Summary of Findings

6th Annual Addiction Day:

Advancing Recovery within Addiction & Mental Health

In recognition of

Leroy H. le Riche Endowment for Research and Education in Substance Abuse

Submitted to: Office of Research

Attn: Carolyn Leger

Prepared May 15th, 2013

On behalf of:

Annual Addiction Day Planning Committee

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Defining Recovery

"Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles; a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness and the development of new meaning and purpose in one's life as one grows beyond the catastrophe of mental illness" (Anthony, 1993)

"Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship" (Betty Ford Centre Working Definition, 2007)

"Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (Substance Abuse and Mental Health Services Administration (SAMHSA) Working Definition, 2011)

"Recovery is about one's ability to live a satisfying, hopeful and contributing life, even with limitations that arise from addiction, mental health problems or mental illness" (Mental Health Commission of Canada, 2012)

"Recovery is living. I think it's as simple as that. I think we've complicated it. I just think Recovery is getting on with life…I don't think anybody knows [the definition] for a collective. I think every individual knows the answer for themselves." (Scotland – Smith-Merry et al. 2011)

"Recovery is a journey, not a destination. Like marriage, it takes daily work, attention to issues & acceptance of things that cannot change". (Anonymous Survey participant, 2013)

"Recovery doesn't need to be defined by professionals. The individual in Recovery defines it". (Anonymous Survey participant, 2013)

"Recovery is the reclamation of self. We are all recovering from something" (Anonymous Survey participant, 2013)

Summary of Findings

6th Annual Addiction Day: Advancing Recovery within Addiction & Mental Health

Recovery, a concept historically limited to stigmatized images of the addicted or mentally ill individual, has evolved to an expression frequently heard within the mental health field, and is often associated with growing grassroots movements and virtual communities (Laudet, 2007). However, as the term recovery increases in popularity, there remains no consensus on what recovery means, how treatment services can foster recovery, nor how researchers, policymakers, stakeholders, and helping professionals may evaluate progression toward this goal (Laudet, 2007; el-Guebaly, 2012).

Although this lack of clarity stems in part from the recovery movement arising from grassroots action rather than from the health profession (clinicians and/or researchers), the remaining ambiguity has the potential to hinder both clinical practice and research in our field (Laudet, 2007), and contributes little to diminishing the highly stigmatized conditions (addiction & mental health) associated with the recovery paradigm (el-Guebaly, 2012). This poorly defined conceptualization of recovery risks creating a perception of the addiction and mental health system as being stuck in providing only cyclical episodes of clinical stabilization from symptom manifestation with an inadequate provision of long-term services and supports for the maintenance of recovery (Laudet, 2007, Davidson and White, 2007; McLellan, 2005).

Despite the limitations of the literature, individuals living with addiction and/or mental health problems experience recovery as an individual process of growth (resolving/healing wounds and actively managing continued vulnerability) and responsibility (voluntarily accessing internal and external resources), emphasizing one's strengths, resources, and capacity to have hope, and to

lead a healthy, meaningful, productive and quality filled life (el-Guebaly, 2012; Mead and Copeland, 2000; Coyhis, 1999; White, 2007, Laudet, Becker & White, 2009). Such conceptualizations of recovery also highlight the role of family, peer support, community, spirituality, inner strength, and the desire to get better as critical sources of strength and the sustenance in one's own personal journey of recovery (Blomquist, 2002; Flynn et al., 2003; Laudet et al., 2002, el-Guebaly, 2012).

Although the recognition afforded those who have chosen recovery from addiction and/or mental health is generally met with uneasy optimism (el-Guebaly, 2012, Twombly, 2004), and has marginal social status (our "survivors" are not applauded publicly, nor provided a coloured ribbon in symbolic recognition of widespread public support), findings suggest (Laudet, 2007) that for those who have embraced recovery, the benefits are many (improved health, life conditions, social life, etc.) and are highly valued (Donovan, Mattson, Cisler, Longanaugh, & Zweben, 2005; ; Laudet, Morgen, & White, 2006; Morgan, Morgenstern, Blanchard, Labouvie, & Bux, 2003; Laudet, Becker,& White, in press).

Relevance to Alberta

The 2011 Canadian Alcohol and Drug Use Monitoring Survey (CADUS) indicates that 80% of Albertans consumed alcohol in the past year with 15.8% exceeding the low risk drinking guidelines for chronic effect, and that 44% of Albertans used an illicit drug in their lifetime, and 9.4% in the past year (Health Canada, 2011). Approximately 16% of Albertans visited a physician for mental health problems in a single year (Alberta Health Services, 2006), and an average rate over a 3year period estimates that a little over 25 per cent of Albertans accessed a physician for mental health concerns (Alberta Health Services, 2006).

Despite the evidence of addiction and mental health concerns among Albertans, an empirical estimate of the number of Albertans who are in recovery remains elusive. The authors of this Summary would argue that this obscurity is not due to a lack of investment, dedication and commitment on behalf of Albertans to conveying the message that recovery is a reality, and to providing hope to affected individuals and to their families, nor is it a result of a lack of commitment from Albertans to de-stigmatizing the image of the" recovered" among the general public, or providing realistic expectations (eg: Creating Connections: AMH Strategy & Action Plan) for stakeholders.

As exemplified during the *6th Annual Addiction Day: Advancing Recovery within Addiction & Mental Health,* Albertans are committed to attaining more than episodic management of addiction and mental health symptoms, more than intermittent improvement in the personal, social and spiritual health of the patient/client, and striving to ensure a health system in which the "recovered" are able to live, work, learn, and participate fully in their communities. (New Freedom Commission on Mental Health, 2003). The challenge faced by Albertans is translating this commitment into a systemic reality.

Recognition & Appreciation

The Annual Addiction Day planning committee (Appendix A), a collaboration of educators, researchers, physicians and policy makers across Alberta , is committed to increasing public awareness of, and enhancing knowledge, competencies and treatment capacity for the integrated care of addiction and mental health problems.

