGHEST	HIGHEST	LOWEST
Tier 4						
Tier 3		MODERATE				
Tier 2						
Tier 1	OPEN	AT RISK	BIGGEST	LOWEST	LOWEST	HIGHEST

From *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*, by National Treatment Strategy Working Group, 2008, Ottawa, ON: National Framework for Action to Reduce the Harms Associated With Alcohol and Other Drugs and Substances in Canada. Reproduced with permission.

Distribution of addiction services and supports along tiers

To illustrate the application of the tiered model, a description of possible distribution of addiction services and supports for each tier is outlined below (National Treatment Strategy Working Group, 2008). Note that exceptions may apply, and population-based demand would contribute to informing the appropriate distribution of services. That is, this model can be applied in a variety of ways to jurisdictions and settings. A focus that begins with an emphasis on settings, a settings approach, is important. It offers broad consideration of the environmental, social, and economic factors that influence population needs as much or more than focusing on access to services. Within a specific setting, the availability of tiered services and supports will be part of creating a health promoting environment.

Tier 1: Services and supports in all communities

Tier 1 refers to services and supports that are available in all communities and are offered in healthy settings where people live and interact (e.g., school, work, neighbourhoods). These services and supports have the capacity to provide early responses in the form of basic health information and linking people with other services and supports. Such services would include youth prevention and education services and supports, community-based support groups and associations (e.g., Alcoholics Anonymous and faith communities) with the capacity to help people manage and sustain their own health while reintegrating into the community.

Tier 2: Services and support in most urban and rural communities

Tier 2 services and supports are available in most urban and rural communities within public health and primary care settings. They have the capacity to provide continuity of care, screening, brief intervention and referral services, along with ongoing shared health-care services with other kinds of service providers. It also includes social services and community mental health teams with the capacity to provide similar services.

Tier 3: Services and supports in most semi-urban or urban settings, and through rural outreach strategies

This tier consists of services in emergency health care and other acute care settings with the capacity to provide focused outreach and risk management in addition to screening, brief intervention and referral services as well as comprehensive assessment and referral services. Services and supports in this tier are available in most semi-urban or urban settings, and through rural outreach strategies. This tier would also include other settings with opportunities for engagement and the capacity to provide focused outreach and risk management.

Tier 4: Services and supports in most semi-urban and urban centres

Tier 4 services and supports are also available in most semi-urban and urban centres; however, this tier includes more intensive, structured and specialized outpatient services. Services and supports within this tier have the capacity to provide comprehensive assessment, maintenance treatment, treatment planning and counselling,

Tier 5: Services and supports in urban centres with a broad catchment area (e.g., regional, provincial)

Services in Tier 5 are typically provided in structured residential facilities with the capacity to provide specialized, intensive multi-disciplinary treatment services. As these services are intended for people with severe and complex substance use problems, they tend to be located in urban centres and are available to those living within a broad catchment area, such as a region or province.

Core operating principles

Core operating principles

- *Any door is the right door*
- *Accessibility and availability*
- *Matching*
- *Stepped care*
- *Flexibility*
- *Choice and eligibility*
- *Responsiveness*
- *Collaboration*
- *Co-ordination*

Along with the relative dimensions or differences among the tiers, the National Treatment Strategy identifies nine core operating principles. These principles reflect the values and assumptions that guide the development and implementation of an effective system of services and supports in response to problematic substance use.

Any door is the right door

People should have access to the continuum of services and supports by way of any of the five tiers and, upon entry, should be linked to other services and supports within or across tiers as appropriate to their needs.

Accessibility and availability

Services and supports across all tiers should be available and accessible within a reasonable distance or travel time from one's home community, notwithstanding the important challenges that exist in providing services to residents of sparsely populated, remote or isolated communities.

Matching

People should receive services and supports within tiers of sufficient intensity to appropriately and effectively meet their needs.

Stepped care

People should be referred or linked from lower tiers to upper tiers (stepped up), and from upper tiers to lower tiers (stepped down) as appropriate to their needs.

Flexibility

Once receiving care, people should have access to services and supports within and across different tiers as needed and over time, even if the focus of care might be in one tier at a given time.

Choice and eligibility

In addition to receiving services and supports according to their needs, people should be able to choose from among the various options for which they are eligible (i.e., meet existing admission criteria) within a given tier.

Responsiveness

People and their needs change over time and circumstance. As people travel along care pathways and through the lifespan, they should be provided with the necessary assistance—be it information, referral, assessment or treatment—to shift the focus of care from upper tiers to lower tiers.

Collaboration

As people move through various tiers based on their needs, pathways through care should be facilitated by collaboration between providers of distinct kinds of services and supports. Collaboration should occur at the clinical level through shared care between service providers, and at administrative and organizational levels, for example, through partnerships and inter-agency agreements.

Co-ordination

Health information systems that allow for easy sharing of information across systems of care are also critical aspects of system planning, monitoring and evaluation.

