2016

# NE LHIN Addiction Services Review

**Prepared by**

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**Prepared for the**

**North East Local Health Integration Network**

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# Acknowledgements

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# 1.0 Introduction and Background

In concert with changing population trends, shifting models of care and iterative government strategies and policy initiatives, there remains a high interest and investment in substance use treatment in Canada, including treatment for concurrent disorders and closer relationship with mental health and primary care services generally. Certainly continued investment in substance use treatment systems is warranted in Canada, as it is globally, by the high economic burden of problems related to substance use on society. This burden, coupled with strong research evidence that treatment is effective, and that it returns an economic benefit, makes investment in substance use treatment systems a wise use of public funds.

The NE LHIN identified improved accessibility to mental health and addictions services as a priority in their 2013-2016 *Integrated Health Service Plan*. The NE LHIN also considered local evidence that regional/local addictions services are struggling to operate with the resources and funding currently available to them and that service demands continue to grow. In response to this pressure on the addiction system, the LHIN commissioned an environmental scan and literature review of best practice for addiction service delivery.

The overall goal of the project is to determine strengths and challenges within the current network of services in the NE LHIN as a whole, and within each of five sub-regions, and to identify in what ways these networks of services can be enhanced.

The region's five sub-regions are:

1 Algoma
2 Cochrane
3 James Bay & Hudson Bay Coasts
4 Nipissing/Temiskaming.
5 Sudbury/Manitoulin/Parry Sound

Within the large geographic region of the NE LHIN these five sub-regions are used for purposes of system planning, quality improvement and performance measurement. Importantly, there are further geographical divisions within each of these sub-regions as well as important relationships *between* them, for example, migration of people for various reasons such as employment, education and natural disasters such as the flooding in the Coast area. There is also movement across the region for accessing health care services, including tertiary mental health care and residential addiction treatment. This adds to the complexity of health service planning, including environmental scans such as this one.

It is important to acknowledge that in the preparation of this report we have reviewed findings from other reports and environmental scans that have been completed to examine various aspects of the substance use system at the provincial, regional, and sub-regional level. These reports include:

Provincial/National

- *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*
- *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addiction Report*

- *Taking Stock: A Report on the Quality of Mental Health and Addiction Services in Ontario*
- *A Place to Call Home: Report of the Expert Advisory Panel on Homelessness*
- *Community Withdrawal Management Services and Day Withdrawal Management Services: Environmental Scan and Overview of Programs in Ontario*
- *Migration among Persons with Mental Health Challenges in Northern and Remote Communities* (presentation)
- *Income Gap between Aboriginal Peoples and the Rest of Canada*
- *The Health of Francophones in Ontario*

*Regional/Sub-regional*

- *NE LHIN Integrated Health Service Plan 2016-2019*
- *Perceptions on the North East LHIN Health Care System*
- *Environmental Scan: LHIN Integrated Health Service Plans 2016-2019*
- *Community Mental Health Services Review, 2015*
- *Transforming Mental Health and Addiction Services for the People of Northeastern Ontario: A Blueprint for Mental Health and Addictions*
- *Algoma Mental Health and Addictions Mapping and Environmental Scan*
- *City of Greater Sudbury Housing and Homelessness Background Study*
- *North East Region Concurrent Disorders Mapping Project*
- *NE LHIN Aboriginal First Nations Métis Mental Health and Addictions Framework*
- *North Cochrane Strategic Health Services Blueprint*
- *Researching Health in Ontario Communities (RHOC): Findings from Research in the Downtown of the City of Sudbury*
- *Researching Health in Ontario Communities (RHOC): Consumer Journey Study. Chelmsford and Downtown Area Sudbury*

Some common findings that have emerged from these reports are:

- Based on recent provincial estimates the health-related burden of mental health and addictions is 1.5 times that of all cancers and over 7 times that of all infectious diseases. These are considered conservative estimates.
- One third of Ontarians who identified themselves as needing mental health or addictions services in a 2012 survey reported not getting help, or having their needs only partially met. The access barriers identified included a fear of social stigma, an inability to pay out-of-pocket for services, and not knowing where to find help. Research identifies additional barriers experienced by those with significant challenges related to housing status.
- One third of emergency department visits for a mental illness or addiction are by people who have never been assessed and treated for these issues by a physician.

- There are high levels of substance use and addiction related challenges in the region; challenges intermixed and closely associated with mental health and violence/trauma.
- Service providers in the NE LHIN, across both mental health and substance use sectors, are recognized as committed, resourceful, and collaborative and are increasingly innovative in their program and local system design.
- There are significant gaps in service in relation to community needs across Northern Ontario, including the North East, as well as some potential duplication of services.
- There is a lack of system-level supports to help strengthen and guide agencies in their work.
- Access to services is a significant issue across the province and exacerbated in the North due to geographic, weather and transportation-related challenges
- There is a lack of information related to substance use, mental health, and overall trends and needs of Francophone people and the First Nation, Inuit, Metis[1] (FNIM) populations and, therefore, often an inadequate response to the complex needs faced by these groups.
- There is a need and desire for more inter-sectoral collaboration to address the complexity of issues facing those with substance use related-challenges.

These and other findings provided initial context to needs and service provision in the NE LHIN, particularly in relation to mental health and addiction services. The various reports are also drawn upon at different stages in data analysis and interpretation throughout the report, particularly recommendations and implications.

[1] In this report we will use the term First Nation, Inuit, and Metis (FNIM) to refer to the indigenous peoples who live both on and off reserve and the term First Nation when referring specifically to on-reserve communities. The term Aboriginal may also be used for both on and off reserve population if it is the term used in original source material (e.g., documents, databases, participant quotes).

# 2.0 Methods

## 2.1 VIRGO Team

*Core team* – Dr. Brian Rush (Project Leader); Ms. Chelsea Kirkby and Ms. April Furlong

*Expert Advisors*: Ms. Caroline Recollet - Aboriginal Health - CAMH; Dr. Jonathan Bertram - Addiction Medicine, CAMH) and Dr. David Marsh - Northern Ontario School of Medicine.

## 2.2 Steering Committee

Members of the NE LHIN Addiction Services Review Steering Committee provided advice, feedback and support on data collection, design and recommended models of care for addiction services throughout the northeast. The objectives of the steering committee were to support the consultation team:

- through the provision of available documents and other resources necessary to complete the review and plan;
- with advice and direction, where appropriate, concerning system priorities;
- by facilitating communications between stakeholders, and through the development of a communication strategy; and
- by providing feedback on recommendations and implications based on the potential impact on program operations and client services.

The Steering Committee met seven times over the span of the project. Membership included participants from all five sub-regions in the NE LHIN, in addition to representation by FNIM and Francophone people to ensure the unique perspectives of those groups were included (see Appendix 2 for committee membership and terms of reference).

## 2.3 Collating Existing Data

### 2.3.1. Population and Substance Use Trends

#### *2.3.1a Population Trends*

A number of data sources were analyzed to determine the demographic profiles of each sub-region and the NE region as a whole – primarily information that has already been gathered and shared by the NE LHIN. The data included age and gender distributions for each sub-region and the NE region as a whole. When possible, French-speaking and FNIM populations were identified. The data include information regarding population size, health status, and the social determinants of health.

#### *2.3.1b Substance Use Trends*

Data regarding alcohol and other drug use in the NE LHIN were made available from the Centre for Addiction and Mental Health (Ialomiteanu et al, 2014; Boak et al., 2014) based on their most recent adult survey: the Substance Use Monitor, 2014. The survey provides comparative information across all the Ontario LHINs based on random sampling and telephone interviews. While the results are informative for the present purposes, the

survey under-represents people with no fixed address and/or phone number, those who were institutionalized, those unable to speak English, and also First Nations people living on reserves.

To capture youth substance use trends, this report also includes highlights from the CAMH report "Drug Use among Ontario Students" based on the Ontario Student Drug Use and Health Survey. This survey is administered by CAMH, reaches Ontario students in grades 7 through 12, and has been ongoing since 1977. It is a self-administered, anonymous survey, conducted every two years, that collects information from thousands of students in schools across Ontario. Like the Substance Use Monitor for adults, this survey does not reach all populations since only randomly selected schools in the public and Catholic systems in Ontario are in the study's sampling frame. Private schools, schools on First Nations reserves, military bases, custodial or treatment facilities, and those in remote Northern regions where not surveyed.

While the adult and school survey data on their own are limited for our purposes here, they do provide additional context, for example, when considered alongside the substance use patterns of people accessing regional treatment services.

### 2.3.2 Use of Substance Use Services

The use of services that support people with substance use issues was examined based on data provided by various sources named below.

#### *2.3.2a Substance Use Treatment Caseload*

The Drug and Alcohol Treatment Information System (DATIS), a provincial client information system, provided data to develop a profile of clients accessing the specialized substance use services within the NE LHIN. This information includes the number and characteristics of clients based on standard definitions of cases, characteristics and treatment service categories. For some analyses, clients were classified according to sub-region of residence within the NE LHIN. The DATIS data are limited by missing information (e.g., non-reporting agencies) and variances regarding data completeness and quality across some reporting agencies.

Client information was organized by postal code to allow for determination of the use of services within a particular sub-region by people who live outside of that area, as their address is coded in the DATIS database. Postal code breakdown by sub-region was made available by the NE LHIN, as was the population data. A limitation of these data is the inability to accurately capture information for those who are not linked to a postal code (e.g. no fixed address or unknown).

#### *2.3.2b ConnexOntario Data on Referral Recommendations*

ConnexOntario is a MOHLTC-funded program that provides free and confidential information regarding health services, with one portal dedicated to services that treat and support people experiencing problems with alcohol and drugs. Programs report information regularly to ConnexOntario on services they offer and on their availability. In turn, ConnexOntario staff provide this information to callers (professionals and the general public) seeking services in Ontario.

ConnexOntario provided data outlining the number of referral recommendations to substance use services that were offered to callers from within and outside the NE LHIN. This information helps illustrate the potential geographic movement of clients within the system, recognizing it only represents referral *recommendations* and not the number of clients who may actually have accessed services (as in the DATIS information). These data may be limited with regard to their accuracy and completeness as it is based on reporting from agencies that may not be as timely as desirable in some instances.

### 2.3.3 Use of Health Care Services for Substance Use-related Problems

The Institute for Clinical Evaluative Sciences (ICES) is a not-for-profit research institute that includes a community of research, data and clinical experts, and a secure and accessible array of Ontario's health-related data. By a request sent through the NE LHIN, ICES provided data regarding service utilization related to substance use, including physician visits, hospital discharges, ED visits and physician-delivered opiate maintenance services (methadone/Suboxone) across the NE LHIN as a whole, and within its sub-regions. This information allows for analysis of the scope of substance use related service utilization in the region as well as patient travel across the sub-regions and outside the region. The main limitation of the data is the chronic under-reporting of substance use related conditions in health care settings. Thus, the data represent a minimum level of health service utilization by NE LHIN residents related to substance use and addiction. An attempt was made to cost these health service encounters but this proved to be beyond the scope of the current project for hospital discharges and the physician-delivered opiate maintenance services.

### 2.3.4 RHOC and Five Views Data on Substance Use, Mental Health and Violence

Two recent, inter-related projects implemented by the Centre for Addiction and Mental Health (CAMH) provided important contextual information for the present project. The Researching Health in Ontario Communities (RHOC) project was a CIHR-funded project between 2012 and 2015 that used the CAMH mobile lab and other strategies to collect community data with a web-based survey on the prevalence and intersection of substance use, mental health and violence. This work was done in diverse communities across Ontario, including the town of Chelmsford and downtown Sudbury, two communities in the NE LHIN. The second related project was the Five Views of a Journey: Partnership for Health Systems Improvement (Five Views: 2012-2015). Built upon the RHOC study, the Five Views project captured data from five perspectives: consumers (i.e., people who had accessed services for mental health or substance use problems), family members, service providers, members of the community, and data on service use (from ICES). Chelmsford and Downtown Sudbury were also included in the Five Views project. The data from these two communities mirrored that of the province in most respects and, therefore, are likely fairly representative of most communities in the NE LHIN, with the exception perhaps of the Coast sub-region.

## 2.4 Compiling New Data

### 2.4.1 Agency Profiles

The network of substance use services in the NE LHIN is comprised of LHIN-funded and non-LHIN-funded agencies or programs within larger organizations such as hospitals. Draft profiles for LHIN-funded services were developed based on information provided by ConnexOntario and the NE LHIN, and then vetted through contacts for each service provider. These profiles include information on services provided, such as, agency name, main service categories (program), clientele served (age, gender, language, FNIM), and details regarding withdrawal management and residential services (occupancy rates, number of beds, etc.).

A small number of non-LHIN-funded agencies also provided information to create a program profile to add to the description of the other substance use services. These profiles, while providing quite a bit of information, were not consistent in the details included, some were missing information, and not all agencies returned a complete profile. That being said, the agency profiles provided in this report can be used as a template for further exploration and information gathering, in particular with respect to service-related costs.

### 2.4.2 Case Descriptions

A small number of service providers shared case descriptions to put a human face on the substance use issues among clients accessing services in the NE LHIN. These cases demonstrate the complexity of issues clients are facing and, in many instances, the extensive and often collaborative responses/support being provided.

### 2.4.3 Steering Committee Member Input

At the outset of the project the members of the NE LHIN Addiction Review Steering Committee provided preliminary input on strengths and challenges in their respective jurisdictions as well as innovative practices in their communities. In most instances, they received input from colleagues and community partners in the development of this initial feedback. The committee met four times during the data gathering phase and the discussion, captured in meeting notes, was also treated as important information for synthesis and triangulation with other sources of input. The Steering Committee met an additional three times to discuss the draft report and implications/recommendation and offer additional feedback.

### 2.4.4 Key Informant Interviews

The NE LHIN Project Lead, members of the Steering Committee and the VIRGO project team identified key informants in each sub-region for individual or group interviews. Between May 11 and 14, 2015 Dr. Brian Rush and Dr. Jonathan Bertram traveled to Moose Factory and Moosonee to conduct face-to-face interviews in six separate meetings with a total of 10 participants. This process was then followed up in June with two weeks of intensive travel from June 6 to 19, 2015 by Dr. Rush to conduct interviews in the remaining four sub-regions, including Nipissing-Temiskaming, Cochrane, Algoma, and Sudbury-Manitoulin-Parry Sound. A total of 28 individual meetings were held during this part of the data collection phase.

After this intensive data collection phase a number of telephone interviews were conducted for those who were either not available during these periods of data collection, or who could not be scheduled due to distance and other considerations during the planning and implementation of the initial travel. Several were recommended through snowball recommendation. With both the in-person and telephone interviews, there were approximately 85 individuals representing 41 separate service providers who participated. For more details, including a list of agencies and regional key informants, see Appendix 3[2]. An additional 6 interviews were held with representatives of the NE LHIN (a total of 11 individuals) and another 5 consultation interviews with provincial experts on opiate maintenance treatment and/or withdrawal management, two critical issues that emerged in the environmental scan. In total, approximately 100 people contributed to the interview and consultation process.

Interviews with regional key informants followed a structured discussion guide, except in a small number of instances where people were being contacted in snowball fashion to follow-up on one or more specific issues that had been previously identified. In addition to the interviews, key informants from specific services were invited to complete and submit a written Interview Guide (see Appendix 4 for the Interview Guide template) if they wished to add any additional comments – a total of nine completed templates were received.

### 2.4.5 Online Survey

An online survey was conducted to gather feedback from a wide range of stakeholders beyond the in-person and phone interviews. The survey was made available in French and English and it explored the strengths and areas of opportunity for the substance use treatment system in the NE LHIN. To maximize dissemination of the survey, a snowball approach was taken and a link was sent via email to Steering Committee members and other key contacts in the region. They were invited to forward it to their contacts (see Appendix 5 for the Online Survey Questions). Participants had just over two weeks to complete the survey and one reminder email was sent out. In total, there were 47 respondents in English and 5 respondents in French across the region.

## 2.5 Best Practice Literature Review

A literature review summarizing best practices for substance use treatment and support services, created by VIRGO consultants for Health Canada and other previous projects, was updated and utilized in this report. Based on this review, a Best Practice Template was created to identify areas of strength and opportunity for providing evidence-informed services across the region, and within each sub-region. The Best Practice Template was used to contrast feedback from key informants on the strengths and challenges in the system. In section 3.2 below the various elements of an evidence-informed treatment and support system are presented (e.g., types of services, collaboration, stepped care, transition support) and then strengths and challenges across the NE LHIN as a whole are summarized in relation to those elements. Implications and recommendations at the regional level

[2] Appendix 3 contains primarily the main contact person for the on-site visit and interviews. However, not all of the individuals providing input are identified in the list since several interviews were in a group format and the names of all participants were not captured (e.g., all managers and staff present).