With recognition for the **Leroy H. le Riche Endowment for Research and Education in Substance Abuse,** and with appreciation to all participants and sponsors of the 6th Annual Addiction Day, the

planning committee is pleased to share a *Summary of Findings* of the *Advancing Recovery* four phase exploratory analysis. Through this phased exploratory process of the recovery paradigm the planning committee was able to capture a variety of insights and perspectives with the intent of advancing the working definition, guiding principles, and identifying commitment/support for the implementation of recovery across Alberta's Addiction and Mental Health care continuum

Provided for your review and reflection is a working summary created with the intention of opening dialogue and supporting first steps towards advancing Recovery across Alberta's Addiction & Mental Health care continuum.

Four Phase Exploratory Analysis

Goals and Objectives

With support from the Leroy H. Le Riche Endowment, the planning committee was able to expand the 6th Annual Addiction Day into a four phase exploratory analysis alleviating limitations for interaction imposed by time and geography (Appendix B). This expansion provided an extended opportunity for the exchange of ideas/considerations/reflections by all individuals with an interest in *Advancing Recovery within Addiction & Mental Health.*

Implementation

Interactive Website Discussion & Knowledge Exchange Forum (Phase One):

The exploratory analysis of *Advancing Recovery within Addiction & Mental Health* was launched on an interactive website (www.addictionday.ca) March 1, 2013 and further disseminated through an email database. Four separate discussion themes (*Exploring the Recovery Paradigm, Measuring Recovery?,, Special Considerations within Recovery, and*

Recovery: The Future & Beyond) were featured weekly. Informed consent was obtained, and participants were advised that all opinions would be collated to inform the conference's plenary panel presentation (Phase 2). To ensure multiple options for knowledge exchange and expression of opinion, the Addiction Day website offered three distinct methods of interaction/participation.

*Brief Literature Scan***:**

Each week an introductory selection of publications specific to the discussion theme was provided. An invitation was publically extended, welcoming additional publications/websites/ resources that the participants felt would enhance the discussion.

Anonymous Opinion Survey

Participants were invited to share personal reflections and thoughts regarding the four discussion themes via a weekly anonymous opinion survey.

Website Discussion/Blog

A weekly discussion forum was created inviting discussion and the exchange of opinions between all participants.

<u>6th Annual Addiction Day Interactive Panel Presentation (Phase Two):</u>

Quantitative data and Qualitative themes (Appendix C) from the Website Discussion & Knowledge Exchange Forum (Phase One) were presented to the 6th Annual Addiction Day conference audience and explored in an interactive panel presentation and discussion between the featured conference presenters/international experts, and Alberta's local researchers, knowledge translators, policy makers and individuals with personal experience of the recovery

journey (Appendix D). Primary themes of discussion were captured for further exploration during Phase Three.

Advancing Recovery within Addiction & Mental Health Think Tank (Phase Three):

Following the conference, 24 individuals consisting of planning committee members, conference presenters, Alberta researchers, knowledge translators, policy makers and individuals with personal experience of the recovery journey joined together as a "think tank" with a primary focus on generating suggestions/strategies in response to the themes/areas of concern identified during Phase One and Two of the exploratory analysis.

Summary of Findings/Respondent Validation (Phase Four):

Understandings from the exploratory process (phases 1-3) were summarized and reflected back to all participants for review and validation. This final summarization has been synthesized for your review and interest, and will be hosted on the conference website (www.addictionday.ca)

Findings & Recommendations

Interactive Website Discussion & Knowledge Exchange Forum (Phase One):

Findings:

The interactive website discussion & knowledge exchange forum garnered 150 anonymous survey responses and 31 comments. The majority of respondents were female treatment providers with an age range of late 20s to early 40s (Appendix C). Although a significant amount of respondents indicated they had personal recovery experience with addiction and/or mental health conditions, there was strong consensus that having personal experience was not required to incur an understanding of what recovery is (Appendix C).

Although half of the respondents (52.8%) considered it impossible to attain a universally agreed upon conceptualization of recovery, 94.4% considered the overarching message of recovery was one of hope and that restoration of a meaningful life is possible. In relation to meeting the recovery needs of Albertans, the majority of participants (86.4%) indicated that more treatment options were required, accessibility to recovery services required improvement (86.4%), and that services should address addiction and mental health in an integrated fashion (96.6%). (Appendix C)

Qualitative responses (n=86) to survey question 18 identified special challenges/barriers that respondents felt Albertans faced as they attempted to advance recovery within addiction and mental health services. The responses were collated and three distinct themes of "disconnection" /fragmentation were identified (Appendix E). This was considered interesting in light of Alberta Health and Alberta Health Services jointly sponsored *Alberta's Addiction & Mental Health Strategy & Action Plan 2011-2016* titled *Creating Connections* (Appendix F). In recognition of the synonymous theme identified by both the survey participants (*disconnection*) and Alberta's Addiction & Mental Health Strategy & Action Plan (*Creating Connections*), a gap analysis was generated to identify/illustrate if Alberta had established initiatives that would target/ resolve the identified areas of participant concern. The gap analysis (Appendix G) highlights the comprehensiveness of Alberta's Addiction & Mental Health Strategy and Action Plan.

<u>Recommendation One:</u>

Albertans are interested in, and committed to advancing the field of Addiction & Mental Health. *Creating Connections: Alberta's Addiction and Mental Health Strategy & Action Plan*

addresses the majority of areas of concern identified by respondents (Appendix G). *Creating Connections* needs to be communicated on a broad level to all Albertans committed to advancing the Addiction & Mental Health System to ensure knowledge translation and mobilization of the Strategy & Action Plan

6th Annual Addiction Day Interactive Panel Presentation (Phase Two):

Findings

A 60 minute interactive discussion with an open invitation for dialogue between all conference attendees and a panel of international plenary/local workshop presenters concluded the 6th Annual Addiction Day. During the time allotted, five questions garnering multi-panel responses were asked and six comments/ reflections were presented from the attending audience.

Due to the international lens, it was readily recognized that residents of Canada were privileged with the opportunity of a government funded/sponsored health system that recognized Addiction and Mental Health as a co-occurring, prevalent condition within our society that deserved adequate/appropriate intervention and treatment. The cost/responsibility of this privilege was for Albertans to optimize the services provided, ensuring the creation of a cost effective system with an ability to provide long term, continuous care to those requiring it.