Application of evidence to practice

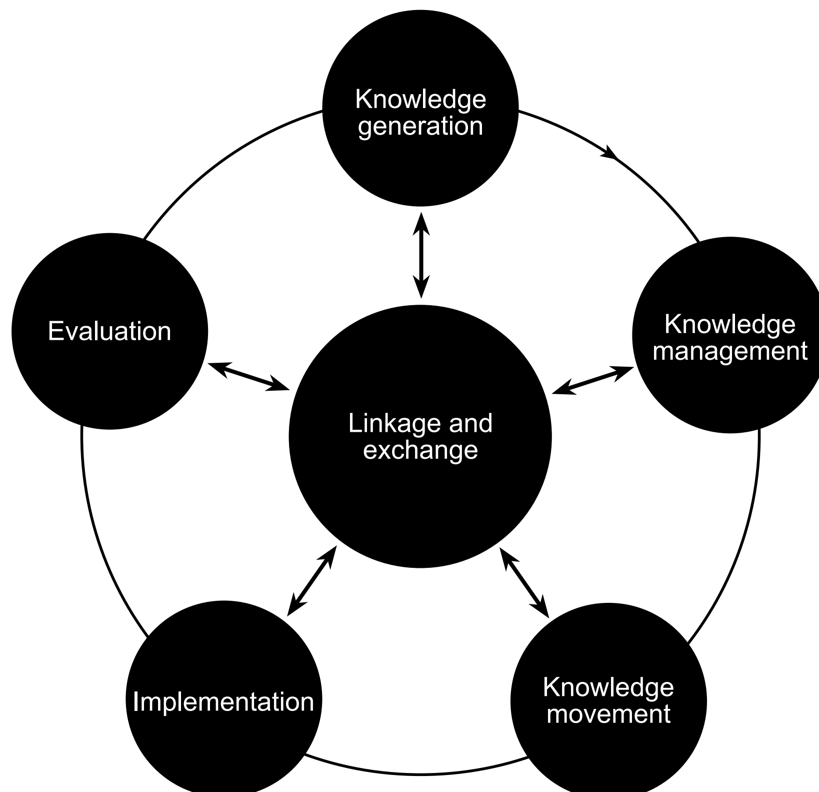
Providing appropriate and effective services and supports reduces the risks and harm faced by people, families and communities. It also reduces the overall health, social and economic burden of substance use. Service delivery should therefore reflect best and promising practices that are informed by the latest evidence. Clients have the right to services and supports strongly supported by research evidence, and informed by critical population differences.

Ensuring that service delivery is informed by evidence requires particular attention to monitoring and evaluation as well as carefully planned knowledge sharing. Effective knowledge sharing across the network of services and supports must link the various producers and users of knowledge. Currently, there is tremendous variability in the degree to which available knowledge is applied within services and supports for substance use problems. This concern is widely recognized in the substance use field and has been observed in Alberta (Miller, Sorensen, Selzer, & Brigham, 2006).

The National Treatment Strategy Working Group has proposed a model of knowledge sharing that has several action phases (as shown in Figure 2) (National Treatment Strategy Working Group, 2008). At the heart of the model is the need to facilitate two-way movement of knowledge among its producers and users. The model links actors with differing knowledge sets and different system roles in the production, management and use of knowledge articulated in the other phases. The model supports knowledge sharing through the following principles:

- Knowledge generation takes place in multiple contexts and is about adding to what we know through the accumulation of evidence.
- Knowledge management is the bringing together of new and existing evidence into knowledge upon which action can be based.
- Knowledge movement involves a variety of techniques to provide access to knowledge.
- Implementation is about applying what we know and involves a conscious process of change management that assesses and nurtures a readiness to change, sets priorities, supports end-users, and targets changes that are practical and feasible within the given context.
- Evaluation measures the progress both in terms of the application of knowledge and the process of bringing it about.

Figure 2: Model of knowledge sharing and action phases



From *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy*, by National Treatment Strategy Working Group, 2008, Ottawa, ON: National Framework for Action to Reduce the Harms Associated With Alcohol and Other Drugs and Substances in Canada. Reproduced with permission of BC Mental Health and Addiction Services, and Centre for Addictions Research of BC.

Overview of key findings

Key findings and discussion are organized into three core areas: enhancing the continuum of care, strengthening relationships along the continuum, and improving addiction services by organizing for success. Integrated within each section is relevant information including stakeholder input, best practices and other information gathered.

Enhancing the continuum of care

Using an upstream-downstream orientation within various settings

Traditionally, substance use services have sought to help people change their patterns of substance use (treatment) or influence individual choices in the development of healthy patterns of use (prevention). Current evidence suggests that societal and biological factors are more influential than personal behaviour in determining overall health status and chronic disease conditions (Ontario Prevention Clearinghouse, 2006). In fact, individual behaviour can only have full impact where people have equitable access to healthy living conditions (World Health Organization, 2005).