(section 4) are based largely on this analysis in conjunction with a synthesis of the various quantitative data described above.

A subsequent section for each sub-region is provided in Appendix 1. Each sub-section of this Appendix draws upon the regional analysis and highlights strengths, challenges and implications at the sub-regional level but without repeating the full Best Practice Template so as to avoid repetition and to manage the overall length of the report.

# 3.0 Environmental Scan - Regional Overview

## 3.1 Regional Context

### 3.1.1 Population and Substance Use Trends

#### *3.1.1.1 Population Trends*

The NE LHIN is the second largest LHIN in the province and, as shown in Figure 1 below, covers a large expanse of land (just under 44% of Ontario's land mass). Although one of the largest LHINs geographically, it has a comparatively small population of about 563,000 people, or 4.1% of the Ontario population in 2014 (NE LHIN, 2014). The most recent data show population levels within each of the five sub-regions to be: Algoma: 115,870 (20.9%); Cochrane: 78,856 (13.9%); James Bay & Hudson Bay Coasts: 6,213 (1.1%); Nipissing-Temiskaming: 117,370 (21.2%); Sudbury-Manitoulin- Parry Sound: 236,782 (42.8%).

**Figure 1: Geographic breakdown of the NE LHIN**


*Map Source: www.nelhin.on.ca*

The regional population has a number of unique characteristics and trends as described in the most recent NE LHIN Population Health Profile (2014), including:

- Between 1996 and 2011, the population of Northeastern Ontario decreased by 6.1% while the population of Ontario increased by close to 21%.

- Between 2014 and 2036, the population of Northeastern Ontario is projected to decrease by less than 1%, while Ontario is expected to increase by 26%.
- The proportion of the population age 65 and over is projected to increase from 19% to 30% by 2036, a projected increase of 55%.
- Only approximately 19% of people living in Northeastern Ontario live in an urban centre, compared to about 69% in Ontario.
- There is a high proportion of Francophone people at 23% with the highest proportion in the Cochrane sub-region (about 50%).
- FNIM people account for approximately 11% of the population; the James Bay and Hudson Bay sub-region having the largest proportion (about 96%).

The available information portrays a region that has both an aging and shrinking population. It is important to recognize that although the projected population decline can be seen as more of a plateau (with a decrease of 1% over the next 20 years), the region is coming out of a larger population decline (6.1% between the years 1996-2011). This will likely have an impact on health system planning as the system must respond to changing pressures that will surely follow.

Even with this overall population decline, stakeholders in different regions have noticed spikes in population related to certain events. The population of Timmins is one example as this city has experienced a small population growth (0.4% between the years 2006-2011) attributed to an increase in jobs in the culture and recreation field. In addition, Timmins has seen an increase in the FNIM population (increased from 6.6% in 2001 to 7.7% in 2007; City of Timmins, 2013). On the other hand, the Cochrane region, in which Timmins is included, has also seen population fluctuations with net out-migration, more commonly amongst those between the ages of 18-24 for educational opportunities.

Another reason for periodic population increases that has had an impact on some Northern communities is the persistent flooding of the small community of Kashechwan in the Coast sub-region. Hundreds of residents of this town were evacuated in the spring of 2015 and were hosted in Kapuskasing and Smooth Rock Falls, increasing the population for an indefinite period of time. Almost 500 people were also hosted outside the NE LHIN in Cornwall Ontario.

### *Trends in Population Health*

The NE LHIN's Population Health Profile (2014) provided a picture of the overall health and wellbeing in the region. This report indicated that there are higher reports of general poor health (15.5% vs. 10.6% in Ontario) in the region and that the unemployment rate is higher than the rest of Ontario (8.4% vs 6.4%). In addition, it showed that the percentage of families living below the Low Income Cut Off[3] is less than the rest of Ontario (9.6% vs 11.7%).

Table 1 shows a finer sub-regional breakdown of population and related social indicators based on 2006 data. While the sub-regional breakdown is slightly different than the five sub-regions used throughout the report, it is the most inclusive set of data available on FNIM status and other relevant social indicators of need such as single parent families and

[3] Low Income Cut-Off: the threshold below which a family spends 20% more of their income on food, shelter, and clothing than the average family. Average expenditures are adjusted for both community and family size.

education level. The shaded cells point out important facts and regional disparities, in particular the significantly higher unemployment rate, child dependency rate and single parent families, lower income and education levels and a much lower percentage of the population aged 65 and over (i.e., reflecting early mortality in the Coast sub-region)

Safe, affordable housing has become increasingly recognized as the foundation for good health and as an important aspect of supporting people with substance use and/or mental health issues. In the NE region as whole the issue of homelessness has not been thoroughly researched. However, different cities and regions have identified a number of issues. The City of Greater Sudbury Housing and Homelessness Background Study (2013) identified a number of problems, including the lack of affordable housing options, a need to improve housing access and affordability for those living with low income, a need to strengthen approaches to prevent homelessness, and a need to increase supportive services associated with permanent housing. These themes are also reflected in other similar reports for other cities or regions in the NE (i.e. Cochrane, Parry Sound, and Sault Ste. Marie).

### *Francophone Population*

The NE LHIN has the largest percentage of Francophone people (23%) of all the LHINs in Ontario. The Francophone population varies by sub-region (see Table 1 below) with the highest percentage in the Cochrane sub-region (about 50% as noted above) and the lowest in the James Bay and Hudson Bay Coast sub-region (less than 1%).

Given the large proportion of Francophones in the region, it is important to include data related to their unique linguistic and cultural needs in health system planning. A recent position statement released by the French Language Health Services Network of Eastern Ontario suggested that there is very little, if any, information on the health of Ontario's Francophone population. They attribute this to various information systems failing to collect this information. It was determined through a study conducted in 2012 that of 19 health system databases, 12 of them did not include a linguistic variable to determine an individual's mother tongue and preferred language for service. While the remaining seven databases included one or more linguistic variables the information was inaccessible[4] or inconsistent (French Language Health Services Network of Eastern Ontario, 2013).

With so little health and socio-economic data, it is difficult to determine the health, social, and economic trends of Francophones in NE Ontario. What small amount of data that is available points to important disparities. For example, 62% of Francophones in the NE LHIN report having one or more chronic diseases, compared to 53% of the general Francophone population in Ontario (The Health of Francophones in Ontario, 2012 Report, Réseau de recherche appliquée sur la santé des francophones de l'Ontario (as cited in NE LHIN, 2013). It is not clear whether these high rates of chronic issues are being adequately addressed by the health system. What is evident is that the provision of accessible health services is important and necessary to enable the health and well-being of this population.

[4] It is not clear why DATIS fell into this category

**Table 1.** 2006 Population and Socio-Demographic Characteristics by Sub-region (NE LHIN, 2008)

| PLANNING AREAS | ALGOMA | COCHRANE | JAMES AND HUDSON BAY COASTS(4) | MANITOULIN-SUDBURY | NIPISSING | PARRY SOUND | TEMISKAMING | NE LHIN | ONTARIO | RANGE within the LHIN | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total population (2006) | 117,461 | 78,692 | 4,258 | 192,392 | 84,688 | 40,918 | 33,283 | 551,691 | 12,160,282 | 4,258 | - | 192,392 |
| Senior population, age 65+ (2006) | 18.6% | 14.1% | 3.3% | 15.1% | 16.0% | 21.4% | 18.2% | 16.5% | 13.6% | 3.3% | - | 21.4% |
| Population with English mother tongue | 82% | 44.7% | 36.6% | 65.3% | 69.6% | 91.2% | 70.4% | 68.7% | 68.4% | 36.6% | - | 91.2% |
| Population with French mother tongue | 6.8% | 49.0% | 0.4% | 25.9% | 24.9% | 3.0% | 24.6% | 23.1% | 4.1% | 0.4% | - | 49.0% |
| Population of Aboriginal identity | 11.0% | 7.8% | 96.2% | 9.2% | 8.7% | 5.4% | 5.0% | 9.2% | 2.0% | 5.0% | - | 96.2% |
| Participation Rate (age 15+) | 57.5% | 62.6% | 47.1% | 61.9% | 59.8% | 57.8% | 58.5% | 60.2% | 67.1% | 47.1% | - | 62.6% |
| Unemployment rate (age 15+) | 8.9% | 8.2% | 16.6% | 8.4% | 8.3% | 6.7% | 8.2% | 8.4% | 6.4% | 6.7% | - | 16.6% |
| Economic families below LICO(2) (2005) | 10.3% | 9.0% | 6.7% | 9.1% | 11.6% | 7.7% | 9.1% | 9.6% | 11.7% | 6.7% | - | 11.6% |
| Families (with children) headed by a lone parent | 16.2% | 13.6% | 35.7% | 16.4% | 16.4% | 11.7% | 12.6% | 15.4% | 15.8% | 11.7% | - | 35.7% |
| Population (aged 25+) without certificate, diploma, degree(3) | 24.3% | 30.4% | 62.0% | 24.1% | 23.9% | 25.9% | 31.8% | 25.7% | 18.7% | 23.9% | - | 62.0% |
| Population (aged 25+) with completed post-secondary education | 49.6% | 46.6% | 30.7% | 52.2% | 52.5% | 46.4% | 45.7% | 50.0% | 56.8% | 30.7% | - | 52.5% |
| Child dependency ratio | 23.0% | 25.3% | 65.0% | 24.8% | 24.3% | 22.0% | 24.0% | 24.3% | 26.6% | 22.0% | - | 65.0% |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Senior dependency ratio | 28.2% | 20.6% | 5.7% | 22.3% | 23.6% | 33.3% | 27.6% | 24.5% | 19.9% | 5.7% | - | 33.3% |
| Total dependency ratio | 51.2% | 45.8% | 70.7% | 47.1% | 47.9% | 55.3% | 51.6% | 48.8% | 46.5% | 45.8% | - | 70.7% |

Source: 2006 Census(1) For details on the census see: http://www12.statcan.ca/census-recensement/index-eng.cfm. In some cases, very minor differences may be found between this table and the summary presented at the beginning of this document due to rounding and different vintages of source data.

Notes:

(1) Census Data and Demographic Estimates and Projections (DEP) are not directly comparable due to 2006 Census undercount

(2) Low Income Cut-Off: the threshold below which a family spends 20% more of their income on food, shelter, and clothing than the average family. Average expenditures are adjusted for both community and family size.

(3) Includes high school graduation certificate or equivalent

(4) The values for the Coast PA should be used with caution due to a large portion of population which is not enumerated in the 2006 Census.

### *FNIM Population*

The NE LHIN has a significant percentage of FNIM people accounting for about 11% of the region's population, according to the most recent estimates. The breakdown of this population by sub-region is shown in Table 1 above, with a high of 96% in the James Bay and Hudson Bay Coasts.

The NE LHIN's Population Health Profile (2014) highlighted the following information related to health from the First Nations Regional Health Survey. Among FNIM adults:

- 62.6% had at least one chronic health condition.
- 43.2% smoked daily.
- 34.8% were obese and 5.4% were morbidly obese.
- 16.2% reported having been diagnosed with diabetes.

This demonstrates the complexity of health conditions that FNIM people are facing and the need for a comprehensive, wholistic response.

Significant economic disparities have also been shown for First Nations communities in terms of significantly lower employment and several other indicators (Wilson and Macdonald, 2010). See also Table 1 whereby the Coast sub-region stands out on several economic and social indicators including employment and income.

Information on substance use and related challenges among FNIM people in the region is reported in the section below.

### *3.1.1.2 Substance Use Trends*

Substance use trends in the NE LHIN are reported as roughly comparable to the general Ontario population, with the exception of tobacco use, according to data collected as part of the CAMH Monitor (2013; see Table 2). However, the region was significantly higher with regards to daily smoking rates (17.8% versus 12.8%), higher with respect to reports of only fair/poor health (15.5% versus 10.6%) and marginally higher on hazardous alcohol use (16.3% versus 14.0%). Opioid use for non-medical purposes in the past 12 months, as well as alcohol and other drug use among adults, is undoubtedly underestimated in the NE LHIN survey data as the CAMH Monitor does not reach Ontarians without a phone, people in institutions or the First Nation population (i.e., those living on reserve).

**Table 2.** Percentage of Ontario Adults (18+) Reporting Selected Substance Use and Health Indicators by Ontario LHINs, CAMH Monitor, Combined 4-Year Data, 2010–2013

| Substance Use and Health Indicator | % NE LHIN | % Ontario |
|---|---|---|
| Daily Smoking | 17.8* | 12.8 |
| Hazardous/Harmful Drinking (AUDIT 8+; past 12 months) | 16.3 | 14.0 |
| Cocaine use, lifetime | 7.9 | 8.3 |
| Cannabis use, past 12 months | 12.7 | 13.9 |
| Prescription opioid use (non-medical, past 12 months) | 2.9 | 4.1 |
| Fair/poor overall health | 15.5 | 10.6 |

*Rate is significantly different from Ontario rate and represents an increasing trend

*Prescription Opioid Use*: Addressing the misuse of opioids is a priority of the Ontario Ministry of Health and Long Term Care as well as nationally. The following are highlights from a presentation at the Ontario Harm Reduction Distribution Program Conference in 2012 that describes the alarming situation in Ontario and Canada, particularly with regard to First Nations communities.

- Ontario has the highest rate of narcotics use in Canada.
- Since 1991, prescriptions for oxycodone-containing products rose by 900% in Ontario.
- Since 2004, the number of oxycodone-related deaths in Ontario has nearly doubled.
- Recent studies suggest that increased rates of opioid prescribing, particularly long-acting oxycodone, is contributing significantly to morbidity and unintentional opioid-related mortality.
- A number of First Nations communities have declared a state of emergency over the abuse of prescription narcotics, particularly oxycodone-containing drugs.

Data from sources other than the CAMH Monitor show that FNIM people in the NE LHIN have worrying levels of substance use and addiction. The NE LHIN FNIM Mental Health and Addictions Framework summarized data from the 2002/2003 First Nations Regional Longitudinal Health Survey (RHS) and found the following:

- Prescription drug use was reported by 12.2% of participants over the past year including codeine, morphine and opiates.
- The proportion of FNIM adults (16.0%) engaged in heavy drinking on a weekly basis is more than double that of the general population.
- 26.7% of respondents reported using marijuana over the past year, compared to only 14.1% in the general population.
- The prevalence of use of other illicit substances was found to be 7.3% over the past year, a rate about double that found in the general population (NE LHIN, 2011).

*Substance Use among People in Treatment*: Information on substance use trends across the region can be gleaned from DATIS which reports substance of concern among new admissions to treatment programs across the province, including the NE LHIN-funded programs (Table 3). For the NE LHIN as a whole, clearly alcohol is the most frequently cited substance of concern (68.0%) followed by cannabis (38.6%), tobacco (30.7%) and prescription opioids (24.5%). There are sub-regional variations with respect to the most frequently reported presenting problem substances among new treatment admissions. For example, 33.9% of new admissions in Sudbury-Manitoulin-Parry Sound and 28.9% of admissions for residents of the Coast sub-region report prescription opioids as their substance of concern, a level quite a bit higher than for the other areas of the region.

Trends in problem substances identified by contacts to the ConnexOntario Drug and Alcohol Helpline from the NE LHIN between 2010 and 2015 are presented in Figure 2. Over this period, alcohol is the most frequently identified. The percentage of individuals reporting concerns with narcotic analgesics (including OxyContin) is second to alcohol and then more or less tied with cocaine in the latter months of 2014. Cannabis and crack cocaine were cited by callers fourth and fifth, respectively.