Recommendations:

Four themes of recommendations during the interactive discussion were identified in response to this query/dilemma of accountability:

Recommendation One: Demystifying/De-Stigmatizing Addiction & Mental Health:

International Anti-Stigma campaigns (Canada, US, UK) were shared allowing panel members to highlight key messages within their originating Countries' campaigns that support successful de-stigmatization of, and advancement of recovery within Addiction & Mental Health.

1) Normalization:

Secrecy ("you are only as sick as your secrets") is "one of the greatest enemies of Addiction & Mental Health". A most effective way to address the stigma of an illness "is to know someone who has that illness....If your girlfriend has addiction/or depression, you have a different perception of what that illness is simply by your girlfriend having it. Shame prevents us from sharing on a level of authenticity and vulnerability. Once we normalize Addiction & Mental Health so that one does not have to be ashamed of it, we can all start talking about it and owning it" (Personal Communication, L. Ashcraft, April 19, 2013)

2) Perception of the Illness Trajectory:

Physical illnesses (ie: broken leg) are "visually identifiable and are perceived as having a specific time frame/trajectory (pre-op/post-op). In contrast, Addiction & Mental Health is perceived as having NO specific time frame/trajectory and one cannot visibly distinguish between if you are sick or, if you are "better". Until there is an understanding/perception that mental illness and addiction can be time defined and one "can truly recover, it is likely that stigma will remain" (Personal Communication, M. Griffiths, April 19, 2013).

3) As Cures evolve; Stigma abates

Initially, Cancer was "not talked about but now it is celebrated by those in remission. When HIV/AIDS first surfaced, it was similarly not talked about. It seems that once "a cure" is

developed for a condition, it is no longer considered taboo or the end of the world if it is contracted. It is likely stigma will remain until society understands that Addiction & Mental Health can be successfully treated/cured. Then the perception may shift from something not wanted to it's not the end of the world if I have it." (Personal Communication, A. Laudet, April 19th, 2013)

Recommendation Two: Cost-Efficiency is Broader than the Addiction & Mental Health Sector

During the interactive audience discussion, it was well identified that the cost of addiction and mental health is not restricted to the health system; it has significant interaction with, and costly implications for enforcement, the criminal/legal system, and all aspects of personal productivity (Personal Communication A. Laudet, C. Wild, G. McQueen, & N. el-Guebaly, April 19, 2013).

There was strong recognition for the need to broaden our focus for cost efficiency beyond the health sector (ie: of every 100 dollars spent on Addiction & Mental Health, 85% goes to enforcement) with participants advocating for initiatives specific to addiction and its interplay with the justice/legal system (an example being the Calgary Drug Court Program) and a balance of investment across the social sectors (Personal Communication C. Wild & J. Poole, April 19, 2013).

This recognition/recommendation was applauded and echoed back from professionals working within forensic/correctional services, noting the double sided stigmatization/ ostracization of their clients due to having both an Addiction/Mental Health condition in addition to a criminal record/history, often rendering services willing to "work with them" as slim to nil.

Recommendation Three: Deliberate Strategy to employ/embed those with Personal Experience into the Service System:

A deliberate strategy to employ/embed individuals with personal recovery from addiction and mental health into the service system was acknowledged as a critically important resource that had not yet been fully explored in relation to the significant cost efficiency it could offer Alberta (Personal Communication A. Laudet & N. el-Guebaly, April 19, 2013). In addition to cost efficiency, it was highlighted that having an individual/health professional "with lived experience who knows what they are talking about can often provide the tools for recovery in a way that is more meaningful than those who have only read the book" (Personal Communication, W. White, April 19, 2013).

A comparison was made with other provinces in Canada, where pilot programs have trained individuals with Axis I disorders to become peer supports and work within the system. Alberta was recognized as having a "resistant and stigmatized climate" (Personal Communication, Mandy X, April 19, 2013) in relation to such innovative practices, noting that health professionals in Alberta's treatment programs with personal recovery experience remain an extreme minority (Personal Communication, W. White, April 19, 2013).

Recommendation Four: 12 Step and the Recovery paradigm. Why are we not fully utilizing this valuable resource?

Twelve Step Programs (AA, NA, CA, GA, SA) were recognized as holding a significant place within the recovery paradigm, and were noted to be an important resource that are offered without cost to all individuals, are available worldwide (virtual and non-virtual) and have no waitlist (Personal Communication, R. Maser, April 19, 2013). Given their accessibility and cost efficiency, it was queried why do most professionals working within Alberta's Addiction &Mental Health services have little to no knowledge of, and/or hesitate/fail to

embed/recommend these resources into the treatment plan of the individuals they serve? It was suggested that health professionals need to fully acknowledge these important resources as a component of their clinical practice (Personal communication, R. Maser, April 19, 2013).

Support for this recommendation also highlighted that "participation in a 12 step program facilitates a component of healing through the re-establishment of a sense of community that is often separated by the addiction" (Personal Communication, W. White, April 19, 2013). However it was noted that aversion to/ interpretation of a "higher power" as a "religious" component is often cited as one of the barriers by non-religious/non-spiritual individuals (Personal Communication, M. Griffiths, April 19, 2013). It was further acknowledged that "health professionals are trained not to talk about spirituality, and are guided to focus exclusively on the biopsychosocial component of recovery" (Personal Communication, L. Ashcraft, April 19, 2013). It was concluded that " ironically when you ask an individual how they recovered, 9 out of 10 of them will reference a component of spirituality,.... When an individual is most vulnerable to their addiction, it is usually when they are spiritually disconnected. When an individual can connect to something beyond themselves, it is when they have more strength and more courage than whenever trying to operate on their own" (Personal Communication, L. Ashcraft, April 19, 2013).

Advancing Recovery within Addiction & Mental Health Think Tank (Phase Three):

Findings:

Following the conference, the conversation was continued with a primary focus on generating suggestions/strategies in response to the themes/areas of concern identified during Phase One and Two of the exploratory analysis.