Moving upstream means more than providing traditional prevention programs. It means addressing the impact of powerful determinants of health, including income and social status, social supports, education and literacy, employment and working conditions, social environments such as housing, physical environments (air, soil, water), healthy child development, gender, culture, biology and genetic endowment, as well as personal health practices and coping skills (Ontario Prevention Clearinghouse, 2006).

Returning downstream, a settings approach is less interested in what specific services can be provided than in clarity about the functions involved in supporting people within a given setting. A settings approach requires greater flexibility in how the supports and services are actually delivered to have the greatest impact on the health of the population. Overemphasis on individual service system components, or even on the delivery of a specific continuum of services, often inhibits access and limits the type of supports provided.

Integrating systems to serve clients and address the determinants of health

Health Canada defines system integration as “the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of services to individuals at the local level ...” (2001, p. vii). System integration is likely essential for effectively responding to the complex issues and broad determinants related to substance use problems.

An integrated system of services and supports to address harm related to substance use must bridge the service delivery gaps that exist within

and among addiction services, mental health services and other sectors such as social services, health care, education and corrections (Canadian Psychiatric Association, 2005; Els, 2007; Health Canada, 2001; Kirby & Keon, 2006; Mueser, Noordsy, Drake, & Fox, 2003; Thornicroft & Tansella, 2003; Ziedonis, 2004). The purpose of systems integration is to encourage seamless service delivery, promote efficiency, optimize the use of scarce resources and improve patient outcomes.

The integration between addiction services and various community-based services seems to vary from community to community and appears to be a function of local relationships rather than system design. Access to care from different systems is particularly problematic for people with co-occurring mental illness and problematic substance use. In general, agencies and providers should be strongly discouraged from excluding people with mental health problems from problematic substance use treatment, and excluding those with alcohol or other drug problems from mental health treatment (Roberts & Ogborne, 1999). Additionally, it is recommended that addiction and mental health services should share information, tools and staff, as well as develop formal and informal working relationships (Skinner, 2006).

Barriers to services and supports for Aboriginal people provide another example of the need for better systems integration. Though ongoing dialogue is taking place between the AADAC-funded and National Native Alcohol and Drug Abuse Program (NNADAP)-funded systems, comments from stakeholders during the review process suggest that several challenges remain. A process of multi-jurisdictional dialogue should be initiated that is designed to achieve clear service delivery agreements and protocols that will remove current barriers to services and supports for Aboriginal people.

At present, insufficient evidence exists to recommend specific models of system integration. Nonetheless, the value of an integrated system of services is clear. Evidence suggests that in both treatment and health promotion, collaborative models can increase the accessibility and capacity of available services, lead to more efficient and economical use of resources, and improve communication between professionals (Centre for Applied Research in Mental Health and Addictions, 2007; Cochrane, Durbin, & Goering, 1997; Hogan et al., 2003; McDaid & Thornicroft, 2005; Thornicroft & Tansella, 2003).

The literature suggests that system integration and collaboration require careful planning, change management and structural reorientation (Craven & Bland, 2006). Co-location of services and building on pre-existing relationships are useful strategies for increasing integration. The goal is a seamless experience for the client; this does not necessarily require administrative integration or reorganization. This might have implications for how services are delivered. For example, co-location of services might be important in some communities. It will also affect what supports are offered. For example, post-treatment social supports may be more important in some contexts than some of the traditional services that are available. A consideration of the determinants of health would

draw attention to weaknesses in the current system to address the unique needs of women, Aboriginal people and other specific population groups.

Bridging the urban-rural divide

Alberta has a higher proportion of people living in rural communities (24.6%) than does Canada as a whole (21.6%), even though it is the fourth most urbanized province. Urban settings differ significantly from rural and remote settings, and the experience of living in a rural remote community is very different from that of living in a rural community with easy access to a metropolitan area. The difference is even greater for those in communities with little or no involvement in the urban workforce (13.3% of Albertans versus 7.7% of Canadians), because these communities are generally more remote (Sorensen & de Peuter, 2005).

Urban Albertans generally make more money, are more likely to be employed and more likely to have higher education than rural Albertans. They are also slightly more likely than rural Albertans to use alcohol, cannabis or other drugs. Rural Albertans are, however, significantly more likely to report having experienced harm as a result of their substance use. Among rural communities, those with the least labour integration with metropolitan areas have the lowest rates relative to income, employment and education. The same pattern is true relative to access to health-care professionals. In fact, the urban-rural gap in the ratio of health-care providers to population has increased in recent years. Again, the more isolated communities have the least access to services per capita (AADAC, 2006a; Sorensen & de Peuter, 2005). Comments by stakeholders suggest that this pattern is also true of addiction services and supports. In fact, some services are only available to rural residents if they are able to temporarily relocate to one of the large urban centres.

Some stakeholders agree that this pattern serves the system, but not the clients. For example, communities with upstream determinants of health predicting the highest level of need have the least access to services and supports. Reducing this disparity is by no means easy, and systems in all jurisdictions across Canada struggle with this. Nonetheless, it is critical that access be improved for rural Albertans. Using a settings approach and the tiered model with systems integration will provide suggestions for moving forward. Some services may have to be delivered in urban centres, with attention given to logistical issues related to transportation, housing and social supports. However, the first consideration should be to explore creative ways to provide the needed support closer to home.