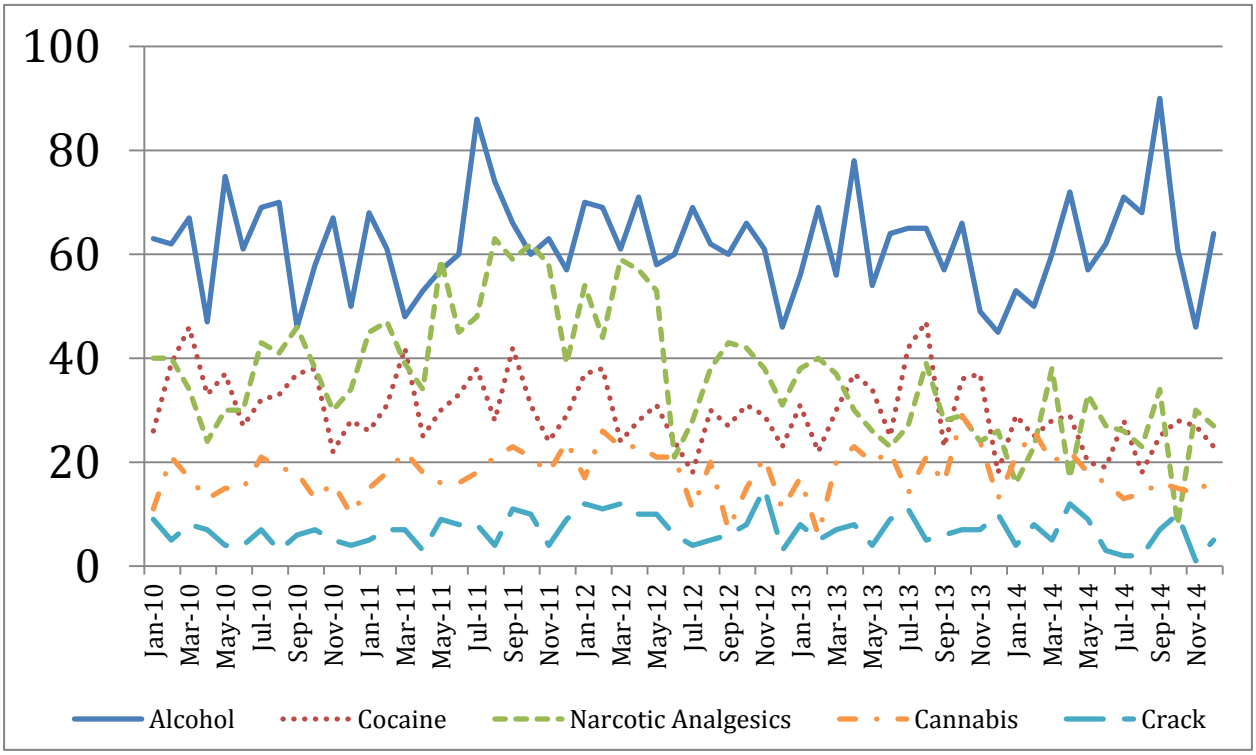
**Table 3.** Top Seven Presenting Problem Substance of New Admissions Who Received Substance Abuse Treatment in the North East LHIN, By Sub-Region of Client Residence, Fiscal Year 2014/15.

| Presenting Problem Substances | NE LHIN Sub-Region of Client Residence | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Algoma | | Cochrane | | Subdury-Manitoulin-Parry Sound | | Nipissing Temiskaming | | James Bay and Hudson Bay Coast[2] | | No Fixed Address | | Outside Region | | Total N | % |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | | |
| Alcohol | 1074 | 69.3 | 766 | 63.8 | 1611 | 69.6 | 751 | 57.3 | 78 | 86.7 | 996 | 77.0 | 825 | 68.2 | 6101 | 68.0 |
| Cannabis | 569 | 36.7 | 494 | 41.1 | 880 | 38.0 | 537 | 41.0 | 43 | 47.8 | 449 | 34.7 | 493 | 40.7 | 3465 | 38.6 |
| Tobacco | 532 | 34.3 | 349 | 29.1 | 512 | 22.1 | 451 | 34.4 | 10 | 11.1 | 453 | 35.0 | 446 | 36.9 | 2753 | 30.7 |
| Prescription opioids | 303 | 19.6 | 236 | 19.7 | 784 | 33.9 | 254 | 19.4 | 26 | 28.9 | 276 | 21.3 | 315 | 26.0 | 2194 | 24.5 |
| Cocaine | 374 | 24.1 | 216 | 18.0 | 431 | 18.6 | 178 | 13.6 | 36 | 40.0 | 223 | 17.2 | 341 | 28.2 | 1799 | 20.1 |
| Crack | 90 | 5.8 | 49 | 4.1 | 258 | 11.1 | 76 | 5.8 | 8 | 8.9 | 155 | 12.0 | 152 | 12.6 | 788 | 8.8 |
| Amphetamines & other stimulants[1] | 42 | 2.7 | 262 | 21.8 | 85 | 3.7 | 107 | 8.2 | 22 | 24.4 | 121 | 9.4 | 95 | 7.9 | 734 | 8.2 |
| Total number of clients | 1549 | na | 1201 | na | 2314 | na | 1310 | na | 90 | na | 1293 | na | 1210 | na | na | |

DATIS 2014/15 [1] Excluding methamphetamines

[2] Numbers are low for the Coast sub-region due to lack of reporting of clients in the sub-region

**Figure 2.** Top Five Substances identified by Contacts in the North East LHIN to the Drug and Alcohol Helpline (2010 to 2014)






### *NE LHIN Youth Substance Use Trends*

There are important differences in patterns of substance use among youth living in northern Ontario[5] as compared to youth in other parts of the province. As examples, and according to a CAMH report on drug use among Ontario students (Ialomiteanu et al., 2014), students in the North East and North West LHINs are *more* likely to participate in the following behaviours:

- Use alcohol (72.5%; over 10% higher than the next highest LHIN).
- Binge drink in the past month (37%).
- Participate in hazardous/harmful drinking (25.6%).
- Drink while operating a snowmobile, motorboat, and/or ATV (for students in grades 10-12; 12.2%).

[5] Data for the North East LHIN were not reported separately.

Students in the North East and North West LHINs are *less* likely to participate in the following behaviours than counterparts in other LHINs:

- Use opioid pain relievers in past month (8.6%).
- Any non-medical prescription drug use (9.4%).

While the rates may appear lower than other areas of Ontario, the data are no doubt limited by exclusion of schools serving First Nations communities. In addition, about 8-10% of students reporting the use of non-medical prescription drugs is still very high and concerning.

### *FNIM Substance Use Trends*

The NE LHIN Aboriginal/First Nation and Métis Mental Health and Addictions Framework (2011) describes the mental health and substance use trends for FNIM populations in the NE of Ontario. Findings are described below. However, it is important to note that there is a paucity of FNIM mental health and substance use data as many administrative data sets do not capture FNIM status and government health surveys do not include populations on reserve.

Highlights from the framework include:

- Compared to non-FNIM people in Ontario, FNIM people are less likely to rate their health as excellent or very good (66.1 % versus 75.1 %).
- FNIM people also report a higher rate of excessive alcohol use (23.3% versus 16.3 %), a higher rate of smoking (40.3% versus 20.2%) and higher rates of prescription and illicit drug use than non-FNIM people.

In developing the framework, consultations were held with FNIM stakeholders to better understand their perception of mental health and substance use amongst this population in the NE of Ontario. Stakeholders identified the following main mental health and addictions issues:

- Historical trauma, including effects of Indian Residential Schools and Post Traumatic Stress Disorder and associated unresolved intergenerational grief.
- Unemployment and low income.
- Suicide and suicidal ideation.
- Depression, low self-esteem, hopelessness and learned dependency.
- Elder abuse, especially financial abuse.
- Substance abuse and addiction of all forms, including alcohol, prescription and illicit drugs and concurrent mental health challenges.
- Chemical-induced psychosis and dual disorders.
- Child and youth mental health issues.

In addition to the above noted challenges, participants from the Coast sub-region highlighted the following mental health and addictions issues (NE LHIN, 2011):

- Crisis proportions in suicide and suicidal ideation amongst youth.
- Solvent abuse, especially gasoline inhaling amongst youth.
- Isolation.

#### *3.1.1.3 Relevant data from the RHOC and Five Views Projects*

Highlights from the RHOC population survey and consumer interviews in Chelmsford and downtown Sudbury (Bernards et al., 2015; MacLeod et al., 2015) are summarized below under three sub-headings: indicators of need, seeking help, and suggestions for enhancing the system of services.

*(a) Indicators of need:*

Among the general population:

- High rates of harmful/hazardous drinking – 22% Chelmsford and 35% downtown Sudbury[6].
- Most commonly used illicit drugs were cannabis (16% and 30%, respectively); opioid medication without prescription (11% and 16%, respectively); cocaine (2% and 8%, respectively).
- Parental alcohol or drug use causing problems in the family was among the most common childhood stressors (27% and 34%, respectively).
- Met criteria for major depressive disorder and/or generalized anxiety disorder (27% and 31%, respectively.
- High levels of co-occurring mental health and substance use/addiction problems (11% and 8.7%, respectively, PLUS an additional percentage with these problems combined with physical aggression (4% and 11%, respectively).

Among past users of mental health or substance use services:

- High levels of co-occurring mental health and substance use/addiction problems (15.4% Chelmsford and downtown Sudbury) PLUS and additional percentage with these problems combined with violence (38% Chelmsford and 60% downtown Sudbury).
- High levels of trauma as a child: experienced violence as a child or teenager (35% and 72%, respectively).

[6] The same order of the communities is used in all the points identified

(b) *Seeking help*:

Among the general population getting help for emotional/mental health, alcohol/drug use or violence:

- 39% and 48% in Chelmsford and downtown Sudbury, respectively, reported getting help from at least one person or service, including family and friends.
- Family doctor or nurse practitioner the most common professional assessed for help (19% and 20%, respectively). Most people used multiple services including the emergency department and hospitals.
- Commonly reported barriers to receiving help included that they:
    - Thought they could deal with it on their own (68% and 66%, respectively.
    - Were embarrassed about what people might think (47% and 45%, respectively).

Among past users of mental health or substance use services:

- Common barriers to receiving help were:
    - Concerns or fears about what might happen to them.
    - Unable to get help (e.g., wait lists, not enough programs or right kind of help).
    - Events and relationship in the person's life.
    - Stigma (experience in emergency departments and by police rated the lowest in terms of being treated with dignity and respect).

- Best experience while getting help were reported as:
    - Someone who listened, understood them, explained things to them, helped navigate the system.
    - Learning to cope with and understand problems.

- Things that could have been better were:
    - Less wait time/more immediate help.
    - Having someone recognize the problem earlier.
    - Help navigating the system; better coordination/communication between services.

*(c) Suggestions to improve the system of services included:*

- More and better services.
- Improved access (e.g., shorter wait times, better access to free services, more evening programs, less red tape, childcare, transportation).
- More holistic services, services provided in one place, better coordination between services.
- Better information about available services and help navigating system.
- More compassionate, understanding and non-judgmental service providers.

### 3.1.2 Agency Profiles

As described in the Methods section, each substance use treatment agency funded in whole or in part by the NE LHIN was asked to complete an Agency Profile, using a template provided by the consulting team. A summary by sub-region can be found in Appendix 8. These summaries illustrate the range of diverse services that the service providers in the NE LHIN offer as well as a profile of the clientele (e.g., gender, age, language). For those that provide withdrawal management and residential services, information regarding number of beds, occupancy rate, and average length of stay is also included.

### 3.1.3 Case Descriptions

Case descriptions provided by a small number of agencies demonstrate the complexity of issues that clients are facing regarding their substance use and interconnected mental health, physical health, and determinants of health (e.g. housing, income, education, gender, race, etc.). These descriptions are useful in planning a system that ensures a range of services that are integrated and responsive to the complexity of needs presented. Two samples of case descriptions are presented in Tables 4 and 5. Refer to Appendix 9 for all NE LHIN addiction agencies' case descriptions submitted by stakeholders in the community.

The clients described in the agency case descriptions present with a range of very complex and intersecting health and social issues. With respect to substance use, most clients had issues with more than one substance, usually including alcohol. They also typically had a long history of use, with some clients' use beginning in childhood. Patterns of use varied; some clients had a clear progression from occasional to severe and chronic use; others had alternating periods of severe use, followed by sobriety when they were engaged with treatment services.

With few exceptions, clients also presented with a range of mental health issues such as anxiety, depression, post-traumatic stress disorder and suicidality. Several clients reported using to cope with a history of trauma, including physical and sexual abuse and loss. Clients commonly had co-occurring physical health problems, such as pain, cognitive deficits secondary to brain injuries, or prolonged substance use, and malnourishment. Most clients also had a range of other life issues including involvement with the criminal justice system, difficulties maintaining safe housing, financial hardship and social isolation.

Most clients had been in contact with a range of treatment services, including mental health, withdrawal management services, and community and residential treatment. Several had had repeat hospitalizations. A small number had exhausted their treatment options due to behavioural/compliance issues while in care.

**Table 4.** Case Description - Manitoulin Community Withdrawal Management Service – Manitoulin Island

| | |
|---|---|
| **Client** | 30 year old FNIM male |
| **Presenting Problems** | • Alcohol dependent and uses cannabis at times. Presenting with symptoms of withdrawal. He was not eligible for in home withdrawal due to being prone to seizures.<br>• Had depression symptoms.<br>• Diagnosed as globally developmentally challenged. Frequently accessed services intoxicated and resisted follow-through. However, has been to treatment in the past three times and experienced sobriety for short periods of time.<br>• Low social supports and feels abandoned by his family.<br>• Experienced periods of homelessness and chose to live on the streets in the summer time returning for services periodically in desperation to make a change. Spends his ODSP cheque on alcohol use and pan handles to get more money for alcohol and drugs. Would often present or call to the local hospital and our service intoxicated and desperate to make changes. |
| **Medications** | • Prescribed an antidepressant but was non-compliant. |
| **Treatment History** | • Attended three short term residential treatment centres and two long term centres. He would frequently attend residential WMS services off of the Island, local hospital, mental health and the community withdrawal management service. |
| **Substance Use Profile** | • He left long term treatment to use substances. Alcohol is his drug of choice. On average drinks to intoxication daily and if no alcohol was available would drink Listerine. |
| **Admission** | • On-going visits and support and weekly phone calls requesting help to quit drinking. He would hitch hike to access services when transportation was not accessible.<br>• Mental health: had difficulty remembering appointments, locations, and names. Needs included; money management, stable housing, and developmental services. However, he declined these services. |
| **Length of Service** | • Mostly brief interactions but high frequency for 8 years. On average most interactions were to connect him to withdrawal management off-Island and to set up transportation. Accessed ADAT assessments to attend treatment. |
| **Scheduled Counselling Sessions** | • Average sessions booked were not attended to follow through with care. On average, drop in, crisis calls or requests for residential WMS. Many times he would leave the residential services and return to the streets or home. |
| **Treatment Summary** | • This program does not provide treatment and are short-term services connecting this person to treatment options. The difficulties were in accessing transportation, the delay in treatment (keeping him engaged until treatment) and his anxiety about going somewhere new. WMS services would often be full or too far to travel for ill patients such as this individual. |

**Table 5.** Case Description - Monarch Recovery Services – Women's Aftercare

| | |
|---|---|
| **Client** | 30 year old female currently living in the Sudbury Area |
| **Presenting Problems** | • Substance abuse<br>• History of child sexual abuse by multiple family members/friend<br>• History of suicide attempts and self-mutilation<br>• Child died of Sudden Infant Death Syndrome (SIDS)<br>• Mental Health Diagnoses**:**<br>  o Adult ADHD, bipolar disorder with depressed features, prolonged bereavement reaction, PTSD<br>  o Borderline personality traits and anti-social personality traits<br>• Legal issues: 18 months on probation and restitution for Theft under $5000, Fraud under $5000, Utter Forged Document and Breach Probation<br>• Physical health:<br>  o tumor on her uterus; doctors to confirm need for complete hysterectomy<br>  o chronic pain |
| **Medications** | • No mental health medications;<br>• Pain medications for chronic nerve pain in legs (which has not been fully diagnosed as to the cause of such pain) |
| **Treatment History** | • Seven treatment episodes between 2009 and 2013 |
| **Substance Use Profile** | • First drink at age 11; client reports that she has drank twice since January 2014<br>• Smoked pot at 12.<br>• Started using amphetamines in 2012 3-4 times a week, 2-3 pills.<br>• First used Cocaine in 2001, used a gram twice a year. In 2013 started using crack daily. Client reports using crack twice since March 2013. |
| **Treatment Summary** | Client is currently active in treatment and supportive housing. There have been many ups and downs with this client throughout the years that she has been involved with Monarch. Her daughter of two months died in 2010 from SIDS, and she sought out treatment from us two years after and has been diagnosed with Prolonged Bereavement Reaction. Her struggles with her grief increased this past year after she gave birth to another baby girl. Referrals to HSN, Mood and Anxiety program has been made with the hopes that she will be seen for her PTSD as well. She is also involved with Healthy Babies, (Health Unit) and CAS.<br><br>This client often has severe flashbacks of her trauma and feelings of guilt related to death of her daughter; despite her grief, she has been an excellent mother and has had a lot of success in her recovery. She stated that she has had a few slips but has not used in excess since 2013. She does pose a challenge to staff as she often talks about suicide. However, there have been no attempts since late 2012. She does, on occasion, still self-mutilate by cutting. In the past it was much more severe requiring medical attention; this behaviour seemed to subside after she has stable housing with ASH.<br><br>She does check in with staff on a daily basis to assess her day as per CAS. They are concerned that her depression/grief will be too much for her and they are concern for the safety of her daughter. She has complied with this request but does feel like she is being punished because she is sad that her first daughter died. |
| **Additional Information** | The plan for this client is to start DBT with her case manager from ASH. She is also currently attending a trauma workshop and tries to come to aftercare groups on Monday nights when she has a sitter. Will continue to work closely with client until she starts with counselling at another centre in their Mood and Anxiety program and starts individual counselling for her PTSD; anticipate involvement with client for many years to come. |

### 3.1.4 Service Utilization

#### *3.1.4.1 ConnexOntario Referral Recommendations: Patterns In and Out of the NE LHIN*

Referral recommendations offered to callers contacting ConnexOntario for treatment availability show different patterns for withdrawal management (Figure 3), residential treatment (Figure 4) and community treatment (data not shown). The large majority of referral recommendations for *residential withdrawal* services are made to callers from within the NE LHIN (n=576), with some "traffic" in and out as well. For *residential medical withdrawal managemen*t some referral recommendations were made from inside the LHIN to outside, perhaps to CAMH Toronto.