The Think Tank session was initiated with a realistic and somewhat "unforgiving" reflection of common "erosions" noted internationally and across current mental health systems ("patients are still falling through the cracks," "an inability/resistance to acknowledge/treat the concurrent nature of addiction and mental health," "a preference to focus on the illness rather than the individual," a "miscomprehension for prescribing practices and treatment of opioid addiction," "the absence of an operational definition of recovery," a "hypervigilance for abstinence at the cost of exploring the efficacy of a model of moderation" and a "lack of support network for professionals serving individuals with, and the truly marginalized populations within addiction and mental health,") (Personal Communication, L. Ashcraft, S. Ulan, D. Scott, A. Laudet, C. Wild, D. Edwards, A. Crabtree, K. Aitchison, E. Tailfeathers, J. Poole, J. Stea, J. Kelland & M. Griffiths, April 19, 2013).

During the opening conversation, it was noted that due to recent and repeated re-organization, Alberta's health system may currently mirror this relative state of "suspension" noted internationally. However, it was additionally noted that there is unquestionable commitment within and across Alberta's health system for the advancement of a recovery strategy, and for the implementation of an expanded recovery paradigm across the addiction and mental health care continuum. An invitation to explore "how" this may be accomplished and the potential "pitfalls" that could/should be avoided was extended to the think tank attendees for reflection and consideration.

Recommendations:

Three primary themes for consideration were generated.

Recommendation One: Why Should/How Could Alberta implement Peer Support

What if Alberta's health system hired those who society considered to be "hopeless and helpless" and they became the "treaters"? Could this offer "another or better way" of implementing recovery services within the addiction and mental health system? (Personal Communication, L. Ashcraft, April 19, 2013). As Alberta seeks to establish accessibility, accountability and cost efficiency within its health system, "would it be unreasonable for a peer support workforce to be considered? It is a well known fact that meaningful employment is a critical component of sustained recovery and that as one experiences their personal journey of recovery, it is not always the "service of a professional" that is of greatest benefit to the individual (Personal Communication, A. Laudet, April 19, 2013).

These and many more queries were explored as attendees from the think tank shared personal experiences and lessons learned (Personal Communication, L. Ashcraft, F. Haynes, J. Poole, J. Kelland, A. Harding, K. Aitchison, April 19, 2013) from establishing, implementing and sustaining peer support initiatives within addiction and mental health.

If Alberta were to explore this opportunity, think tank attendees (Personal Communication, N. el-Guebaly, L. Ashcraft, J. Kelland, F. Haynes, April 19, 2013) highlighted the importance for specific education/training with an identified career trajectory be made available to individuals with established recovery from addiction and/or mental health. Components for the selection of, and training of this workforce could/should include:

1. Screening of potential employees through an acknowledgement for, and commitment to training (ie: if the training is 80 hours, participants can only miss 12 hours) with an expectation of/commitment to the discontinuation of financial assistance (eg:: EI, AISH) upon initiation into the work force.

2. Provision of education/training that is relevant and competency-based (substances of abuse, this is "addiction"/"mental illness"), individualized (self esteem, self skill identification, telling one's story), and encompasses skill development within and across the employment system (boundary management, conflict resolution, team work, performance management).
3. A significant component of work experience (100 hours) prior to initiation within the workforce.
4. Recognition/identification as a unique discipline (eg: "ITE: I am The Evidence") that upholds the vision of what the "recovered" could be and can achieve, even if the "recovered" cannot yet see that for himself/herself.

Recommendation Two: How Can/Why Should Alberta Leverage Technology

"Technology is not a solution to all problems, but our research shows significant impact on quality of care, accessibility, cost efficiency and the ability to extend the reach of one's system of care that can be personalized and meaningful and demonstrate real time/real world effectiveness within behavioural health" (Personal Communication, L. Marsch, April 19, 2013).

Despite this substantial potential, Dr. Marsch cautioned attendees of the think tank that in Alberta's pursuit for leveraging technology within the addiction and mental health system, it is imperative to be mindful of the following:

1. Technological evolvement is not always driven by clinical consideration, and that it is easy to become "wowed" simply by the "existence" of innovative technology, and overlook the intricacies of "how" the technology needs to be leveraged/managed to ensure that its implementation does indeed *advance* rather than simply "*technologize*" the field of addiction

and mental health. Many technologies are being developed. Some work and bring value, many do not (Personal Communication, L. Marsch, April 19, 2013).

2. With leveraging of technology comes new responsibilities and risks, with many unanswered questions remaining regarding the privacy/confidentiality and security of electronically supported data collection, communication, and clinical interventions. Although enhanced accessibility and cost efficiency is demonstrated, it is still very early and there are limited to no standards of practice for technology in the behavioural health system (Personal Communication, L. Marsch, C. Wild, M. Griffiths, April 19, 2013).

Recommendation Three: What can Alberta Learn from the Trajectory of Behavioural Addiction

Alberta was identified as having an operational definition of addiction that was expanding / evolving to recognize various behavioural addictions, such as sexual and internet gaming addiction. Attendees of the think tank inquired what learnings could be obtained from the treatment trajectory of gambling addiction, and if/how could these be applicable to other behavioural addictions. Primary learnings/current areas of consideration included:

1. There is an incongruence between the perception of /cited prevalence of individuals experiencing gambling addiction and the number of individuals who seek/present to treatment facilities, suggesting that:
   a) the true prevalence is not as great as suggested,
   b) many individuals with gambling addiction spontaneously/naturally recover, or
   c) the trajectory of gambling addiction is intermittent rather than continuous, having "episodes" that meet diagnostic criteria/could be classified as pathological events (e.g.:

four periods of pathological gambling with a duration of three to six months each over a 20 year period). (Personal Communication, M. Griffiths, April 19, 2013)

2. Although many commonalities exist when comparing behavioural with substance addiction, a significant differentiation between the two is the common presentation of a participant with significant financial implications and distresses when the addiction is gambling. Given the often long term and severe financial consequences, it is a "very big ask" for the gambler who is typically quite impulsive in character, to "start over", and the recovery course is subsequently very challenging. (Personal Communication, D. Hodgins, April 19, 2013).

Significance of Project

With recognition for the **Leroy H. le Riche Endowment for Research and Education in Substance Abuse,** the 6th Annual Addiction Day (Appendix H) was able to offer an interactive four phase exploratory analysis of the recovery paradigm, and capture a variety of insights and perspectives from individuals committed to advancing recovery (working definition, guiding principles, implementation strategies).