Two further considerations should be kept in mind. The proportion of the population that represents Aboriginal people increases as isolation from metropolitan centres increases. This means that the urban-rural divide is interconnected with the jurisdictional issues cited above, and must be addressed with that in mind. Second, discussion of the urban-rural divide should not blind us to disparities within urban settings that also need special attention.

Strengthening relationships

As noted above, having the capacity to provide the services and supports called for along the full continuum of care largely depends on levels and forms of system integration. Lack of integration was among the most commonly identified issues in the review.

There are various issues to consider when it comes to achieving system integration. Organization-level issues are discussed in more detail in the section on Organizing for Success. Here, the focus is on issues at the level of relationships between practitioners. This is where system integration happens in the first instance.

Within the addiction system

The complexity of planning and delivering services that meet the needs of clients in a holistic and seamless way depends partly on the partnerships between organizations that provide or fund specialized addiction treatment. In Alberta, the marketplace of addiction services has evolved into a complex network of providers. AADAC is the pivotal organization in this regard, because it is both a funder and a provider of services. A central challenge for AADAC is to perform both functions well, without allowing either to compromise the other.

Overall, AADAC is seen as both a good partner and a funder of some excellent and valued programs. However, in AADAC's complex role of funder, sometimes addiction treatment programs may also be competitors for funding, clients and staff. It appears that many programs external to AADAC, including those it funds, are not as well resourced as programs operated by AADAC. This may result in wide disparities in quality and availability of services, and may place extra strain on the smaller agencies. To begin to address this disparity, AADAC may wish to explore ways of sharing human resources with the treatment agencies it funds. This could be accomplished, for example, through two-way mentorship exchanges between AADAC and its funded service providers. This might be done as a way to enhance professional development in the field overall, and would link well with the knowledge exchange strategy discussed earlier.

There are apparent philosophical differences between AADAC and some of the service providers it funds. In contrast with some funded providers, AADAC strives to keep up to date with evidence-based practices in its own programming. This has implications for the role that AADAC might be playing in setting standards for the services to which it distributes public funds. More generally, this points to an ongoing challenge that AADAC faces: to use its influence to see that all aspects of the biopsychosocial approach that it follows are adopted throughout the Alberta system of addiction services and supports.

The challenges concerning the relationships AADAC has with other addiction treatment providers will likely become more acute over time as increasing demands are placed on the system. This may warrant a review of the central role it should play to add the greatest strength to the broad continuum of addiction services and supports in Alberta.

With the broader health system

How AADAC and its funded service providers work with non-addiction service providers in the health, social and educational sectors across the province has implications for the effectiveness of preventing and reducing harm related to addiction. Clarifying roles and relationships among the partners is important to developing consistent and effective approaches to both prevention and treatment.

At the level of providing services to clients, it is clear that the addiction treatment system needs to routinely collaborate with practitioners elsewhere in the broader health system. This would be consistent with the biopsychosocial model used by AADAC. The model assumes that addiction problems develop from a spectrum of sources, and in turn require a spectrum of treatment responses. A few issues emerged, however, during consultation with stakeholders in the health professions about challenges to effective collaboration between their services and addiction treatment services in the province.

Primary care, addiction medicine and emergency clinicians may be well positioned to provide screening, brief interventions and referrals that can link to addiction treatment services as needed. According to evidence from the research literature, brief interventions are among the most strongly supported prevention and treatment strategies for people with non-dependent hazardous patterns of alcohol use (Miller, Wilbourne, & Hettema, 2003). Primary care practitioners interviewed saw their practices as important doorways within the health system for improving access to other relevant general and specialized services, particularly in rural areas. This is especially crucial for people receiving pharmacological therapies for addiction, such as methadone treatment.

When it comes to making better use of general practice physicians in the continuum of addiction services and supports, AADAC is seen as being well positioned to build the necessary bridges across health sectors. Primary care networks in Alberta may be one of several useful points of connection at the clinical level. At the administrative level, a number of physician stakeholders made positive mention of AADAC's ongoing dialogue with the Alberta Medical Association and other professional organizations in the province.

Some specific concerns were raised during interviews about the capacity of Alberta addiction treatment services to deal with more complex cases (e.g., co-occurring mental health and addiction problems). Medical, mental health and addiction treatment professionals struggle with challenges to effective partnerships. In these cases, though most addiction treatment service providers are able to deliver basic evidence-based psychosocial interventions, other professional competencies are also needed.

The willingness to build partnerships for shared care to address these issues appears to be growing. A number of stakeholders interviewed were hopeful of seeing positive steps emerging from joint initiatives between the mental health professional community and addiction services. They could envision future partnerships with the addiction treatment system in such areas as joint assessment and treatment planning, delegation of responsibility, evaluation, and co-ordination of cases involving people with co-occurring mental health problems.