In contrast, the majority of referral recommendations for *residential treatment* involving the NE LHIN are offered to callers from outside the region (N= 4963) compared to those calling from inside the LHIN: N=1263 calls for "inside to inside" recommendations and N=2421 for recommendations "inside to outside" the LHIN (Figure 4). This may reflect the greater acceptance of clients on methadone among NE LHIN residential services compared to residential services in other parts of Ontario.

As one would expect, based on the nature of *community treatment*, referral recommendations to this level of care within the LHIN are made almost exclusively to callers from within the LHIN (data not shown).

**Figure 3.** Connex Ontario Withdrawal Management Referral Recommendations – NE LHIN (August 2013 – June 2015)

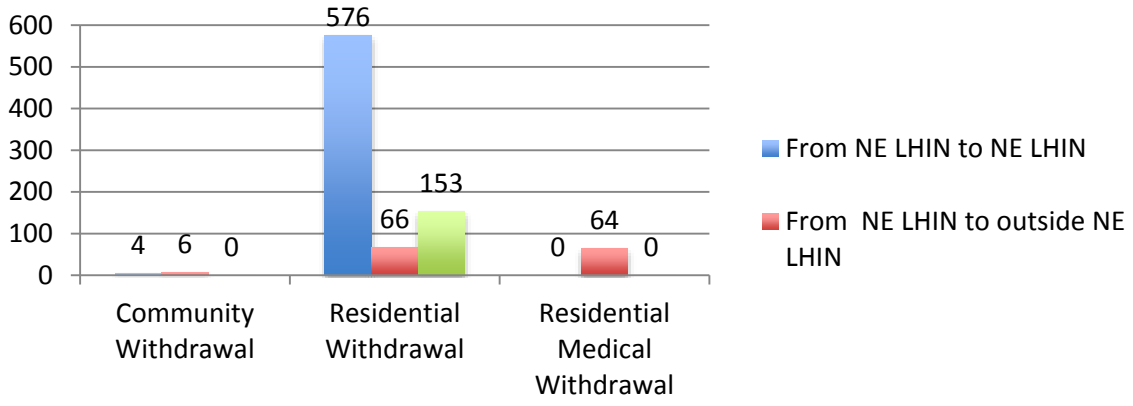
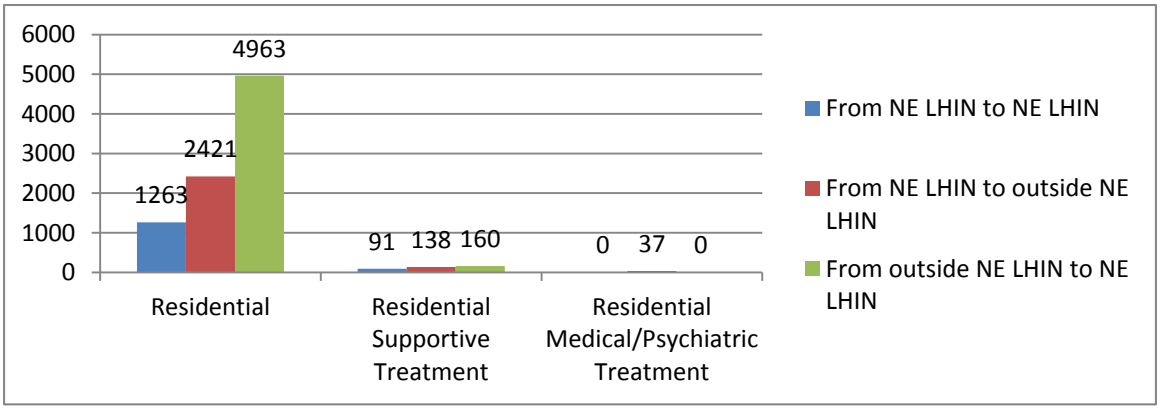


**Figure 4:** ConnexOntario Residential Treatment Referral Recommendations – NE LHIN (August 2013 – June 2015)




### *3.1.4.2 DATIS: Utilization of Specialized Addiction Services*

This section describes substance use service utilization in the NE LHIN among service providers reporting to DATIS. The data describe who is accessing the specialized substance use services in the NE LHIN, as well as movement of clients across the sub-regions.

The numbers of new individuals served by provincial service category and by sub-region of client residence are presented in Table 6. Throughout the NE LHIN the type of treatment individuals are accessing will reflect a number of factors including population size (note the data are organized by residence of the client) as well as the nature of treatment and support services offered by regional providers.

Important highlights of these data include:

- Of the total number of new admissions in 2014-15 (N= 11,591), 4340 were in residential WMS; 3155 were in community treatment, 149 in day/evening treatment, and 992 in residential treatment.
- With respect to withdrawal management, clearly the majority of cases are in residential versus community withdrawal management *(Note: 143 cases of the 144 cases reported to DATIS from the Manitoulin Community Withdrawal Management Service were reported under Case Management).*
- Combining community and day/evening treatment, this represents a ratio of 3304/1399 = 2.4:1 relative to short-term and supportive residential treatment. The ratio is 3.6 to 1 if cases residing outside the NE LHIN jurisdiction are excluded.
- There is very limited use of day/evening services due to lack of availability of this level of care in the entire region. Also the 42 cases in the Cochrane area may not reflect the current situation as the day program at Jubilee Centre is no longer operational.

- There is a high proportion of cases (45.2%) in the region's residential treatment services who reside outside of the region.
- The relatively low number of cases in supportive housing (n=66) probably underestimates the real situation due to lack of reporting o DATIS by some services outside the addiction agencies (e.g., within community mental health). The addiction cases may also be reported under case management or community treatment.

**Table 6.** New Admissions Who Received Substance Abuse Treatment in the NE LHIN, By Service Category and Sub-Region of Client Residence (Fiscal Year 2014/2015) - DATIS

| Provincial Service Category | NE LHIN Sub-Region of Client Residence | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Algoma | | Cochrane | | Sudbury-Manitoulin-Parry Sound | | Nipissing-Temiskaming | | James Bay and Hudson Bay Coast | | No Fixed Address | | Outside Region | | Total NE LHIN | Total % |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | | |
| Case Management | 334 | 13.5 | 476 | 19.2 | 864 | 34.8 | 352 | 14.2 | 29 | 1.2 | 184 | 7.4 | 242 | 9.8 | **2481** | **100.0** |
| Community Treatment | 783 | 24.8 | 699 | 22.2 | 635 | 20.1 | 702 | 22.3 | 24 | 0.8 | 151 | 4.8 | 161 | 5.1 | **3155** | **100.0** |
| Community Day/Evening Treatment Services | 5 | 3.4 | 42 | 28.2 | 12 | 8.1 | 42 | 28.2 | 2 | 1.3 | 12 | 8.1 | 34 | 22.8 | **149** | **100.0** |
| Residential Treatment Services | 89 | 9.0 | 112 | 11.3 | 165 | 16.6 | 129 | 13.0 | 13 | 1.3 | 36 | 3.6 | 448 | 45.2 | **992** | **100.0** |
| Residential Support Treatment Services | 29 | 7.1 | 83 | 20.4 | 49 | 12.0 | 29 | 7.1 | 10 | 2.5 | 119 | 29.2 | 88 | 21.6 | **407** | **100.0** |
| Community Withdrawal Management Services | 0 | 0.0 | 0 | 0.0 | 1 | 100.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | **1** | **100.0** |
| Residential Withdrawal Management Services | 694 | 16.0 | 280 | 6.5 | 1226 | 28.2 | 381 | 8.8 | 55 | 1.3 | 983 | 22.6 | 721 | 16.6 | **4340** | **100.0** |
| Support Within Housing | 24 | 36.4 | 14 | 21.2 | 3 | 4.5 | 6 | 9.1 | 1 | 1.5 | 16 | 24.2 | 2 | 3.0 | **66** | **100.0** |
| **Total by Sub-Region** | **1958** | **16.9** | **1706** | **14.7** | **2955** | **25.5** | **1641** | **14.2** | **134** | **1.2** | **1501** | **12.9** | **1696** | **14.6** | **11591** | **100.0** |

Table 7 presents data that illustrate the movement of individuals who received substance use treatment in the five sub-regions of the NE LHIN based on their sub-region of residence. These data reflect service use patterns only for service providers reporting to DATIS, for example, excluding FNIM treatment programs funded exclusively with Federal funding, and potentially concurrent disorder services operated by CMHA.

Although the data show that the majority of clients (between 60% and 70% - see shaded columns) received services in their sub-region of residence, there is also quite a bit of movement between sub-regions. In addition there are a large number of unknowns related to either "no fixed address" or "other region" listed as location of residence. The majority of those with no fixed address can be assumed to live in the sub-region unless they are from away and chose not to give their address at the point of intake. This is difficult to estimate.

Individuals living outside the region but who are served by a service provider within the region represented 13.5% of all new admissions in 2014-15. The largest proportion of new admissions who reside outside the region are served in the Algoma region (20.3%) and Nipissing-Temiskaming (20.3%). Agencies in the Sudbury-Manitoulin-Parry Sound sub-region serve the smallest proportion of residents living outside the region (6.7%). These sub-regional patterns clearly reflect the data from individual residential treatment centres within each respective area, with Cochrane and Sudbury-Manitoulin-Parry Sound being more heavily invested in non-residential services, comparatively speaking.

With respect to the Coast sub-region, the WAHA mental health and addiction program has no data represented in the table as they were not reporting to DATIS during this period (2014-15). Individuals from the Coast sub-region are, however, represented in the data (N= 90), in particular accessing services in the Cochrane area (N=69), no doubt the withdrawal management program at Smooth Rock Falls.

**Table 7.** New Admissions Who Received Substance Abuse Treatment in the NE LHIN, by Agency and Sub-Region of Client Residence (Fiscal Year 2014/2015) - DATIS

| Treatment Agency[7] | NE LHIN Sub-Region of Client Residence | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Algoma | | Cochrane | | Sudbury Manitoulin | | Nipissing Temiskaming | | James Bay and Hudson Bay Coast | | No Fixed Address | | Outside Region | | Total by Treatment Agency (and sub-region of treatment agency) | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| **Algoma** | | | | | | | | | | | | | | | | |
| Algoma Family Services (10206) | 126 | 92.6 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 2.2 | 7 | 5.1 | 136 | 100.0 |
| Benbowopka Treatment Centre (10218) | 9 | 16.7 | 14 | 25.9 | 12 | 22.2 | 2 | 3.7 | 6 | 11.1 | 0 | 0.0 | 11 | 20.4 | 54 | 100.0 |
| Breton House (10213) | 49 | 79.0 | 3 | 4.8 | 1 | 1.6 | 1 | 1.6 | 0 | 0.0 | 1 | 1.6 | 7 | 11.3 | 62 | 100.0 |
| Community Alcohol/Drug Assessment Program, Algoma Public Health (10229) | 345 | 91.8 | 0 | 0.0 | 2 | 0.5 | 0 | 0.0 | 0 | 0.0 | 16 | 4.3 | 13 | 3.5 | 376 | 100.0 |
| Counselling Centre of East Algoma, Family Addictions Program (10049) | 76 | 96.2 | 0 | 0.0 | 2 | 2.5 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 1.3 | 79 | 100.0 |
| Ken Brown Recovery Home (10207) | 14 | 23.0 | 4 | 6.6 | 3 | 4.9 | 2 | 3.3 | 0 | 0.0 | 17 | 27.9 | 21 | 34.4 | 61 | 100.0 |
| Sault Area Hospital Community Addiction Services (10043) | 728 | 67.3 | 5 | 0.5 | 10 | 0.9 | 0 | 0.0 | 0 | 0.0 | 145 | 13.4 | 194 | 17.9 | 1082 | 100.0 |
| St. Joseph's General Hospital Elliot Lake (10221) | 85 | 20.0 | 7 | 1.6 | 95 | 22.3 | 23 | 5.4 | 2 | 0.5 | 6 | 1.4 | 208 | 48.8 | 426 | 100.0 |
| **Total for Algoma by Sub-Region of Client Residence** | **1432** | **62.9** | **33** | **1.4** | **125** | **5.5** | **28** | **1.2** | **8** | **0.4** | **188** | **8.3** | **462** | **20.3** | **2276** | **100.0** |

[7] No data by name and location of provider are included here for the James Bay and Hudson Bay Coasts as the WAHA Mental Health and Addiction program did not report information to DATIS during this period.

| Treatment Agency[7] | NE LHIN Sub-Region of Client Residence | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Algoma | | Cochrane | | Sudbury Manitoulin | | Nipissing Temiskaming | | James Bay and Hudson Bay Coast | | No Fixed Address | | Outside Region | | Total by Treatment Agency (and sub-region of treatment agency) | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| **Cochrane** | | | | | | | | | | | | | | | | |
| Cochrane Region Detox Centre (10225) | 5 | 1.4 | 202 | 56.7 | 12 | 3.4 | 14 | 3.9 | 42 | 11.8 | 55 | 15.4 | 26 | 7.3 | 356 | 100.0 |
| Jubilee Centre Inc. (10241) | 5 | 2.4 | 91 | 43.5 | 14 | 6.7 | 3 | 1.4 | 4 | 1.9 | 46 | 22.0 | 46 | 22.0 | 209 | 100.0 |
| Maison Arc-En-Ciel (10036A)[1] | 2 | 3.3 | 6 | 10.0 | 6 | 10.0 | 0 | 0.0 | 0 | 0.0 | 18 | 30.0 | 28 | 46.7 | 60 | 100.0 |
| Maison Renaissance (10036) | 1 | 1.3 | 43 | 53.8 | 0 | 0.0 | 12 | 15.0 | 0 | 0.0 | 2 | 2.5 | 22 | 27.5 | 80 | 100.0 |
| North Cochrane Addictions Services Inc. (NCAS) (10255) | 4 | 0.8 | 439 | 84.6 | 6 | 1.2 | 7 | 1.3 | 22 | 4.2 | 33 | 6.4 | 8 | 1.5 | 519 | 100.0 |
| South Cochrane Addiction Services (10179) | 0 | 0.0 | 280 | 91.5 | 4 | 1.3 | 0 | 0.0 | 1 | 0.3 | 8 | 2.6 | 13 | 4.2 | 306 | 100.0 |
| Turning Point Decisif (11743) | 0 | 0.0 | 8 | 100.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 8 | 100.0 |
| **Total for Cochrane by Sub-Region of Client Residence** | **17** | **1.1** | **1069** | **69.5** | **42** | **2.7** | **36** | **2.3** | **69** | **4.5** | **162** | **10.5** | **143** | **9.3** | **1538** | **100.0** |
| **Sudbury- Manitoulin-Parry Sound** | | | | | | | | | | | | | | | | |
| Health Sciences North/Horizon Santé-Nord (10378) | 32 | 1.3 | 48 | 2.0 | 1480 | 62.4 | 70 | 3.0 | 7 | 0.3 | 615 | 25.9 | 120 | 5.1 | 2372 | 100.0 |
| Manitoulin Community Withdrawal Management Service (11737) | 3 | 2.1 | 0 | 0.0 | 139 | 96.5 | 1 | 0.7 | 0 | 0.0 | 0 | 0.0 | 1 | 0.7 | 144 | 100.0 |
| Monarch Recovery Services (10304) | 37 | 6.2 | 13 | 2.2 | 338 | 56.5 | 17 | 2.8 | 1 | 0.2 | 108 | 18.1 | 84 | 14.0 | 598 | 100.0 |
| N'Swakamok Native Friendship Centre (10243) | 0 | 0.0 | 2 | 1.7 | 97 | 80.2 | 0 | 0.0 | 1 | 0.8 | 10 | 8.3 | 11 | 9.1 | 121 | 100.0 |

| Treatment Agency[7] | NE LHIN Sub-Region of Client Residence | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Algoma | | Cochrane | | Sudbury Manitoulin | | Nipissing Temiskaming | | James Bay and Hudson Bay Coast | | No Fixed Address | | Outside Region | | Total by Treatment Agency (and sub-region of treatment agency) | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | N | % |
| **Total for Sudbury-Manitoulin-Parry Sound by Sub-Region of Client Residence** | **72** | **2.2** | **63** | **1.9** | **2054** | **63.5** | **88** | **2.7** | **9** | **0.3** | **733** | **22.7** | **216** | **6.7** | **3235** | **100.0** |
| **Nipissing Temiskaming** | | | | | | | | | | | | | | | | |
| North Bay Recovery Home (10194) | 1 | 0.8 | 6 | 4.7 | 8 | 6.3 | 37 | 28.9 | 0 | 0.0 | 22 | 17.2 | 54 | 42.2 | 128 | 100.0 |
| North Bay Regional Health Centre (50927) | 27 | 2.5 | 30 | 2.7 | 81 | 7.4 | 453 | 41.3 | 4 | 0.4 | 179 | 16.3 | 322 | 29.4 | 1096 | 100.0 |
| Alliance Centre, Addiction Counselling For Youth and Adults (10178) | 0 | 0.0 | 0 | 0.0 | 3 | 1.9 | 153 | 97.5 | 0 | 0.0 | 1 | 0.6 | 0 | 0.0 | 157 | 100.0 |
| Canadian Mental Health Association and Temiskaming Health Unit (50211) | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 199 | 98.5 | 0 | 0.0 | 0 | 0.0 | 3 | 1.5 | 202 | 100.0 |
| Community Counselling Centre - Addiction Services of Nipissing (10180) | 0 | 0.0 | 0 | 0.0 | 1 | 0.3 | 316 | 94.3 | 0 | 0.0 | 8 | 2.4 | 10 | 3.0 | 335 | 100.0 |
| **Total for Nipissing-Temiskaming by Sub-Region of Client Residence** | **28** | **1.5** | **36** | **1.9** | **93** | **4.8** | **1158** | **60.4** | **4** | **0.2** | **210** | **10.9** | **389** | **20.3** | **1918** | **100.0** |
| **Total for NE LHIN** | **1549** | **17.3** | **1201** | **13.4** | **2314** | **25.8** | **1310** | **14.6** | **90** | **1.0** | **1293** | **14.4** | **1210** | **13.5** | **8967** | **100.0** |

[1] Maison Arc-en-Ciel had 14 residential addictions admissions in 2014-15. The remainder recorded here are follow up, case management, cases.