This Summary of Findings features the key messages and learnings that were shared during this process, and highlights recommendations that were considered by the participants to hold promise as potential future directions/strategies as the implementation of a recovery oriented system across Alberta's addiction and mental health care continuum is explored.

It is the hope of the 6th Annual Planning Committee that this synthesis/demonstration of widespread interest and dedication to advancing recovery will support a continued dialogue between researchers, knowledge translators, policy makers and individuals with personal interest to ensure this commitment becomes a reality within Alberta.

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Appendix Overview

Appendix A: 6th Annual Addiction Day Planning Committee

Planning Committee Members	Planning Committee Member
Dr. Ann Crabtree; Chair, Addiction Day Planning Committee Member of Governance Council College of Physician & Surgeons of Alberta **David Crockford** Associate Professor, University of Calgary, Dept of Psychiatry and Chair, Section of Addiction Psychiatry Canadian Psychiatric Association **Dawn Edwards** Education Consultant I, Addiction Program Addiction & Mental Health, Calgary Zone **Nady el-Guebaly;**, Professor & Head, Division of Addiction Department of Psychiatry, University of Calgary, Consulting Psychiatrist, Alberta Health Services **Calder Fertig** Education Consultant I, Addiction Program Addiction & Mental Health, Calgary Zone **Ann Harding** Manager Professional Development Addiction & Mental Health, AHS	**David Hodgins;**. Professor and Head Department of Psychology, University of Calgary **Stacey Peterson** Executive Director Fresh Start Recovery, Calgary, AB **Dan Scott** Education Manager Information and Evaluation Services Addiction and Mental Health, Edmonton Zone **Robbin Sutherland** Education Consultant I, Addiction Program Addiction & Mental Health, Calgary Zone **Susan Ulan** Senior Medical Advisor College of Physicians & Surgeons of Alberta Assistant Professor, University of Alberta **Tuxephoni Winsor** Education Consultant II, Addiction Program Addiction & Mental Health, Calgary Zone

Appendix B:

The Recovery Paradigm: Four-Phase Exploratory Analysis

Process	Event	Date	Location	Participation
Phase One	**Interactive Website Discussion & Knowledge Exchange Forum**	March 1st, 2013 – March 31st, 2013	www.addictionday.ca	Anonymous survey participants n=150 Website forum n=31
Phase Two	**6th Annual Addiction Day Interactive Panel Presentation**	April 19th, 2013 1345-1515	MacEwan Conference & Event Centre; University of Calgary	280 Conference attendees
Phase Three	**Advancing Recovery within Addiction & Mental Health Think Tank**	April 19th, 2013 1700-2100	NOtaBLE Private Event Room	24 participants
Phase Four	**Respondent Validation/Summary of Findings**	June 15th, 2013	www.addictionday.ca	Phase 2 & 3 participants

Appendix C:
The Recovery Paradigm
Week 1: n=30; Weeks 2-4: n=8

Demographics:

- Sex – F 82.8%
- Age – 26-35 = 34.5% (10); 46-55 = 27.6% (8); 55-65= 24.1% (7)

Perspectives:

- Treatment/healthcare provider 83.3% (25)
  Patient/client 16.7% (5)
- Personal experience:
  - Recovery & addiction 34.5% (10)
  - Recovery & mental health 43.3% (13)
  - Both addiction & mental health 13.3% (4)
  - Prefer not to say 6.6% (2)
- Must have personal experience with recovery to understand:
  - Agree 3.3% (1); Disagree 66.7% (20); Unsure 30% (9)

Personal Experience & Recovery (34 Comments)

- **“We are all recovering from something”.**
- **“Recovery is a journey, not a destination.**

  Like marriage, it takes daily work, attention to issues & acceptance of things that cannot change”.
- **“Recovery doesn’t need to be defined by professionals.**

  The individual in Recovery defines it”.
- **“One theme in post-cancer recovery & survivorship is**

  The reclamation of self **”.**
- **“Number of definitions = number of measures”.**
- **Natural Recovery?**

"Addiction Day" Recovery Survey (n=103/207)

Demographics:

- Sex – F 86.4%
- Age – 36-45 = 25.2% (26); 46-55 = 33% (34); 56-65= 21.4% (22)

Perspectives:

- Treatment/healthcare provider 87.4% (90)
  Patient/client 1.9% (2)
- Personal experience:
  - Recovery & addiction 36.3% (37)
  - Recovery & mental health 45.6% (47)
  - Both addiction & mental health 27% (27)
  - Prefer not to say 7% (7)
- Must have personal experience with recovery to understand:
  - Agree 9.7% (10); Disagree 74.8% (77); Unsure 15.5% (16)

Thoughts about Recovery (n=89)

Statements	Disagree	Neutral/ Not Sure	Agree
“Impossible to attain a universally agreed conceptualization”	33.7% (30)	13.5% (12)	52.8% (47)
The definition must incorporate distinct uses of the term (i.e. client, family, community, researcher, program)	17% (16)	25.0% (22)	58% (51)
Recovery remains ill-defined, hindering the development of assessment tools	31.8% (28)	18.2% (16)	50% (44)
The overarching message is that hope and restoration of a meaningful life is possible	3.4% (3)	2.2% (2)	**94.4% (84)**

Thoughts about Recovery (n=89)

Statements	Disagree	Neutral/ Not Sure	Agree
Recovery is an ongoing process without endpoint	6.7% (6)	7.9% (7)	**85.3% (76)**
No consensual theoretical framework , but major elements, including a healing and growth process that spans years	3.4% (3)	8.0% (7)	**88.6% (78)**
No single agreed-upon definition = no single way to measure it	24.7% (24)	18.8% (16)	56.5% (48)

Meeting Recovery Needs in Alberta
(n=88, 15-18 skipped)

Statements	Agree	Disagree	Unsure	Comments
Providers & community work collaboratively on Recovery	55.2% (48)	23% (20)	21.8% (19)	(21)
More treatment options are required	**86.4% (70)**	5.7% (5)	8% (7)	(18)
Accessibility to Recovery Services	Within expectations 13.6% (12)	Needs improvement **86.4% (76)**	---	Exceeds 1!! (10) Wait lists
Should address Addiction & Mental Health in collaborative/ integrated fashion	**96.6% (86)**	3.3% (3)	---	