Physicians who are specialists in addiction medicine noted that they are also potential sources of education for addiction counsellors on the biomedical aspects of addiction and complicating physical health factors, both in general and with respect to individuals. At the same time, it was widely acknowledged by physicians and other stakeholders that family physicians generally do not have adequate training in the area of addiction. This is reflected to some degree in the lack of general practitioners in Alberta who practice addiction medicine. It is also reflected in the shortage of community-based physicians who are licensed to prescribe methadone.

Clinicians noted the challenges AADAC faces in playing a large enough role in providing education and clinical support to community-based health professionals. Mental health as a field has been shifting from an office-based to a street- or home-based style of service delivery by engaging people in a diverse range of settings (e.g., hospital emergency departments, public health clinics). The same shift may not have occurred to the same extent in the area of addiction service delivery in Alberta. Nevertheless, health professionals highlighted specific instances in which AADAC has been piloting innovative outreach partnerships with community-based practitioners. These are seen as valuable opportunities for mutual education on the latest evidence-based understanding and treatment of addiction. Examples of this kind of knowledge exchange included sharing information in general, as well as discussing how to apply the information to individuals. A number of community-based physicians looked to see more outreach of this kind to keep up to date on services offered by agencies such as AADAC, as well as on procedures for referring patients into addiction treatment.

Given the wide range of training and expertise needed to provide good health care (including complex addiction treatment), it is probably not possible for one professional group or sector to deliver all that is required. There are numerous challenges, however, to be addressed in improving linkages between addiction treatment providers and the rest of the health system, in Alberta and elsewhere. Physicians noted the artificial divide between addiction and medical services, which may make access to both types of services difficult for patients. The barriers in this regard are not limited to a lack of physician training; they also include institutional problems such as legislative constraints on sharing client/patient information.

With community-based agencies

Many stakeholders interviewed noted that clients struggle without adequate aftercare, housing and other post-intervention services and supports. Clients can be well served by being routinely referred to community-based social and housing services supports by the addiction system as a follow-up to treatment. This is consistent with the tiered continuum of care model outlined above.

Community agencies, broadly conceived, are settings for connection with three types of people:

- those in need who have not yet come into addiction treatment
- those who have completed some kind of treatment and now are in a process of reintegrating back into their lives
- those at risk who may never seek treatment in a structured program

These agencies are often critical points of contact or liaison with the addiction treatment system for populations that are particularly vulnerable. Such vulnerabilities translate into greater risks for "falling between the cracks" in the system of services and support. This in turn may lead to marked health disparities.

A best practice for creating and maintaining a balanced and comprehensive addiction services system is to reduce inequities in health status among population groups, and to remove systemic barriers that create disparities in service access and use. These inequities may be a consequence of race, culture, ethnicity, age, gender, language, disability, sexual orientation, socio-economic status, or other individual and collective factors (Kirby & Keon, 2006; U.S. Department of Health and Human Services, 1999). Indeed, there is a growing need to develop systems-level interventions for engaging marginalized populations.

Community agencies and groups are one set of vehicles for improving service access and use. They may do this by

- undertaking initiatives to improve awareness of and access to informal help
- providing specialized services through outreach efforts
- involving local primary health-care providers in identifying problematic substance use
- offering culturally relevant services (e.g., healing lodges)
- offering educational programs for service providers
- providing case management services that can effectively attend to multiple, complex and diverse needs

Also important in this regard are municipal efforts to bring together multiple sectors within the community to provide integrated responses to identified problems, as evident in centres such as St. Paul in central Alberta.

At the broader system level, nurturing partnerships between the addiction treatment system and community agencies in Alberta is yet another important role that AADAC has taken on to some extent. Various stakeholders interviewed noted that AADAC was "at the table" with social support agencies such as the Boyle McCauley Health Centre in Edmonton. These efforts are to be strongly encouraged, and should be adopted as a system-level approach rather than just in local pockets where service providers have taken it upon themselves to develop such partnerships.

From the perspective of the National Treatment Strategy, effectively sewing community agencies into the fabric of the service and support continuum is critical to success across the addiction treatment system. Community agencies are part of the foundational tier in the broader continuum of care. For many people, the first step toward an optimal level of treatment in an appropriate setting is taken through such agencies. In some cases, community agencies also provide post-intervention support and, for many people, the services and supports provided at the local level are the only ones they will ever receive.

Organizing for success

This section considers the kind of organization Albertans need AADAC to be a part of in the next decade, based on themes emerging from the findings. It is evident that after a long history of strong leadership, innovation and growth, AADAC is at a fork in the road.

A learning organization

How can AADAC continue to grow as a learning organization? A "learning organization" simply means an organization that is continually engaged in processes of knowledge exchange, including the creation and implementation of new insights. In the case of AADAC, these insights include evidence built on external research into the effectiveness of prevention and treatment strategies. Just as important, AADAC manifests itself as a learning organization by taking insights from its own local operations on how to accomplish the partnerships discussed above. Several examples were voiced by stakeholders, such as creative activity by AADAC staff on the front line. These examples point to the presence of an organizational environment that encourages local innovation, and that takes from this innovation lessons to be applied elsewhere in the organization.