With regard to client characteristics, Table 8 outlines the characteristics of new admissions to substance use treatment in the 2014/2015 fiscal year in the NE LHIN. The data show that more men than women are receiving treatment across the region (66% men versus 34% women). In terms of age, the largest proportion of new admissions served is between the ages of 25 and 34 (31%). Individuals under the age of 16 and over the age of 65 both represent only 2% of new admissions. Individuals between the ages of 16 and 24, often referred to as "transition age youth" because many will be transitioning from youth to adult services, represent almost 20% of all new admissions.

The main sources of income for clients was Ontario Works (25.6%), ODSSP (24%) and employment (17%); just over 10% reported no source of income.

Thirty percent (30%) of new admissions were FNIM, which is disproportionately high compared to their proportion in the general population in the region (about 11%). Considering FNIM clients who are residents of the NE Region the percentage of the total client population is estimated at 35%.

As shown previously with regard to presenting issues at time of treatment, the data show that alcohol (63%), cannabis (41%), and tobacco (30%) are the most common issues among clients seeking treatment across the region. Although the use of prescription opioids (25%) is reportedly less than alcohol and cannabis use, it is the drug of choice for a quarter of clients in the NE LHIN who are accessing these services. Slightly fewer report cocaine (21%) as their presenting problem substance.

The comparison of the NE LHIN clients to clients in the remainder of the Ontario system is informative.

- The gender distribution is about the same.
- Percentage of clients under the age of 16 is somewhat lower (1.6% vs 2.4%).
- Percentage of clients who are unemployed, on ODSP or other disability insurance or Ontario Works is significantly higher on all these categories.
- Percentage of FNIM clients is significantly higher (30.1% vs 6.5%).
- Reporting of prescription opioids among presenting problem substance is higher (24.5% vs 17.6%).

**Table 8.** Characteristics of New Admissions Who Received Substance Abuse Treatment in the North East LHIN (Fiscal Year 2014/15) - DATIS

| Characteristic | NE LHIN | | Ontario (excluding NE LHIN) | |
|---|---|---|---|---|
| | New Admissions | | | |
| **Gender** | N | % | N | % |
| Male | 5913 | 65.9 | 41250 | 67.3 |
| Female | 3053 | 34.0 | 19954 | 32.5 |
| Other | 0 | 0.0 | 113 | 0.2 |
| *Total* | *8967* | *100.0* | 61317 | 100.0 |
| **Age Group** | | | | |
| Under 16 | 139 | 1.6 | 1496 | 2.4 |
| 16-24 | 1760 | 19.6 | 11498 | 18.8 |
| 25-34 | 2740 | 30.6 | 17475 | 28.5 |
| 35-44 | 1824 | 20.3 | 12449 | 20.3 |
| 45-54 | 1423 | 15.9 | 11372 | 18.5 |
| 55-64 | 902 | 10.1 | 5416 | 8.8 |
| 65 and over | 179 | 2.0 | 1611 | 2.6 |
| Total | 8967 | *100.0* | 61317 | 100.0 |
| **Source of Income** | | | | |
| Employment | 1506 | 16.8 | 15212 | 24.8 |
| Employment Insurance | 432 | 4.8 | 2312 | 3.8 |
| ODSP (Ontario Disability Support Program) | 2105 | 23.5 | 10995 | 17.9 |
| Disability Insurance | 319 | 3.6 | 1557 | 2.5 |
| Other Insurance (excluding Employment Insurance) | 54 | 0.6 | 402 | 0.7 |
| Ontario Works | 2293 | 25.6 | 13024 | 21.2 |
| Retirement Income | 227 | 2.5 | 2000 | 3.3 |
| Other | 293 | 3.3 | 2487 | 4.1 |
| None | 933 | 10.4 | 5771 | 9.4 |
| Family Support | 497 | 5.5 | 5463 | 8.9 |
| Unknown | 221 | 2.5 | 1893 | 3.1 |
| Missing | 26 | 0.3 | 201 | 0.3 |

| Characteristic | NE LHIN | | Ontario (excluding NE LHIN) | |
|---|---|---|---|---|
| | New Admissions | | | |
| **Gender** | N | % | N | % |
| *Total* | *8967* | *100.0* | 61317 | 100.0 |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 2695 | 30.1 | 3955 | 6.5 |
| Non-FNIM | 6272 | 69.9 | 57356 | 93.5 |
| *Missing* | *0* | *0.0* | 6 | 0.0 |
| *Total* | *8967* | *100.0* | 61317 | 100.0 |
| **Presenting Problem Substances** | | | | |
| None | 245 | 2.7 | 1304 | 2.1 |
| Alcohol | 6101 | 68.0 | 41144 | 67.1 |
| Cocaine | 1799 | 20.1 | 11078 | 18.1 |
| Amphetamines. & other stimulants exc. methamphetamines | 734 | 8.2 | 1883 | 3.1 |
| Cannabis | 3465 | 38.6 | 21060 | 34.3 |
| Benzodiazepines | 441 | 4.9 | 2189 | 3.6 |
| Barbiturates | 25 | 0.3 | 139 | 0.2 |
| Heroin/Opium | 197 | 2.2 | 2871 | 4.7 |
| Prescription opioids | 2194 | 24.5 | 10822 | 17.6 |
| Over-the-counter codeine preparations | 142 | 1.6 | 881 | 1.4 |
| Hallucinogens | 89 | 1.0 | 539 | 0.9 |
| Glue & other inhalants | 30 | 0.3 | 100 | 0.2 |
| Tobacco | 2753 | 30.7 | 18312 | 29.9 |
| Other psychoactive drugs | 95 | 1.1 | 770 | 1.3 |
| Steroids | 9 | 0.1 | 100 | 0.2 |
| Crack | 788 | 8.8 | 8236 | 13.4 |
| Ecstasy | 66 | 0.7 | 977 | 1.6 |
| Methamphetamines (crystal meth.) | 152 | 1.7 | 4744 | 7.7 |
| Unknown | 71 | 0.8 | 676 | 1.1 |
| Missing | 0 | 0.0 | 7 | 0.0 |

### 3.1.5 Other Health Service Utilization

***Institute for Clinical Evaluative Sciences (ICES) – Health Service Utilization Data***

As noted earlier, there is significant migration of the population within the NE LHIN from one sub-region to another, for example, for work or school or due to weather conditions (as in the Coast sub-region), and due to frequent severe flooding. Thus, people whose official residence may be in one sub-region may use services outside their area. One key indicator of service access is the extent to which the population travels to other regions for addictions-related health care, for example, utilization of inpatient mental health care or other hospital care. Data provided by ICES assist in this mapping of health service utilization, including physician-delivered opiate substitution services, across the NE LHIN as a whole and within its sub-regions.

This section presents the nature and level of "in-the-area" and "out-of-the-area" addiction-related health service utilization among the adult population of each sub-region in the NE LHIN. For the purposes of this analysis, addiction–related care is defined by having a positive response to any one of the following[8]:

a. At least one physician OHIP claim for substance-related diagnostic codes in ICD- 8.
b. At least one discharge from a non-mental health bed (i.e., recorded in the Discharge Abstract Database) for a primary or secondary substance-related diagnosis.
c. At least one discharge from a mental health hospital bed (i.e., recorded in Ontario Mental Health Reporting Systems, OMHRS) for a substance-related primary or secondary diagnosis.
d. At least one emergency room visit/event recorded in National Ambulatory Care Reporting System (NACRS) for a substance-related diagnosis.

For our purposes here, ICES analysts first identified all individuals with any service event related to substance use according to the study definitions as defined above and in Appendix 6. They then calculated the total number of such encounters for these individuals[9]. These data <u>for all service types combined</u> are shown in Table 9 below - subsequent tables report separately for the different types of service utilization, namely, physician visits, hospital discharges (non-mental health beds and mental health hospital beds) and ED visits. A table also follows that reports on opiate maintenance treatment (methadone and buprenorphine/Suboxone) by sub-region of residence and total.

The rows for each region are based on the location of the individual and the columns reflect the location of the provider. The data in each cell of the table show both the

[8] See Appendix65 for the precise codes used for each database
[9] A parallel set of tables was prepared based on the number of individuals not encounters. We have elected to use the encounter data as it better reflects the overall level of service utilization related to substance use (except for opiate maintenance treatment where we report both encounters and individuals).

absolute number of encounters recorded for these individuals and then standardized according to the size of the population in the sub-region. Standardization per 1000 population allows for comparison across sub-regions and the rest of Ontario (i.e. excluding the NE LHIN). For comparative purposes the Ontario totals, excluding the NE LHIN data, are reported in the text and at the bottom of each individual table.

The ~ symbol denotes that the data in the cells are estimates. Since some of the individual cells in these tables included small cell sizes, contraindicated by ICES reporting policy, ICES analysts rounded all data to avoid reporting a significant number of blank cells. While the data may be "estimated" in this way they are assuredly are very close to the actual numbers.

*Any substance use health service encounter:* For residents in regions in Ontario outside the NE LHIN, the overall encounter rate for any of the above types of substance-related service events was 457.2 per 1000 population. As can be seen in Table 9, the overall substance use-related encounter rate for residents of the NE LHIN is double that at approximately 911.6 per 1000 population (ranging from a high of 1027.2 in Sudbury-Manitoulin-Parry Sound to a low of 513.8 per 1000 population in James Bay and Hudson Bay Coasts). Importantly, these data reflect the availability of certain services in the Coast sub-region, for example, there are no acute care mental health beds. Availability of services will affect other regional data as well (both row and columns totals and individual cells).

Across the sub-regions one observes significant variation in the utilization of services outside the LHIN region (second last column on the right). Whereas the overall rate for out-of-region services is 226.5 per 1000 population, residents of Algoma primarily utilize services in their sub-region (with only 56.3 per 1000 going anywhere outside the region). Residents of other areas, including the James Bay and Hudson Bay Coasts sub-region, are more likely to access services outside the NE LHIN. A significant rate of encounters among residents in the Cochrane sub-region occurs in Sudbury-Manitoulin/Parry Sound, perhaps reflecting access to services at Health Sciences North in Sudbury.

**Table 9.** Encounter Rate per 1000 Population, Patient Had at Least One Substance-Use Related OHIP Visit, DAD Discharge, OMHRS Discharge or ED Visit during the 2012 fiscal year in the NE LHIN

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma<br>n(rate per 1000) | Cochrane<br>n(rate per 1000) | James Bay and Hudson Bay Coast<br>n (rate per 1000) | Sudbury-Manitoulin-Parry Sound<br>n(rate per 1000) | Nipissing-Temiskaming<br>n(rate per 1000) | Outside Region<br>n(rate per 1000) | Total Ontario for NE LHIN residents<br>n(rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~56,900 (~561.0) | ~260 (~2.6) | 0 (0) | ~6200 (~60.7) | ~980 (~9.7) | ~5700 (~56.3) | ~70040 (~690.3) |
| | Cochrane | ~75 (~1.1) | ~27,800 (~401.3) | ~50 (~0.7) | ~8900 (~129.1) | ~260 (~3.8) | ~21,400 (~309.7) | ~58485 (~845.6) |
| | James Bay and Hudson Bay Coast | < 10 | ~420 (~86.2) | ~690 (~141.6) | ~50 (~10.5) | ~35 (~7.6) | ~1300 (~267.2) | ~2505 (~513.8) |
| | Sudbury-Manitoulin-Parry Sound | ~540 (~2.8) | ~420 (~2.2) | < 10 | ~158,900 (~837.7) | ~2000 (~10.7) | ~33,000 (~173.7) | ~194,870 (~1027.2) |
| | Nipissing-Temiskaming | ~320 (~2.7) | ~10,100 (~85.7) | < 10 | ~7000 (~59.7) | ~49,000 (~415.7) | ~48,000 (~407.2) | ~114,430 (~971.0) |
| | Total NE LHIN | ~57,845 (~119.7) | ~39,000 (~80.7) | ~ 760 (~1.6) | ~181,050 (~374.8) | ~52,275 (~108.3) | ~109,400 (~226.5) | ~440330 (~911.6)[1] |

***[1]Total NE LHIN = 911.6 per 1000. The total for the rest of Ontario = 457.2 per 1000. Differential is 2.0 to 1.***

Source: ICES AHRQ Project 2016 0900 775 000

Patterns of encounters with physicians for substance-related concerns (see Table 10) are virtually identical to those described above for all types of encounters, as physician visits undoubtedly account for the majority of encounters. The substance use-related encounter rate for residents of the NE LHIN (879.9 per 1000 population is about double that of the rate among residents of regions of Ontario outside the NE LHIN (439.6 per 1000 population).

Patterns and variation across the sub-regions are similar to that shown above, again since physician encounters account for the bulk of service utilization encounters.

**Table 10.** Encounter Rate per 1000 Population, Patient had at Least One OHIP Visit During the 2012 Fiscal Year in the NE LHIN

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | n (rate per 1000) | N (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~54290 (~535.4) | ~250 (~2.5) | 0(0) | ~5980 (~59.0) | ~960 (~9.43) | ~5330 (~52.6) | ~66810 (~658.9) |
| | Cochrane | ~60 (~0.8) | ~25220 (~364.1) | ~20 (~0.3) | ~8850 (~127.8) | ~230 (~3.3) | ~21270 (~307.1) | ~55650 (~803.45) |
| | James Bay and Hudson Bay Coast | < 10 | ~230 (~47) | ~150 (~29.8) | ~20 (~4.7) | ~20 (~3.1) | ~1060 (~217.4) | ~1490 (~302.6) |
| | Sudbury-Manitoulin-Parry Sound | ~500 (~2.6) | ~350 (~1.9) | < 10 | ~154510 (~814.6) | ~1890 (~10.0) | ~32240 (~170.0) | ~189500 (~999.0) |
| | Nipissing-Temiskaming | ~300 (~2.5) | ~10050 (~85.3) | < 10 | ~6940 (~58.9) | ~46680 (~396.1) | ~47660 (~404.4) | ~111640 (~947.1) |
| | Total NE LHIN | ~5160 (~114.2) | ~36100 (~74.7) | ~190 (~0.4) | ~176300 (~365.0) | ~49780 (~103.0) | ~107560 (~222.7) | ~425090 (~879.9)[1] |

***[1]Total NE LHIN = 879.9 per 1000. The total for the rest of Ontario = 439.6 per 1000. Differential is 2.0 to 1.***

Source: ICES AHRQ Project 2016 0900 775 000

With respect to individuals who had at least one substance-use related discharge from a non-mental health hospital bed (see Table 11), the encounter rates are significantly lower than physician utilization since they reflect hospital discharges. However, some patterns still apply, including the approximate doubling of service utilization compared to residents living in other regions of Ontario (8.7 per 1000 compared to 3.8 per 1000 population: data not shown). Overall encounter rates by sub-region vary substantially with the highest rate found for residents in the James Bay and Hudson Bay Coasts (34.7 per 1000 population) utilizing services either in their sub-region, in Cochrane (no doubt Timmins), and outside the LHIN. Across all sub-regions, residents were more likely to be discharged from a hospital located within their sub-region.