Meeting Recovery Needs in Alberta
(n=88, 15-18 skipped)

Statements	Agree	Disagree	Unsure	Comments
Methadone, Bup is an integral component of Recovery "assisted"	50.6% (44)	14.9% (13)	34.5% (30)	(19) Cop out → beneficial but not integral → success
The role of AA sponsor & recovery coach are distinct	30.3% (27)	13.5% (12)	56.2% (50)	(5) "Sponsor does service to stay sober"; "Coaches for person that doesn't want to go to AA"; "Peer support worker should have training & career trajectory"
Technology (internet, mobile) offer tremendous promise	53.4% (47)	10.2% (9)	36.4% (32)	
Use of tracking devices (location, alert)	47.8% (42)	13.6% (12)	38.6% (34)	

Appendix D: Advancing Addiction & Mental Health Think Tank Attendees

Research & Knowledge Translation	Policy Makers	Conference Presenters	Personal Interest
Beverly Adams Department Head Psychiatry University of Calgary. Medical Leader, Community Rural & Mental Health Addiction & Mental Health Calgary Zone	**Joan Campbell** Executive Director Community Rural & Mental Health Addiction & Mental Health Calgary Zone	**Lori Ashcraft** Executive Director, Recovery Innovations/Recovery Opportunity Centre Phoenix, Arizona	**Fiona Haynes** Schizophrenia Society of Alberta Calgary Branch & Area Calgary, AB
Katherine Aitchison Alberta Centennial Addiction & Mental Health Research Chair, Dept of Psychiatry, Faculty of Medicine & Dentistry University of Alberta	**Superintendent Hinse** Chief of Police Calgary Police Service Calgary, AB	**Mark Griffiths** Director International Gaming Research Unit Nottingham Trent University, United Kingdom	**Jeffery Poole** Alcoholics Anonymous Central Service Office Calgary, AB
Cam Wild Professor and Associate Dean (Research), School of Public Health University of Alberta	**Cathy Pryce** Vice President Strategic Clinical Network Addiction & Mental Health, Alberta Health Services	**Jennifer Hibbard** Clinical Lecturer, Dept of Psychiatry, University of Calgary, Child & Adolescent Psychiatrist, Alberta Health Services	**Esther Tailfeathers** Family Physician Community Addictions Stand Off, AB
	Michael Trew Senior Medical Director Strategic Clinical Network. Medical Director, Primary & Community Care Addiction & Mental Health Alberta Health Services	**Alexandre Laudet** Director, National Development and Research Institute, Center for the Study of Addictions and Recovery New York City, NY	**Rachel Massur** Psychiatric Resident University of Calgary
		Jill Kelland Director, Edmonton Zone, AMH, Alberta Health Services	
		Glenda MacQueen Vice Dean, Faculty of Medicine, University of Calgary. Director, Mental Health Research & Education	
		Lisa Marsch Director, Centre for Technology & Behavioural Health Dartmouth Psychiatric Research Centre, Lebanon, NH	
		Jonathan Stea BSc(Hons), MSc, PhD Candidate, Calgary, AB	

Appendix E: Themes of Disconnection

Opinion survey N=103

Treatment Service to Consumer

Awareness

- …"Public awareness needs to be increased" ***x 2***
- …"Insufficient services and insufficient information about them" ***x 3***
- …"Lack of knowledge about what happened to AADAC, even amongst health care professionals".

Access

- …"Lack of available and accessible services" ***x 40***
- …"Fear/Stigma" ***x 17***
- …"by the time the service can be provided it may not even be what the individual is wanting/needing at that point"

Family/Community

- …"Focus on individual only, not the families, couples, nor community" ***x 3***
- …"Non-specific for different cultures and languages" ***x 2***
- …"do not acknowledge/deal with the disease as affecting the entire family" ***x2***

Within Treatment Service

Continuum of Care

- …"lack of a continuum of services/continuity of care" ***x 8***
- …."More "organization" of the services as they cross the continuum, rather than needing more services" ***x 3***
- …"no appropriate follow-up/access to aftercare services once residential treatment has been completed" ***x 4***
- …"Most programs are too short "spin cycles", with counselling appearing limited & short term" ***x 2***
- …" limited capacity (both resources and knowledge base) within primary care to take on this role.
- …"different types of recovery exist in addiction and in mental health…need for different services."

Developmental Span

- …"episodic care" only throughout the life-span….
- …"longer term and more comprehensive tx services for 12-16 year old kids who use drugs" ***x 2***
- …"more education/counsellors in schools with specific training on this issue"

Complex Populations

- …"services need to address needs of those who are challenged/ complex " ***x 3***