Measurement and monitoring of system-level performance are essential to ensuring that the addiction services system as a whole is comprehensive, balanced, integrated, inclusive, efficient, needs-based, accessible and cost-effective (Cochrane, Durbin, & Goering, 1997). A systems-focused evaluation considers the overall performance of the addiction system, rather than simply assessing the effectiveness of specific interventions. The management information system, AADAC's System for Information and Service Tracking (ASIST), provides outstanding opportunities to work

toward improvements in system integrity, component integration and service consistency.

ASIST is a resource that AADAC should maintain and use as much as possible to monitor key indicators across addiction services in Alberta, including those not directly provided by AADAC. Several reviews conducted in British Columbia and Alberta provide evidence-based recommendations for selecting performance indicators, implementing performance measurement systems, and addressing information systems issues (Adair et al., 2003; Goldner, Tompkins, & Cardiff, 2001; McEwan & Goldner, 2001). Such information is critical in informing quality improvement initiatives, broad system and resource planning activities, and policy decisions.

System-wide improvements can also be achieved through facilitating the uptake of research evidence by addiction practitioners (Skinner, 2006). A number of stakeholders noted the challenges faced by addiction treatment services in Alberta in trying to be adequately prepared to deal with the reality of significant co-morbidities (e.g., trauma, polysubstance abuse, concurrent mental health disorders). It has been suggested that although many practitioners are trained in basic addiction counselling, they may not be entirely equipped to address the therapeutic issues found in an increasingly complex client population or with increasingly dangerous (or less well understood) drugs.

AADAC staff underscored AADAC's reputation in the areas of innovation and research. This reputation was highly valued by staff interviewed, with some expressing the need to nurture these aspects of the organization as AADAC moves forward. To this end, AADAC leadership will need to continue its commitment to removing organizational barriers to knowledge uptake and rigorous program evaluation.

Disconnected services

During focus groups and interviews with stakeholders from across the province, facilitators heard various references to the problem of professional groups and organizations working independently or separately, including but not limited to AADAC. There are indications that these organizational ways of working have had an impact on relations among health sectors, among addiction treatment providers and within AADAC itself.

Though AADAC strives to operate as an increasingly integrated organization, silos of service delivery were perceived to remain within its structure. This type of disconnect can have implications on service delivery. For instance, working in silos may affect AADAC's capacity to apply standards across its own system and to ensure consistent conformity to evidence-based best practices. It may also have implications for how each program contributes to external partnerships and engages effectively in the broader continuum of care.

One or two systems?

Discussion throughout this report has underscored the value seen in enriched working relationships between AADAC (as well as other treatment agencies) and other service and support providers. Health outcomes would likely be improved through better and more extensive collaboration with primary care, emergency care and mental health practitioners, as well as with other sectors (e.g., education, social services, criminal justice).

With this end in mind, it is worth considering the difficult question of how and how much AADAC might further enhance its integration with broader health and social service systems in Alberta. In the view of the review team, the status quo is not in the best interest of clients and patients. But how to move ahead is not so clear.

Although concern was expressed with increased integration related to a perceived potential loss of capacity to deliver addiction services, viable changes could be envisioned that would retain the strengths of having AADAC as a provincial organization, while also working toward realistic and beneficial increases in collaboration among medical, mental health and addiction practitioners and programs. This would require formal administrative linkages between AADAC and other health services in Alberta, to drive forward and co-ordinate service delivery of shared care on a variety of fronts. This type of approach to “soft integration” is sometimes referred to in the organizational analysis literature as “loose coupling.”

Loose coupling describes a resilient relationship between two or more systems or organizations with some kind of exchange relationship. This approach specifically seeks to sustain flexibility while facilitating shared efforts. But the participants must work toward some shared understandings and develop protocols to ensure joint (though loosely coupled) activities that can unfold at the level of front-line service delivery as well as at administrative levels.

Clearly, priority would need to be given to developing the regional mechanisms and protocols necessary to provide joint assessment and treatment for people with co-occurring mental health and addiction problems. More general models of shared care involving family physicians and other health providers with addiction practitioners might then be implemented as a second priority. It would be critical to engage in these efforts as equal partners at the administrative level as well as the clinical level.

If efficiencies were to develop over time, it might be possible for AADAC to shift some of its resources away from direct service delivery toward a greater leadership role in addiction treatment standards, strengthening the network of community agencies, and more substantially fulfilling its prevention mandate. AADAC might also then engage more intensely in provincial-level partnerships in research and evaluation, knowledge exchange and policy.

The Alberta Government may be able to facilitate a loose-coupling strategy by creating a supportive provincial policy framework, possibly establishing an arms-length systems manager, and providing adequate infrastructure to support the integration process (Durbin, Rogers, Macfarlane, Baranek, & Goering, 2001).