**Table 11.** Encounter Rate per 1000 Population, Patient Had at Least One Addictions-related Discharge from a Non-Mental Health Hospital Bed (i.e. as reported in the DAD) during the 2012 fiscal year in the NE LHIN.

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~1090 (~10.8) | < 10 | 0(0) | ~70 (~0.7) | ~10 (~0.1) | ~60 (~0.6) | ~1240 (~12.2) |
| | Cochrane | < 10 | ~480 (~6.9) | ~10 (~0.1) | ~30 (~0.4) | 10 (~0.1) | ~40 (~0.5) | ~580 (~8.1) |
| | James Bay and Hudson Bay Coast | 0(0) | ~30 (~5.8) | ~70 (~15.2) | ~10 (~1.9) | ~10 (~1.2) | ~50 (~10.7) | ~170 (~34.7) |
| | Sudbury-Manitoulin-Parry Sound | ~10 (~0.1) | ~20 (~0.1) | < 10 | ~1150 (~6.1) | ~20 (~0.1) | ~100 (~0.6) | ~1310 (~6.9) |
| | Nipissing-Temiskaming | < 10 | ~10 (~0.1) | 0(0) | ~50 (~0.4) | ~770 (~6.6) | ~70 (~0.6) | ~910 (~7.7) |
| | Total | ~1120 (~2.3) | 550 (~1.1) | ~90 (~0.2) | ~1310 (~2.7) | ~820 (~1.7) | ~320 (~0.7) | ~4210 (~8.7)[1] |

[1]***Total NE LHIN = 8.7 per 1000. The total for rest of Ontario = 3.8 per 1000. Differential is 2.3 to 1.*** Source: ICES AHRQ Project 2016 0900 775 000

With respect to rates of discharge from a mental health hospital bed, the encounter rate among NE LHIN residents is 4.6 per 1000 population (see Table 12), double that of residents in other regions of Ontario (2.3 per 1000 population). As in the previous table for non-mental health hospital bed utilization, residents of the James Bay and Hudson Bay sub-region have the highest overall encounter rate (8.6 per 1000 population) with most service utilization by these residents occurring in the Cochrane sub-region. As with discharges from a non-mental health hospital bed, NE LHIN residents in all but the James Bay and Hudson Bay Coast sub-region are most likely to be discharged from a hospital bed within the NE LHIN and their own sub-region.

**Table 12**. Encounter Rate per 1000 Population, Patient Had at Least One Addictions-related Discharge from a Mental Health Bed (i.e., as reported in OMHRS) during the 2012 fiscal year in the NE LHIN (Source: ICES AHRQ Project 2016 0900 775 000)

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | N (rate per 1000) | N (rate per 1000) | N (rate per 1000) | N (rate per 1000) | N (rate per 1000) | N (rate per 1000) | N (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~350 (~3.4) | < 10 | 0(0) | ~50 (~0.5) | < 10 | ~60 (~0.6) | ~480 (~4.5) |
| | Cochrane | < 10 | ~240 (~3.4) | 0(0) | < 10 | ~10 (~0.1) | ~30 (~0.5) | ~300 (~4.0) |
| | James Bay and Hudson Bay Coast | 0 (0) | ~30 (~6.0) | 0(0) | < 10 | < 10 | ~10 (~1.9) | ~60 (~8.6) |
| | Sudbury-Manitoulin-Parry Sound | < 10 | ~10 (~0.0) | 0(0) | ~800 (~4.2) | ~20 (~0.1) | ~220 (~1.2) | ~1060 (~5.6) |
| | Nipissing-Temiskaming | ~10 (~0.1) | ~10 (~0.1) | 0(0) | ~20 (~0.2) | ~250 (~2.1) | ~110 (~0.9) | ~400 (~3.4) |
| | Total NE LHIN | ~380 (~0.8) | ~300 (~0.6) | 0(0) | ~890 (~1.8) | ~300 (~0.6) | ~430 (~0.9) | ~2300 (~4.6)[1] |

***[1]Total NE LHIN = 4.6 per 1000. The total for rest of Ontario = 2.3 per 1000. Differential is 2.3 to 1.***

With respect to encounter rates for emergency department visits related to substance use, there is just short of a two-fold difference, between residents of the NE LHIN (18.4 per 1000 population; see Table 13) and residents in all other regions of Ontario (11.5 per 1000). Among the sub-regions, residents from James Bay and Hudson Bay Coasts had almost 10 times the encounter rate of substance use-related ED visits (167.9 per 1000 population) as for the region as a whole. Interestingly, a significant number of these ED visits occur in Cochrane and outside the LHIN as a whole. Cochrane ranked second in the rate of ED visits (30.0 per 1000) followed by the remaining sub-regions, ranging roughly between 13 and 15 per 1000

**Table 13.** Encounter Rate per 1000 Population, Patient Had at Least One ED Visit related to Substance Use during the 2012 fiscal year in the NE LHIN

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | N (rate per 1000) | n (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~1160 (~11.4) | 10 (~0.1) | 0(0) | ~50 (~0.5) | ~10 (~0.1) | ~260 (~2.6) | ~1490 (~14.8) |
| | Cochrane | ~10 (~0.1) | ~1860 (~26.9) | ~20 (~0.3) | ~60 (~0.8) | ~20 (~0.3) | ~110 (~1.7) | ~2080 (~30.0) |
| | James Bay and Hudson Bay Coast | 0(0) | ~130 (~27.5) | ~470 (~96.7) | ~20 (~3.5) | ~10 (~2.9) | ~180 (~37.4) | ~820 (~167.9) |
| | Sudbury-Manitoulin-Parry Sound | ~30 (~0.1) | ~40 (~0.2) | <10 | ~2420 (~12.8) | ~100 (~0.5) | ~390 (~2.0) | ~2980 (~15.7) |
| | Nipissing-Temiskaming | ~10 (~0.1) | ~30 (~0.3) | <10 | ~3026 (~0.2) | ~1290 (~11.0) | ~150 (~1.3) | ~1510 (~12.8) |
| | Total NE LHIN | ~1210 (~2.5) | ~2070 (~4.3) | ~510 (~1.0) | ~2580 (~5.3) | ~1430 (~3.0) | ~1090 ((~2.3) | ~8890 (~18.4)[1] |

[1]***Total NE LHIN = 18.4 per 1000. The total for the rest of Ontario = 11.5 per 1000. Differential is 1.6 to 1.*** Source: ICES AHRQ Project 2016 0900 775 000

Table 14 shows the number and rate per 1000 of individuals in the NE LHIN receiving a prescription for opiate maintenance treatment. This is followed by Table 15 showing the number and rate of encounters (i.e., total prescriptions). Just short of 5000 people (N=4830) obtained an opiate maintenance prescription in the one year study period (2012). As we have seen for the other types of substance use-related health service utilization, for opiate maintenance prescribing activity, the rate per population is also substantially higher than the rest of Ontario. The rate of individuals with at least one opiate substitution prescription among residents of the NE LHIN is 9.9 per 1000 population versus 5.2 per 1000 for Ontario residents, excluding the NE LHIN. This rate ranges from a high of 12.0 per 1000 among residents of Nipissing-Temiskaming to 3.2 per 1000 population in the Coast sub-region. This reflects the lack of availability of methadone prescribing in the area due to distance and other factors related to access. Algoma is slightly lower than the regional rate of 12.0 per 1000 but at 7.9 per 1000 is still substantially higher than the provincial rate.

A significant number of NE LHIN residents (1290 people or 2.7 per 1000 population) receive their opiate maintenance prescription from a provider outside of the NE LHIN region. This is most pronounced for the Nipissing-Temiskaming sub-region where a higher rate of residents receives their opiate substitution prescription from a provider outside the region (5.3 per 1000 population) than from a provider within their sub-region (4.6 per 1000 population). Cochrane residents also have a comparatively high rate of prescriptions obtained from providers outside the area.

As shown in Table 15, and similar to above, rates of "encounters" for opiate maintenance prescriptions for NE LHIN residents are substantially higher (1067.8 per 1000 population) as compared to residents in other regions of the province (648.8 per 1000 population). Residents of Nipissing-Temiskaming have the highest encounter rate (1558.5 per 1000 population), compared to a low of 53.2 per 1000 population in the Coast sub-region, again reflecting availability of methadone prescribing. Also, as with rates of individuals with at least one opiate maintenance prescription, encounter rates with providers outside the region are high for the region as a whole (339.0 per 1000 population) and particularly for residents of the Nipissing-Temiskaming sub-region (720.5 per 1000 population) and Cochrane (445.7 per 1000).

**Table 14.** Individual Rate per 1000 Population, Patient had at Least One Opiate Substitution Prescription in ODBP during the 2012 fiscal year in the NE LHIN

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~530 (~5.3) | < 10 | 0 (0) | ~120 (~1.2) | ~10 (~0.1) | ~80 (~0.8) | ~750 (~7.4) |
| | Cochrane | < 10 | ~350 (~5.1) | 0 (0) | ~60 (~0.9) | ~10 (~0.1) | ~230 (~3.3) | ~660 (~9.5) |
| | James Bay and Hudson Bay Coast | 0 (0) | < 10 | 0 (0) | 0 (0) | 0 (0) | ~10 (~2.5) | ~20 (~3.2) |
| | Sudbury-Manitoulin-Parry Sound | < 10 | ~10 (~0.0) | 0 (0) | ~1590 (~8.4) | ~20 (~0.1) | ~350 (~1.8) | ~1980 (~10.4) |
| | Nipissing-Temiskaming | < 10 | ~160 (~1.4) | 0 (0) | ~80 (~0.6) | ~550 (~4.6) | ~620 (~5.3) | ~1420 (~12.0) |
| | Total NE LHIN | ~560 (~1.1) | ~540 (~1.1) | 0 (0) | ~1850 (~3.8) | ~590 (~1.2) | ~1290 (~2.7) | ~4830 (~9.9)[1] |

[1]***Total NE LHIN = 9.9 per 1000. The total for the rest of Ontario = 5.2 per 1000. Differential is 1.9 to 1.*** Source: ICES AHRQ Project 2016 0900 775 000

**Table 15.** Encounter Rate per 1000 Population, Patient Had at Least One Opiate Substitution Prescription in ODBP during the 2012 fiscal year in the NE LHIN (Source: ICES)

| Sub-region | | Provider Location | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Algoma | Cochrane | James Bay and Hudson Bay Coast | Sudbury-Manitoulin-Parry Sound | Nipissing-Temiskaming | Outside Region | Total Ontario for NE LHIN residents |
| | | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) | n (rate per 1000) |
| **Residence of Person Accessing the Service** | Algoma | ~53140 (~524) | ~440 (~4.3) | 0(0) | ~17280 (~170.4) | ~3390 (~33.4) | ~13850 (~136.6) | ~88100 (~868.7) |
| | Cochrane | ~20 (~0.3) | ~30970 (~447.19) | 0(0) | ~9180 (~132.6) | ~590 (~8.5) | ~30860 (~445.7) | ~71620 (~1034.2) |
| | James Bay and Hudson Bay Coast | 0(0) | ~30 (~5.8) | 0(0) | < 10 | 0(0) | ~230 (~46.8) | ~270 ~(53.2) |
| | Sudbury-Manitoulin-Parry Sound | ~210 (~1.1) | ~480 (~2.5) | 0(0) | ~135360 (~713.6) | ~2220 (~11.7) | ~33890 (~178.7) | ~172160 (~907.6) |
| | Nipissing-Temiskaming | ~380 (~3.2) | ~16110 (~136.7) | 0(0) | ~16040 (~136.1) | ~66250 (~562.1) | ~84920 (~720.5) | ~183700 (~1558.5) |
| | Total NE LHIN | ~53750 (~111.3) | ~48030 (~99.4) | 0(0) | ~177870 (~368.2) | ~72450 (~150.0) | ~163750 (~339.0) | ~515850 (~1067.8)[1] |

[1]***Total NE LHIN = 1067.8 per 1000. The total for the rest of Ontario = 648.8 per 1000. Differential is 1.6 to 1*** Source: ICES AHRQ Project 2016 0900 775 000.

## 3.2 Synthesis of Evidence and Feedback from Participants

The significant health burden as well as well-documented family and social costs associated with substance use and addiction argue strongly in favour of continued investment in substance use treatment systems in the NE LHIN, as is the case provincially and nationally. The economic costs associated with this burden, coupled with strong research evidence that treatment is effective, and that it returns an economic benefit, makes investment in substance use treatment systems a wise use of public funds.

To help inform how best to make these investments in the NE LHIN, this section synthesizes available evidence and expert opinion in relation to several key principles of substance use treatment system design. The approach is to contrast stakeholder feedback regarding policy and practice in the NE LHIN against the current knowledge base so as to identify system gaps and to support recommendations for system enhancement. For each key principle, we summarize "*what the evidence says*" and then highlight key themes that emerged from the interview and survey data that relate to the same principle and associated evidence - that is "*what participants told us*".

To begin, however, several important themes are identified below that either do not fit neatly under the core principles or which were so salient in the data that we felt they should be identified at the outset.

### 3.2.1 Common Feedback across Sub-regions

***Variation across the region:*** The first common theme is in fact the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions but also *within* these areas. For example, the Algoma sub-region is really comprised of three ecological areas for service delivery – East Algoma, Central Algoma and North Algoma. This is also the case in most of the other sub-regions used for LHIN planning. In short, it is very difficult to generalize the regional-level themes identified below to all parts of this vast area of Ontario.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the NE LHIN for several reasons, including:

- The vast geography and mix of urban/rural/remote communities.
- The variable concentration of the population mix, in particular, non-FNIM, FNIM and Francophone people).
- The challenges with recruitment and retention of qualified staff in part due to the rural/remote nature of the region and the population mix.
- The weather conditions in the winter that impact travel.

- Other transportation challenges such as lack of bus service to many communities or no/limited public transit within communities.
- Significant migration patterns, for example, for work, school, justice involvement and in response to natural disasters.
- A shortage of affordable housing/rental options and employment opportunities in many communities.

***Highly valued workforce:*** The staff members who are providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants commonly highlighted that staff are working in challenging circumstances, at a comparatively low level of compensation and, in most cases, without a salary increase for several years. The experience and length of time that most managers and key leaders have been working in the field was also highly valued.

> "*The people who work in the field are dedicated and go above and beyond to fight for their clients. The services that are available have heart, are passionate and work with the community*"

***Changing nature of those seeking help*:** There was strong, almost unanimous, opinion among those interviewed who are providing direct service to clients, that client complexity has increased dramatically in the last decade or so—the typical presentation now includes use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health. As shown earlier, many participating service providers offered case scenarios to help bring this case complexity to life in this report (see section 3.1.3 above and Appendix 9). To put it simply, the level and complexity of community need appears to be increasing.

***FNIM people and choice:*** It is conservatively estimated that FNIM individuals comprise 30% of the total client population in the region's specialized treatment services. FNIM and non-FNIM participants alike reflected on the significant and urgent needs within First Nations communities and among the individuals and families seeking help. They cited high rates of suicide, and epidemic levels of prescription opioid addiction layered on top of high rates of alcohol and other drug abuse.

While there is significant support in the region for culture-based treatment, experiences of stigma and discrimination in the regions' mainstream health services were commonly reported and much more needs to be done within many programs to ensure cultural safety and choice for people seeking help. The need was also commonly voiced for more support and engagement of FNIM leaders, organizations and traditional healers in planning regional and local treatment system enhancements. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement under challenging

circumstances and effective transitions to continuing care within the family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual level (e.g., front-line workers facilitating transitions across services). This affirmation notwithstanding, tensions exist in the sub-regions and many communities that significantly challenge collaboration and coordination, particularly at the organization-level. Participants most commonly referred to tensions between hospital and community; mental health and addiction services; addiction medicine and mainstream addiction treatment; and FNIM and non-FNIM services. In some instances these tensions result from failed efforts at program integration; in other instances the tension arises from previous competition for limited funding, and in still other instances the underlying tension comes from differing world views of substance use/addiction and how it should be treated. While to a certain extent such tensions are to be expected in Ontario's complex health and social service delivery system, the tensions are running very deep in many communities and strong leadership is needed at the LHIN-level, and collaborative leadership at the community level, to work together in the interests of the community as a whole.