Between Treatment Service Providers

Universal Concurrent Capability

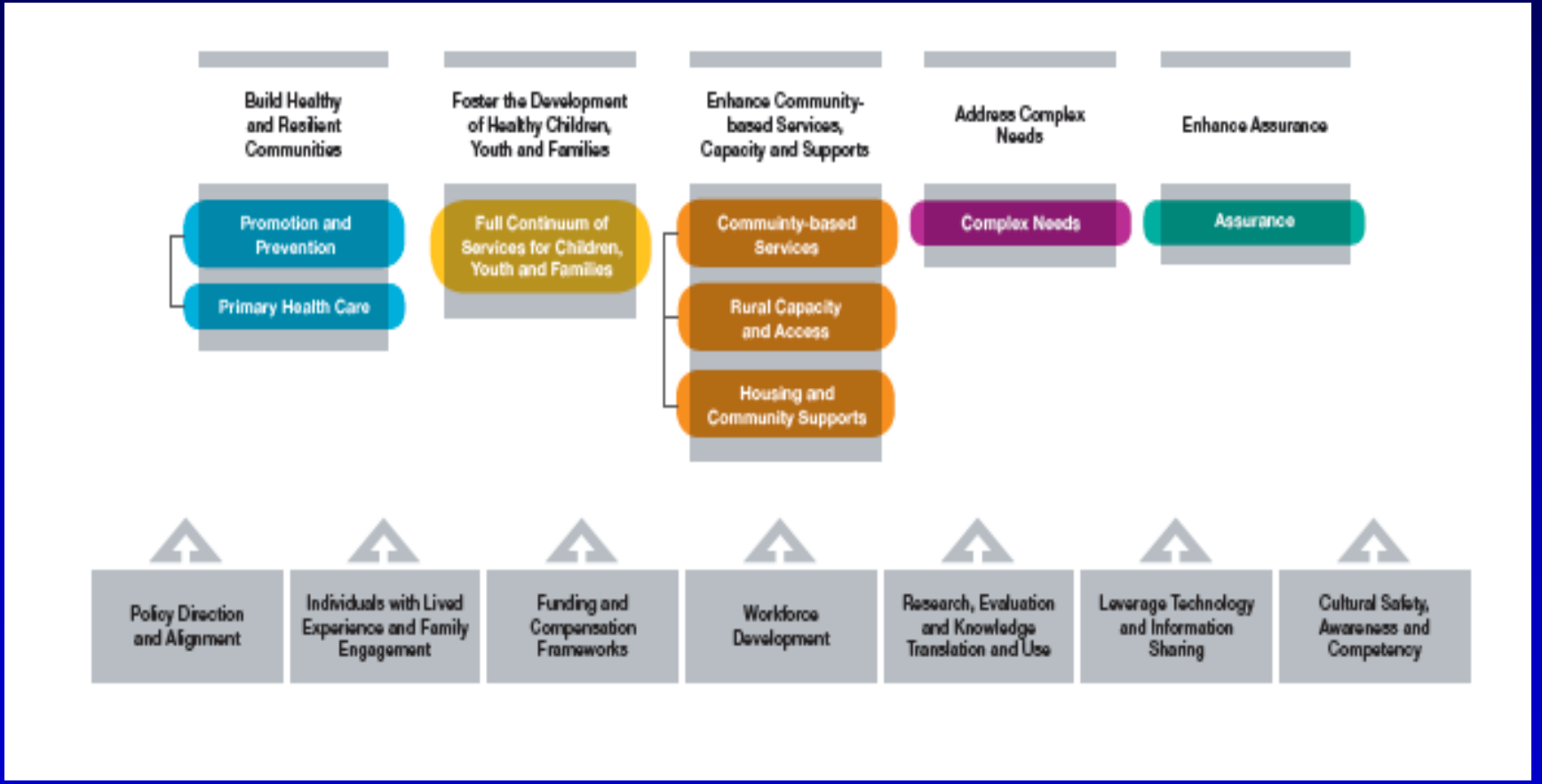
- …"lack of consensus among service providers regarding understanding of "recovery" ***x 2***
- …"insufficient & inconsistent education/training & understanding of addiction, mental health & recovery" ***x 16***
- …"Compulsive behaviours including sexual addiction is unaddressed"

"Unwillingness" to integrate

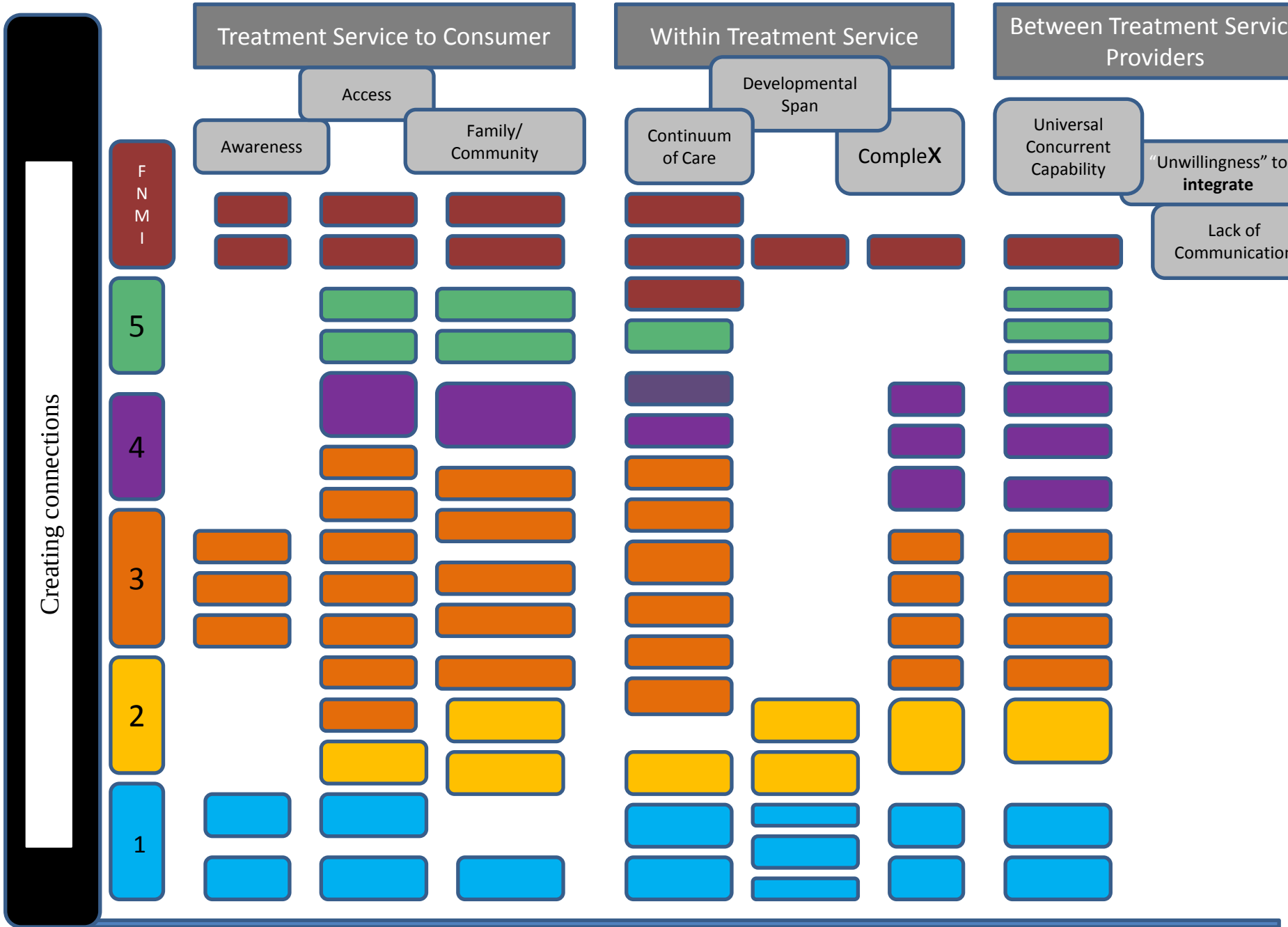
- …"Treatment Centres keep to themselves and almost hide from the community"
- …"Need for more community membership on health services planning committees "
- …"lack of AHS collaboration with AA and community partners & different philosophies "
- …"Silos maintained"
- …"Unwillingness to collaborate /communicate/coordinate with other professionals" ***x 9***