Key recommendations

The expert advisory panel concluded that the review provided an excellent opportunity to examine the issue of addiction services in Alberta, using the current literature together with data supplied by AADAC. The findings of the review are consistent with similar studies in other parts of Canada and beyond. The need to further enhance and integrate addiction service delivery at the systems level is a challenge that is not unique to Alberta. However, by beginning the service review process, Alberta has positioned itself to become innovative in this area (Expert Advisory Panel, 2008).

The panel further concluded that the review could be used as a springboard for action. It makes explicit some tools, such as the tiered model of service delivery and the knowledge exchange model, that provide a useful guide to who should be part of the continuum of addiction services and how information might be exchanged. The review can be used to foster a collaborative approach to delivering addiction services in Alberta. It creates constructive opportunities for AADAC and other key provincial stakeholders to develop and enhance their working relationships in ways that improve services and supports for people affected by addiction problems. The recommendations from this review will allow the province to be proactive in building a more integrated and inclusive treatment system for addiction and related problems.

Based on careful consideration of the review team's report and recommendations, the expert advisory panel provided commentary outlining key recommendations, which are provided below. From the panel's perspective, the review presents an opportunity to improve and redesign the system of addiction services in Alberta in a thoughtful, co-ordinated and congruent way.

Recommendations to improve the system of addiction services in Alberta

Adopt the tiered model as a tool to guide the following actions:

- Plan and design addiction services in Alberta.

  Key to the tiered model is that while it identifies specialized addiction services (both outpatient and residential, in tiers 4 and 5) as essential, it also includes community resources (tier 1), both informal (families and neighbourhoods) and formal (e.g., mutual aid and faith communities) as important participants in any effective addiction strategy. In addition, it sees primary care and community social services (tier 2) as key, as well as services that provide walk-in and outreach options (tier 3). Because addiction problems can be prevented, and identified earlier, tiers 1, 2,

and 3 are best positioned to do this. They are also the best resources for providing continuing care and support, given that for many with these problems, addiction is a chronically relapsing condition.

- Complete a mapping of addiction services, by settings and demographics, to identify duplications and gaps in services by region.

  This would identify duplications and gaps in services, and provide an overview of the current balance of resources that are deployed to address addiction problems. Considering population demographic characteristics associated with addiction problems by region, and then mapping to existing services, is a process that draws on the tiered model to identify duplications and gaps in services by regions.

- Identify existing strengths of Alberta's health-care and social service system along the five tiers as described in the National Treatment Strategy in terms of its ability to contribute to a redesigned continuum of services and supports for addiction.

- Identify strategic partnerships across government departments and community organizations, and within the health-care system and social service system.

Put in place a mechanism to oversee the redesign of addiction services in Alberta by establishing a Provincial Addiction Steering Committee with a provincewide focus.

The committee would

- be accountable to the Minister of Health and Wellness
- be chaired by someone who will champion addiction issues in the province, is knowledgeable and experienced in the addiction field and possesses a passion about creating a vision for integrated addiction services in Alberta
- implement the recommendations using a phased-in approach and focus initially on recommendations that will have the greatest impact on the addiction system
- include membership of a small group of key people with relevant expertise, interest in addiction and an understanding of the political climate; key areas for representation are AADAC, mental health, justice, community health and the health-care sector
- be guided by core system operating principles
- focus on provision of co-ordinated and integrated prevention and treatment services in Alberta (not just AADAC)
- develop terms of reference that are mission driven with clear deliverables, timelines and performance measures to monitor progress; policy recommendations and development of standards for service delivery are key elements of this group

- establish specific task groups at the operational level that would address the implications of how policy and standards would affect current service delivery; members would be selected based on the policy being implemented (e.g., community-based agencies, health services)
- ensure implementation through the establishment of tactical groups responsible for implementation at the program and front-line level

A collaborative and integrated approach, adhering to the nine core system operating principles noted in this report, would permeate all three levels of implementation. All levels need to start removing the barriers.

Recommendations for strengthening relationships to improve the delivery of AADAC services

Clarify AADAC's role

- The expert advisory panel recommends that AADAC review its role to determine what it is best at and focus on its strengths. For example, one of AADAC's strength is its funding of initiatives in the community. AADAC is both a provider of direct service and a funder of services across the province. This can produce role confusion and service disparities. It is important that there be clarity regarding these two roles, and that strengths in each be recognized.
- In addition, AADAC might be best suited to play a hub role in co-ordinating, facilitating and supporting a wider set of services that include addiction in their work.

AADAC take on a central role in accountability in the addiction services system

- The expert advisory panel recommends that AADAC take a lead role in setting the standards for addiction practice for the system, and more broadly, in getting tools to partners in the addiction system. As a funder and provider of services across the province, AADAC needs to be consistent in specifying standards of services that it will fund. Issues of philosophy, inconsistent standards, and observed differences in service delivery were noted in the review. AADAC has an opportunity to address inconsistencies in standards and practice.
- A tiered model providing a continuum of services and supports, and a knowledge exchange strategy drawing on evidence-informed practices and policies, would allow Alberta to develop a comprehensive approach to addiction and play a lead role in an emerging national dynamic that is moving in this direction.
- More essentially, such an approach will provide a more responsive and effective system of care for Alberta's diverse population, and for the considerable harm that people, families and communities are experiencing from substance use and gambling problems.