***Funding challenges****:* Participants commented at length on the funding challenges that present barriers to the delivery of quality services. These challenges are further described below but primarily reflect the lack of basic increases to budgets for several years despite rising costs and the concomitant reductions in service required to manage the increasing shortfall. Participants also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to other professionals and staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this review shows the significant level of utilization of physicians and hospitals, including ED visits, for substance-related conditions. The costs are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example. All parts of the region are working to reduce the use of emergency services and other acute health care resources and acknowledge the importance of addressing substance use and related concerns as part of the community strategy to reduce related costs.

Participants affirmed the need to reduce costly health care utilization related to substance use and addiction (as well as other high social and justice-related costs) and called for more focused collaborative efforts that engage both hospitals and community services in seeking solutions. This includes more sharing of strategies across the region. Evidence suggests that the costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals; models of addiction nursing liaison and collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

There are many other key themes central to this review that are derived from the contrast to the evidence base for treatment system enhancement. In the concluding section we summarize implications and recommendations regarding these thematic areas, and the many others to be developed below from participant feedback.

### 3.2.2 Principle 1: Broad Systems Approach

**A broad systems approach is needed in order to address the range of substance use and related problems in the community, including severe substance use problems, and to achieve a population-level impact.**

#### *3.2.2.1 What the Evidence Says*

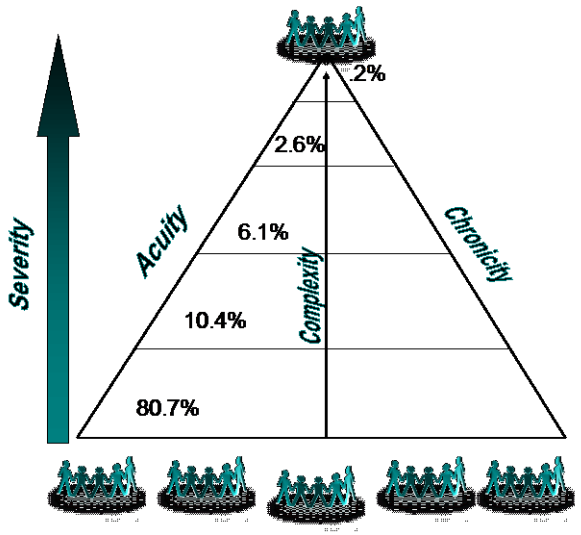
*A population health approach:* Treatment systems must be planned on the basis of population health, not solely on the basis of those seeking assistance at a given point in time. This approach demands consideration of the strengths and needs of the entire community and across the full spectrum of risks and harms associated with substance use, including, but not limited to, severe addiction/dependence. For individual treatment and support, as well as for system planning, it is important to consider how a wide range of acute and chronic problems converge at different points in time in the individual's life course and thereby influence the trajectory of help-seeking and service utilization. The large majority of people seeking help for severe problems do so multiple times, from different service providers, and typically

move in and out of substance-related challenges of varying degrees of severity several times before achieving sustained recovery.

Figure 5 presents a *population health pyramid* which illustrates the distribution of substance use problem severity within the general population. Levels of severity correspond to the need for primary, secondary and tertiary type interventions. The percentage of the population noted in each tier were compiled in the context of the national Drug Treatment Funding Program (DTFP) project on Needs-based Planning but approximate the distribution of need in the NE LHIN.

The highest levels of severity are associated with the fewest number of people who need the most costly specialized and/or intensive care. Those with lower levels of problem severity are more numerous and their needs can be met by less intensive or less specialized care which can be made more widely available in a variety of health and social service contexts, as well as through service outreach and more informal community and/or family networks of support. Internet- and mobile-based services are also highly relevant for people at all levels of severity and risk and are becoming more widely available. The bottom of the pyramid reflects people at low risk – the target population for secondary and primary prevention. Simply put, the broad "treatment system" must be planned in such a way as to respond effectively, efficiently and comprehensively to this *full spectrum* of acute, chronic and complex needs, including alcohol and drug policies that affect whole or targeted populations.

**Figure 5.** The Population Health Pyramid for Substance Use Problem Severity Using Canadian Data




*The importance of prevention and health promotion:* A person-centred approach to service delivery does not mean that interventions should focus only on the

individual. Substance use, addiction, and mental health issues are not separate or isolated from the other dimensions of an individual's overall personal well-being, nor isolated from political, economic, and social conditions around them. Ensuring adequate housing and access to food, as well as effective alcohol and drug policies are but three highly salient examples of the required "basket" of interventions. In practical terms how does this focus on the social determinants of health relate to treatment systems and treatment outcomes? It does so by recognizing that community-based recovery capital (e.g. housing, employment, education, access to healthy food and safe water) is more important in determining the eventual success of substance use treatment than the various dimensions of individual recovery capital (e.g., psychoeducation, personal motivation, treatment history, therapeutic relationships). This community-based recovery capital also includes the degree of family and community support for seeking help and maintaining short term benefits of treatment. These concepts of community health and community recovery capital are very familiar to First Nations communities and reflected in their planning frameworks for treatment services and supports.

Although challenges exist in the usual division of current socio-political structures for public health and health service planning and delivery, every jurisdiction must consider: (a) the relative balance of independent resource allocation for population-level health promotion and prevention and for substance use services and supports, and (b) the operational details and resources required to embed health promotion and prevention functions inside and alongside substance use treatment services and supports. The important point is that substance use treatment systems should not be planned and resourced separate from prevention and health promotion. At present this is more of an ideal than a reality in most, but not all, Canadian jurisdictions.

System design requires the implementation of early intervention and health promotion and prevention policies and services for those at risk of developing substance use problems as well as work to link these initiatives to the specialized treatment system. Policies and programs designed to reduce stigma and discrimination of people with substance use problems are also critical since they can impact help-seeking and engagement in treatment and early intervention services.

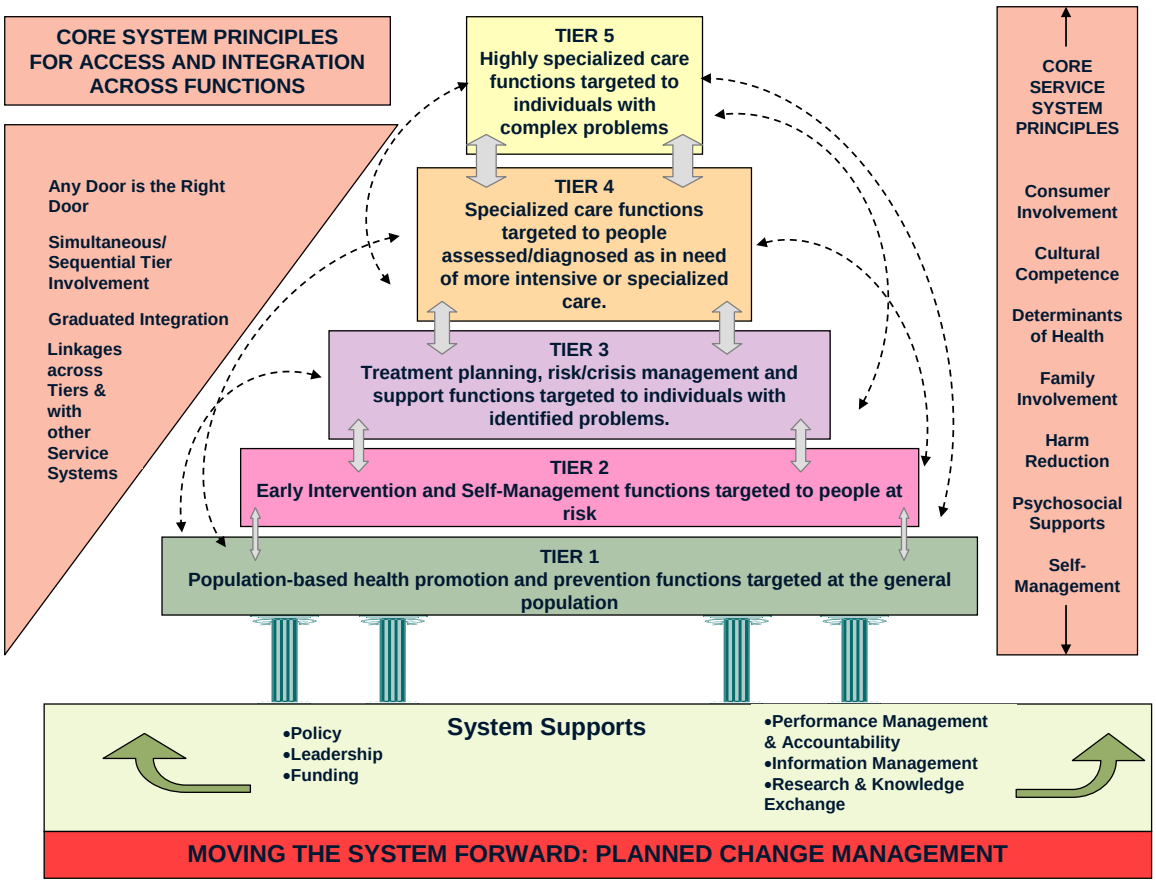
*More than "specialized" services are needed:* It is now well established that a relatively small proportion of people in the community who experience substance use problems seek assistance from the specialized sector of services that has been commissioned specifically to provide treatment and support. Data on the so-called "treatment gap" have supported the case for a more comprehensive view of the substance use treatment system, arguing that a discernible impact at a population level is not likely to be achieved only through substance use agencies and services mandated specifically to serve people with the most severe and complex needs. A broader approach is needed; one that engages multiple sectors such as health, social welfare, criminal justice, and education in a comprehensive system of services and supports. This requires building service capacity in the settings where people with

substance use problems are more typically engaged (e.g., primary care, emergency departments, social assistance, criminal justice, health services, friendship centres, and supported housing initiatives).

A systems approach to substance use treatment system planning and resource allocation, therefore, requires consideration of a wide range of service delivery settings and contexts in order to broaden the base of treatment and integrate services into a coherent treatment system. An important example of this is "mutual help", such as Alcoholics Anonymous or other self-help groups, which represents an important part of the treatment system and is well-supported by research evidence, but which lies outside the scope of formally planned and funded services.

A "tiered model" for substance use and mental health service planning, introduced in the Canadian National Treatment Strategy, and subsequently refined by of Rush and colleagues in Ontario, reflects this broader vision for substance use treatment systems (Rush, 2010). The tiered framework (Figure 6) is aligned with the various levels of problem severity/complexity in the population health pyramid. There are many elements to the tiered model that are empowering for treatment system development and performance monitoring, including: the importance of linking prevention, early intervention and treatment services and supports; key principles such as "any door is the right door"; critical services such as transition support; and the need for *system supports* to ensure services are adequately resourced, led by strong leadership and have strong attributes related to quality improvement and performance measurement.

**Figure 6.** Tiered Framework for Substance Use (and Mental Health) Service Planning




### *3.2.2.2 What We Learned from Participants*

*Strengths in the region*

Endorsement of a broad systems view*:* Almost universally, key informants endorsed a broad view of the "treatment system" and noted the important role for "non-specialized services" such as primary care, acute care in hospitals, mental health services, women's shelters and other trauma services, justice, children's services, education, etc. Many concrete examples of the operationalization of this broad system view currently in practice were identified including:

- LHIN outreach officers are "generalists"[10] and having responsibilities that cut across many health care providers including, but not limited, to addictions (and mental health).

[10] With the exception of Sylvie Guenther, who had considerable experience in the addictions field and was accessed for many specific initiatives, and Mike O'Shea, the current NE LHIN Mental Health and Addictions Lead

- Broadly representative local planning tables (except in Sudbury and the Coast sub-region at present).
- Many specific projects with a strong collaborative backbone (e.g., the Harm Reduction Home in Sudbury; responding to the pending closure of methadone services on Manitoulin Island).
- Community mobilization hubs in many communities (most sub-regions have one).
- The development of a "common referral form" to facilitate referral and transitioning across multiple sectors and services in the region.

Important prevention and health promotion initiatives: There was clear acknowledgement among participants of several important prevention and health promotion services and activities including, but by no means limited to, the collaborative community-level work on local Drug Strategies, Fentanyl Task Forces and Harm Reduction Committees. Many addiction service providers and public health departments are also closely involved in harm reduction-related work, including ensuring availability of needle exchanges, safe injection kits and safe sex education and materials. In one notable instance, a department within Algoma Public Health provides direct addiction services which facilitates and leverages prevention resources in the larger organization. Also noteworthy are the many school, workplace and community presentations made by representatives of a large number of service providers across the region; a community service typically provided outside the scope of their funding and accountability agreements. There is also significant engagement in schools beyond these educational presentations *per se*, including outreach, screening and assessment. The important role being filled by the Ministry of Children and Youth Services - funded mental health and addictions nurses working within the school system also has elements related to prevention, and more so with respect to early identification and intervention.

> "*North Bay was the first to introduce the Fentanyl Patch-for-Patch program now modelled across the province".*

*Challenges in the Region*

Limitations in operationalizing the broad system view: Despite the wide endorsement of the broad systems perspective, participants identified major challenges with planning, communication and collaboration *across* the following three major sectors:

- LHIN-funded addiction services (including mental health services)
- addiction medicine services providing medication-assisted treatment for opiate addiction

- FNIM services - both addiction specific and more general

Challenges with communication and coordination, especially at the planning level, were viewed as critical barriers to the provision of integrated addiction services and continuity of care. Challenges with the intersection of these three "sectors" are further discussed below under "collaboration" as well as in other sections of the report aligned with the research evidence.

The flip-side of the LHIN generalist role: The strength of the generalist role of the LHIN outreach workers was also noted as a challenge to implementing a truly systems perspective, given the many competing priorities in their day-to-day activities, and challenges in giving appropriate priority to addictions-related work (also discussed below under Planning).

Low priority for prevention and health promotion: Key informants acknowledged that prevention and health promotion efforts (i.e. "Tier one" services) have not been sufficient to "stem the tide" and that these efforts are challenged by the need to respond to the more pressing and immediate needs for treatment and support.

> *"It's the same as other communities but in smaller communities …it's worse – nurses and doctors see the same patients and recognize the people – 'here he comes again'"*

Limited early identification and intervention*:* Prevention work in the education system and public space notwithstanding, there was a noticeable absence of early identification and intervention work reported in various sectors, and particularly in the primary care sector. This gap in "Tier two" of the tiered framework for system planning is addressed in more detail in a subsequent section on evidence-based interventions (Screening and Brief Intervention).

Stigma and discrimination: Stigma and discrimination remain significant challenges and were frequently noted among the major barriers identified with respect to planning and delivery of addictions services. These challenges were noted as particularly exacerbated in smaller communities, such as smaller cities of northern Ontario, (e.g., North Bay), and within medical services across the board. The other key element related to stigma and discrimination was with respect to Children's Aid Society (CAS) and FNIM people, specifically the reported challenges with having children taken into custody more rapidly and the "*flaming hoops*" FNIM women are required to go through to regain custody.

> *"….if an outreach worker that is known goes to the ER with the person, they fly through – if he or she goes alone, it will be 4-5 hours minimum*"

The provision of outreach services (e.g., accompanying people to ER or to a court appearance) was seen as key to addressing these challenges, as was the need for ongoing training and capacity building in many sectors, including the medical sector and CAS.

### 3.2.3: Principle 2: Collaboration across Multiple Stakeholders

**Accessibility and effectiveness of services for people with substance use problems are improved through collaboration across multiple stakeholders.**

#### *3.2.3.1 What the Evidence Says*

Consistent with a broader systems approach, it has now become commonplace in the planning, delivery and evaluation of substance use services and supports to look to "collaboration" as a solution, or at least a partial solution, to challenges in giving timely access to individuals in need in ways that also capitalize upon their strengths and address their often complex array of needs. In the literature, collaboration is not just about "working together" but rather is the term used to describe a continuum of options that includes:

- effective communication
- coordination
- co-location and
- integration

How these options are defined can vary, making the concept of collaboration difficult to operationalize. For example, the term "integration" has multiple meanings, many of which are often threatening to independent organizations, and research shows that integration can be implemented in a host of ways.

There are three key elements encompassed by the integration construct: (1) types of integration (e.g. functional, organizational, clinical); (2) breadth of integration (vertical versus horizontal); and the process of integration (i.e. structural, cultural, social). Cultural integration, sometimes referred to as *normative integration,* is particularly relevant for substance use, mental health and primary care collaboration as it pertains to the convergence of values, norms, working methods, approaches and symbols used within the planning and daily work of the sectors. Divergence of these important aspects of services and organizational culture are recognized as deeply entrenched within substance use, mental health and various health services including primary care, emergency departments and inpatient care.