Appendix F: Creating Connections

Alberta's Strategic Directions and Enablers



Appendix G: Gap Analysis



Date: 06/07/2013

Appendix H: Budget Addiction Day - April 19, 2013

Note: 235 Participants, 12 Planning Committee, 25 networking, 10 Faculty = 284 delega

Internal #				Totals	Actuals
Revenue					
Tuition - Physicians (54 @ $166.67 per)	54	166.67		$9,000.18	
Tuition - Allied Health (100 @ $166.67 per)	100	166.67		$16,667.00	
Tuition - Residents/Students (17 @ $115)	17	115.00		$1,955.00	
Networking Fair booths (15 @ 204.76)	15	214.31		$3,214.65	
Networking Fair extra reps (20 @ $166.67)	20	166.67		$3,333.40	
Tuition - Late registrants (11 @ $ 201.67)	11	201.67		2,218.37	
Tuition & Networking booths revenue					41,590.74
Norlien Foundation				10,000.00	
Leroy LeRiche Endowment				15,800.00	15,800.00
Alberta Gaming Research Institute (AGRI)				5,000.00	5,000.00
Alberta Medical Association - Addiction Section				1,000.00	1,000.00
Last Door				1,000.00	1,000.00
Orion Health				1,000.00	1,000.00
Addiction Day 2012				$4,579.43	$4,579.43
AMH, Calgary ZoneSponsorship in kind (Addiction Program Education Initiative Team)				in kind	
Total Revenue				**$74,768.03**	**$69,970.17**
Speaker Expenses	Accom & Meals	Travel	Honoraria		
Plenary # 1: Mark Griffiths	800.00	1,400.00	2,500.00	4,700.00	
Plenary # 2: Alexandre Laudet (Intrnl)	450.00	650.00	2,500.00	3,600.00	
Plenary # 3: Lori Ashcraft (Intrnl)	450.00	1,400.00	2,500.00	4,350.00	
Plenary # 4 Glenda McQueen			1,500.00	1,500.00	
Plenary # 5: Nady el-Guebaly			1,500.00	1,500.00	
Workshop # 1: Lisa Marsch	450.00	1,400.00	1,500.00	3,350.00	
Workshop # 2: David Crockford			1,500.00	1,500.00	
Workshop # 3: Jennifer Hibbard			1,500.00	1,500.00	
Workshop # 4: Jill Kelland	450.00	300.00	1,500.00	2,250.00	
Workshop # 5: Jonathon Stea			1,500.00	1,500.00	
Speaker Honorarium total					18,086.59
Travel & Meals - Speaker, Think Tank, CME Staff					4,912.10
Hotel Alma - Speakers & Think Tank					2,190.29
Total Speaker/Think Tank Expenses	**$2,600.00**	**$5,150.00**	**$16,250.00**	**$25,750.00**	**$25,188.98**
Operating Expenses					
Phase One ~ Interactive Website/Blog					
Complimentary Bloggers:					
Jenn Corbiel				167.00	167.00
Ed Kemp				167.00	167.00
Shannon Middlemiss				167.00	167.00
Trish Dribnenki				167.00	167.00
Mila Wendt				167.00	167.00
Phase Two ~ Conference & Networking Fair					
Outstanding charges from venue - 2012					2160
Venue Rental (MacEwan Hall & Conference Centre)				Complimentary	
Catering - Food Services ($57.00 / person)	300	57		17,100.00	16550.38
Breakfast(s) (280 delegates @ $14.00 per delegate)					
Lunch(es) (280 delegates @ $23.00 per delegate)					
Coffee / Nutrition Break(s) (280@ $10.00 per break * 2)					
Audio Visual -					
Technician & Equipment Rental				1,500.00	4867
Podcasting				400.00	400
Brochure -					
Design				300.00	228.71
Printing (200 brochures @ $1.00 per)				200.00	
Handbook/Course Materials				800.00	587.67
CME Office Photocopying				250.00	250
Office Expenses -					
CME Fee (284 delegates @ $75.00 per delegate)	287	75		21,525.00	21,525.00
CME Staff Overtime (5.5 hrs @ $40.00 per hr)				220.00	300
Bank Charges (2.0% of total credit card charges)				872.50	748.07
Parking (25 @ $10.00)				250.00	250
Phase Three ~ Interactive Think Tank					
Venue ~ NOtaBLE Private Event Room				2,000.00	1360.03
Complimentary Catering with Room				Complimentary	
Recording/Scribing Equipment & Material				150.00	150
Thank you Cards				180.00	174.26
Think Tank Attendee expenses available		Conference	Travel & Accom		
Mike Trew		166.67		166.67	
Cathy Pryce		166.67		166.67	
Laurie Beverly		166.67		166.67	
Cam Wild		166.67	500	666.67	
Esther Tailfeathers		166.67	500	666.67	
Joan Campbell		166.67		166.67	
Peter Silverstone/Kay		166.67	500	666.67	
Bev Adams		166.67		166.67	
Katherine Aitichison		166.67	500	666.67	
Rick Hanson/Designate		166.67		166.67	
Jeffrey Poole		166.67		166.67	
Fiona Hayes		166.67		166.67	
Daniel Scott			500	500.00	
Susan Ulan			500	500.00	
					166.6667
Phase Four ~ Summary of Findings					
				NA	
					8.3335
					175
Total Operating Expenses				**$51,582.54**	**$50,211.86**
Total Expenses				**$77,332.54**	**$75,400.84**
Surplus to Client (Loss - Amount owed to CME)				**-$2,564.51**	**-$5,430.67**