Other considerations

In pursuing implementation of the recommendations, it is important that AADAC take advantage of several national initiatives in which it currently has representation. Useful linkages can be made or can continue with such groups as the National Treatment Strategy Working Group, the Mental Health Commission of Canada and the Canadian Executive Council on Addictions, as well as in initiatives such as the National Strategy on Workforce Development and the National Framework for Action. Each of these initiatives provides excellent guidance in developing improved addiction service delivery systems.

AADAC response to key recommendations

AADAC accepts the recommendations put forward by the expert advisory panel and sees the review as an important step in setting future direction for addiction services in the province. These recommendations are congruent with the direction emerging from AADAC's strategic planning process.

Further, the recommendations are consistent with current direction of the Ministry of Health and Wellness in taking a broader system view of health services, and with the Alberta Government priority to increase access to quality health care and improve the efficiency and effectiveness of health delivery.

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Appendix A: Review team

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Appendix B: Stakeholder consultations

The first stage of consultations involved site visits to representative communities of the province to facilitate focus group sessions with interested stakeholders. AADAC representatives identified key stakeholders and facilitated the co-ordination of site visits in the six communities chosen for this purpose. In an effort to ensure broad representation, the review team's project manager liaised with AADAC to ensure a diversity of representation from different geographic regions (southern, central, northern), settings (remote, rural, urban), focus populations (determined by gender, ethnicity), service provision agencies (e.g., AADAC, NNADAP), disciplines (e.g., addiction counsellors, nurses, physicians), and sectors (e.g., primary care, mental health).

Three teams of two facilitators travelled to the communities in each of the three regions. One team member recorded session discussions while the other team member facilitated the groups. To alleviate fatigue, roles were alternated for each focus group session.

The focus group sessions were two hours long. Each focus group began with an AADAC representative describing the review, introducing the facilitators and encouraging stakeholder input. The AADAC representative then withdrew from the session to encourage candid and open feedback and discussions between stakeholders and facilitators. Each session was guided by a set of predetermined but flexible questions designed to generate discussion among the participants about the system of services in Alberta. The following are some examples of questions:

Service providers and staff

- In terms of the range of existing prevention and treatment services in Alberta for alcohol, other drug and gambling problems, what is currently working well?
- What practices should be reduced?
- How does the system respond to client needs in other life domains?
- How well connected are AADAC services with other health and social services in the community?
- What is the current focus in prevention messaging? What should it be?
- Do clients ever fall between the cracks? Why?

Clients of addiction services

- How easy was it to access the services you needed?
- Are there sufficient services in your area? Are the right kinds of services available?
- What would you like to see more of?

- Were other health and social issues identified and addressed in the context of receiving addiction-related services?
- What is the current focus in prevention messaging? What should it be?

Participants were invited to sign an attendance sheet in an effort to capture some basic information about the participants and to ensure a diversity of representation across the consultation process. Contact information was solicited on this same sheet to allow facilitators to send a follow-up e-mail thanking stakeholders for their participation and providing them with the opportunity to communicate any further input and relay any questions or concerns they might have had about the review process.

Table 1: Summary of focus group and interview participants

Main groups		Locality		Region			Focus population			
	N	Urban	Non-urban	Central	North	South	Women	Youth	First Nations	General
AADAC staff and service providers										
Management and staff	24	22	2	9	3	12	0	5	0	19
Physicians	1	1	0	1	0	0	0	0	0	1
Front-line staff	23	20	3	3	6	14	0	7	0	16
Subtotal	**48**	**43**	**5**	**13**	**9**	**26**	**0**	**12**	**0**	**36**
Non-AADAC service providers										
Community-based	45	30	15	11	11	23	2	11	6	26
Criminal justice	10	8	2	4	4	2	0	1	0	9
Physicians	14	14	0	8	0	6	1	4	0	9
Education	2	1	1	0	1	1	0	1	0	1
Municipal/ provincial gov't	6	3	3	3	1	2	0	0	0	6
Subtotal	**77**	**56**	**21**	**26**	**17**	**34**	**3**	**17**	**6**	**51**
Clients/family/ public										
Clients	4	4	0	4	0	0	0	0	0	4
Family members	6	4	2	1	4	1	0	0	0	6
Other	5	4	1	4	0	1	0	0	0	5
Subtotal	**15**	**12**	**3**	**9**	**4**	**2**	**0**	**0**	**0**	**15**
Total	**140**	**111**	**29**	**48**	**30**	**62**	**3**	**29**	**6**	**102**

Note: An additional 33 participants responded to the questions online, for a grand total of 173 participants in the stakeholder consultation process.

For more information, contact your local AADAC office, call 1-866-332-2322 or visit our website at aadac.com

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