Challenges with operationalization notwithstanding, a major trend underway over the past several years with respect to treatment systems is the expansion of collaborative efforts, including integration, to embrace both the mental health and primary care sectors, as well as other sectors such as justice and education. An emphasis on mental health and addiction services integration has been transforming relationships between these two sectors in Canada since the seminal Health Canada best practice report on concurrent disorders (Health Canada, 2000). In the United States, recent changes in legislation for financing and payment to physicians for substance use-related care is prompting significant collaborative

developments between addiction services and primary care. This same trend is underway in Canada, albeit at a slower pace and unaided by financial incentives. In addition to this work in primary care, co-location among a range of community partners, including mental health, primary care and other sectors, is increasingly being viewed as an important element of collaborative care arrangements and is supported by evidence reviews.

Generally stated, the purpose of collaboration, or any form of cooperative enterprise, whether it be shared or collaborative care, a partnership, a network, a community coalition or various forms of integration, is to increase the chances of achieving some objective compared to acting alone as an individual or organization. In addition to this common, somewhat abstract goal, the literature highlights several key benefits that are *expected* from collaboration, including:

- Being better equipped to support people with complex conditions (e.g. head injury, trauma).
- Improved access to services.
- Earlier detection and intervention.
- Improved quality of care.
- Improved continuity of care.
- More satisfied health care consumers.
- Improved client/patient outcomes and reduced costs.

Given these multiple objectives and the diversity of collaborative approaches, the reality is that no one service provider, or sector for that matter, can address all the needs of the many people presenting with substance use problems, especially those with the most complex and persistent, and often urgent, challenges. However, it is not possible at present to pinpoint the most effective collaborative models or the "active ingredients" of these models, due in part to the many different types of strategies being studied. Another reason for some uncertainty in the research evidence relates to the attribution challenge experienced in the evaluation of collaborative initiatives – it being extremely difficult to link changes made at the system-level to *health outcomes* of service users, since the system supports need to be translated in some fashion through direct service delivery. The evidence does, however, suggest that many collaboration and integration strategies are positively and consistently related to *improved intermediate outcomes related to continuity of-] care.* In other words, when the outcomes assessed are proximally connected to the integration supports and strategies, the evidence is much stronger than observed for outcomes a bit farther removed from collaborative or integration activities.

When the research aims to discover critical features that might help explain outcomes, the benefits appear to be greater when the integration effort is characterized by stronger management arrangements, fewer service sectors involved, and system-wide implementation of intensive case management and improved access to services. Thus, there is some evidence supporting collaborative

care, including integration, if it is targeted, relatively circumscribed and person-focused on access and navigation. It is important that appropriate evaluation expectations and indicators of success be established and well-communicated from the outset.

### *3.2.3.2 What We Learned from Participants*

*Strengths in the region*

> "*I see it holistically, client-centered – we are not everything to everybody. We need to partner*"

Endorsement of the importance of collaboration: Many examples of successful collaboration and joint planning at the local level were noted, often connected to the resilience among those living in small to mid-sized communities and the need to work together in the face of limited resources. One participant noted that it wasn't just the need to collaborate but rather that stakeholders could see the success of past efforts and that this motivated them to continue to work together.

A number of particularly important sub-topics within this general theme of collaboration are summarized below.

Perceived value-add of co-location: In a small number of communities, the issue of co-location was seen as a positive step forward for collaborative care. One example was in Elliot Lake with the current co-location of Oaks Withdrawal Management Service, Camillus Residential Treatment Centre, different community treatment services, as well the Elliot Lake Community Care Access Centre.

In Sudbury, a major co-location project known as the Shared Space Initiative is in the planning stages, and offers to bring together all five locations of Monarch Recovery Services, the hospital-sponsored withdrawal management service, Sudbury Counselling Services, CMHA, United Way, and a designated space for the University of Sudbury Social Work department which provides placement students to many of these programs. Challenges have recently been experienced with finding a location suitable to all potential partners. The community treatment services sponsored by Health Sciences North are not included in the proposal.

Another significant co-location project in the planning stages is being led by Jubilee Centre in partnership with several community agencies, including Acquired Head Injury Services, given the high co-morbidity between brain injury and hazardous substance use or addiction. The proposal includes plans for add-on construction and expansion/renovation of the current facility for a housing component that would generate income. The current proposal for the new Centre does not include other community addiction service providers.

Mental health and addiction services*:* It is difficult to make a broad generalization about the current status of collaboration between mental health and addiction services for the region as a whole, including various forms of structural or functional integration. Certainly our environmental scan encountered many very positive working relationships between mental health and addiction providers. It was particularly noteworthy to see the highly functional integration of mental health and addiction services in smaller areas/communities, for example, in Sturgeon Falls, Chapleau, East Algoma, Parry Sound (including B'saanibamaadsiwin, the CMHA Aboriginal Mental Health Service), and the North Shore Tribal Council.

> "We are the only game in town for mental health and addiction services. There is no 'you take care of it. There is no - you!'"

In Sudbury, mental health and addictions services within Health Sciences North are completely integrated and functioning well within the scope of the hospital, and, in Sault Ste. Marie, one can look to Algoma Family Services and the seamless work in their youth program. Some mental health services receive funding for concurrent disorder workers (e.g., CMHA in Timmins, North Bay Regional Mental Health Program) and this has increased their role and responsibility for addiction work in the community as a whole. Many agencies have significantly upgraded the concurrent disorder competencies of staff, for example, Jubilee Centre in Timmins.

There are also many examples of excellent partnerships across community agencies, including, but by no means limited to, partnerships for supportive housing such as in Timmins between the CMHA and South Cochrane Addiction Services, and the good working relationship between Monarch Recovery Services and CMHA in Sudbury (as well as Health Science North). There have been significant local planning efforts for "CD mapping" such as in Timmins/Cochrane and, in 2013, a major regional-level CD mapping exercise in support of the Regional Concurrent Disorders Advisory Committee at the North Bay Regional Health Centre.

A large number of addiction, and combined mental health and addiction, programs are also utilizing sessional fees to access psychiatry supports for case consultation as well as for training of staff (e.g., North Cochrane Addiction Services).

Many more examples of collaborative arrangements can be cited and, in general, one can say that through specific funding initiatives such as for concurrent disorders, supported housing, safe beds and sessional fees, as well as through longstanding working relationships in the community, the two previously quite separate worlds of addiction and mental health have been drawn much closer together across the NE LHIN.

Hospital and community collaboration: Many excellent examples of collaboration were noted between area hospitals and community service providers. This includes, but is not limited to:

- The full continuum of multi-disciplinary mental health and addictions services at Sudbury Health Science, including a shared electronic record, and excellent community collaboration.
- Excellent collaboration between the Manitoulin hospital and community services.
- In-kind shared resources (Nurse Practitioner) offered by the Blind River Hospital to Benbowopka, the local residential treatment centre.
- The collaboration between the Emergency Response Service (EMS), the ER and the withdrawal management service in Sudbury.
- Outreach workers going to ER to support clients (South Cochrane Addiction Services).
- The new Ontario META-PHI project, which includes a site in Sudbury, is an important research and development project led by Dr. Mel Kahan (himself Toronto-based) and involves significant collaboration between the ER, withdrawal management services, addiction medicine practitioners and other community services.
- The hospital in Moose Factory (WAHA) and the provision of a high level of collaborative support to clients of local community services, including significant travel to give on-site support to Coast communities, as well as significant Ontario Telemedicine Network (OTN) support.

*Challenges in the region*

Change management: One major challenge noted with respect to collaborative efforts was the reported difficulty experienced with change management – that is, seeing plans and ideas carried through to implementation. Others commented on the extent of engagement of managers in collaborative activities and committees and the often conflicting demands placed on them with respect to time management and their responsibilities for program administration. Still others commented on the different perspectives within the addiction field and among important community partners, and the inherent challenges working within these different world views.

> *"Remove the red tape [and] territorial issues. We have these ideas but don't get implemented for years."*

Addiction medicine and the provision of counselling supports: A major challenge was noted across the region with respect to coordination of services, and specifically, the provision of counselling, for people receiving medication-assisted treatment (primarily methadone) for opioid addiction. Although many positive collaborations were noted in selected communities between addiction medicine providers and LHIN-funded addiction services the situation was more often

characterized to as "two worlds" of addiction treatment. This was a common characterization despite sharing many of the same clients and, in some instances, being co-located or being "right across the street from each other". This is discussed further in a separate section below on medication-assisted treatment.

Mental health and addiction: Notwithstanding the earlier examples of strong collaboration between mental health and addictions services, significant challenges remain in some areas. These are briefly summarized below.

- *Challenges in specific programs* - Program-specific situations in the NE LHIN were noted, where the capacity to manage people with concurrent disorders was perhaps questionable (e.g., medication management) but were outside the scope of this review to investigate further. Also, program-specific challenges related to cultural safety (e.g., inflexible rules, lack of cultural content, institutional setting) mean that FNIM people with concurrent disorders have less access to mental health supports than non-FNIM clients. The lack of CD capability in Health Canada-funded FNIM treatment centres was also noted in this regard. Finally, program-specific admission policies related to excluding people on psychiatric medication (in other parts of Ontario) put pressure on more CD-capable, residential treatment services across the NE LHIN.

> From a participant speaking about an Aboriginal client who was drinking and suicidal… "*I asked the CD worker there 'Why are you releasing her'? They said 'she isn't giving the right answers'. They said 'call the crisis service at the hospital' which also brushed her off…I won't refer Aboriginal clients to the hospital…"*

  - *Challenges due to lack of mental health resources*: This challenge took several forms but included the oft-expressed need for more services for the most complex clients, including the reported lack of access to North Bay Regional Mental Health Program for clients outside the immediate area; the lack of access to Francophone psychiatrists; and the poor access to ACT or PACT teams due to the very limited flow through of clients in these programs in most if not all jurisdictions in the region. In the Coast sub-region, there are no acute care mental health beds making it particularly challenging and costly to serve people with severe concurrent disorders, due to the need for transportation to other facilities, for example, in North Bay Regional Mental Health Centre, Timmins, Kingston and Toronto.

> "*There are different ways of looking at things and organizations do different things. It doesn't mean better or worse.*"

- *Challenges with past integration efforts*: There have been various attempts at integration of mental health and addictions services that have not worked out (the oft-cited example being the Anchor Project in Sault Ste. Marie) and which have resulted in considerable mistrust among community partners. In some instances this was said to have subsequently increased more voluntary forms of collaboration. In some areas lingering mistrust was sometimes framed as hospital "versus" community which adds additional challenges (see below). Experience across Canada has told us that full integration of mental health and addiction services can result in an apparent loss in focus on addictions work, for example, where new managers come from a mental health background and lack experience with addictions or develop inappropriate performance measures for addiction services (e.g., devaluing outreach contacts). This creates a sensitivity among addictions providers about mergers with mental health services – a sensitivity that was evident among some participants in this environmental scan. In general, the prevailing view across the region's providers and among system planners appears to be that mental health and addictions services should be well-coordinated and collaborative but *not necessarily* structurally integrated. There are, however, exceptions in the region where some community providers are still thinking about "merger" and these considerations were typically expressed by mental health rather than addiction providers. While the value of integrated mental health and addictions treatment is generally supported by the research literature, there are many functional, collaborative approaches in which integration can be delivered outside a formal organizational/program merger. An important caveat, however, is that any attempt to adopt these approaches should not diminish the role and expertise of the addiction-specific partners.

> *"We want to integrate, be seamless, but maintain a distinction at the same time. You need to be vigilant and protective because the history and experience is that addictions loses out. Better to keep some distance for now".*

> *"As soon as you say 'mental health and addiction' you split things".*

- *Challenges in planning:* Related to the last point, several participants noted the challenge at the planning level in the region, and expressed the view that the

> *"As long as your mind is thinking in a box we are going to stay in a box – but we aren't there yet. [Addictions] still needs to be protected".*

LHIN overtly and covertly supports the separation of mental health and addiction services. Certainly, there are specific system enhancements that come down from the MOHLTC and which are variously targeted at mental health or addiction services. No doubt this doesn't help with the optics at the planning level, although one can now point to examples of other funding announcements that stimulate collaborative relationships (e.g., supportive housing). The observation of the review team is that there is a desire at the LHIN-level to improve integrated care for mental health and addictions and that, at least for the present, the LHIN is well advised by the view expressed above by some service providers that addiction services need to be protected. This perhaps contributes to the view expressed by some providers that the LHIN aims to separate mental health and addictions.

An illustrative case in point regarding challenges with addiction and mental health integration concerns Maison Renaissance in the Cochrane area, an addiction residential treatment program. This provider expressed a desire to provide mental health services to its community target population, in this case Francophones, but felt handicapped in doing so by a "policy" that required the agency to remain "addiction-specific" and manage mental health only in the context of people with a concurrent disorder. At one time in its history this same program had offered a wider range of mental health services and was sometimes called upon by the community to offer this type of support since other options were not readily available. While it may be necessary in some situations to "protect" addiction services via overt or implied policy directives and/or by maintaining dedicated funding allocations for addiction services, situations such as Maison Renaissance illustrate how more flexibility may be needed to meet the needs of some communities and specific populations. Certainly there are now many good examples in the region of effective integration without a loss of quality of addictions services.

"*Hospital doctors are managing the acute care cases – it's part of the continuum but it's disconnected from the rest. What part of the business do we want to be in?*"

<u>Strained community and hospital relationships</u>: While in some areas of the NE LHIN, particularly smaller sub-regions, the relationships between community addiction services and hospitals were quite collaborative, in other sub-regions, significant tension was apparent between a major hospital offering addictions services and other addiction services in the community. In some instances this tension has resulted from, or been exacerbated by, previous integration efforts (e.g., in Sault Ste. Marie) as

well as by some locally perceived duplication of services that could potentially be resolved by integrating a hospital and a community addiction service.

In North Bay, tensions were noted due to previous allocation of designated concurrent disorder resources to the hospital and an apparent re-allocation of these resources for within-hospital support. This was said by some participants to have diminished capacity for handling complex clients for the community at large.

In another situation, significant delays were reported in filling concurrent disorder positions in the Timmins and Region Hospital which, after 2-3 years, divested the still unfilled positions to the community (i.e., to CMHA).

These are a few of the overt and covert factors reported to underlie tensions between some NE LHIN hospitals and non-hospital sponsored programs in the same community. Some of the nuances and complexities of these tensions are further illustrated in the points below and in some reflective quotes from participants.

- *Perceived accountabilities*: Several participants reflected that there is an increased expectation on community-based services to work together to address common concerns and that, on the flip side, hospitals are freer to pursue internal needs and pressures, while often remaining in a deficit situation. This puts resources intended to support the wider community at risk of being diverted to manage other internal needs. There was also a sense that too much pressure is being put on community agencies to divert cases from the ER without close collaboration between the ER and other hospital services themselves.

> "*When hospitals cut, they cut the appendages first*"

> "*The LHIN requires us to report what we are doing to relieve pressure on emerg. Seems backwards to me. The ER isn't required to sit at the table with us and why aren't we notified and follow up on Monday morning? They just discharge and send to detox."*

- *The need for medical supports*: Since withdrawal management services, and in the case of North Bay, the residential treatment centre, are sponsored by the local hospital and are managing an increasing level of physical and psychiatric complexity, there were significant concerns expressed by hospital managers about managing risk in these essentially non-medical services. This is increasing pressure for closer engagement of hospital services and an increasing role in management of addiction services more generally. The increasing role of addiction medicine for medication-assisted treatment and the importance of psychiatric support for people with concurrent disorders are also giving momentum to a general "medicalization" of addiction. This can also impact hospital and community tensions if communication and relationships are not healthy.

- *Cultural safety:* Some FNIM participants voiced that, while acute care hospital services are sometimes needed, the strong preference is for accessing community services for non-acute problems as they are more culturally appropriate, typically more flexible, and less-office bound (i.e., more outreach oriented). One participant positioned these comments in the context of the tiered framework for treatment system planning, stating that FNIM people need more community supports focused on Tiers 3 and 4 in the tiered framework as they need these supports to ensure long term sustainable recovery after intensive treatment.

- *LHIN-level planning and priorities:* In some communities there was a strong impression stated among some hospital-affiliated participants that the LHIN was *"anti-hospital"* when it comes to investment in addiction and mental health services. This perception may be exacerbated by the above mentioned tensions regarding mental health and addictions services integration, in those situations where the mental health services are in the hospital and the addiction services in non-hospital affiliated programs.

> *"The LHIN supports community programs, not hospitals. Is a hospital not part of the community?"*

### 3.2.4 Principle 3: Wide Range of Systems Supports

**A wide range of systems supports are needed to support and facilitate the effective delivery of services.**

#### *3.2.4.1 What the Evidence Says*

One of the strengths of the tiered framework for planning substance use treatment systems (Figure 6) is the distinction drawn between the services needed for people at different levels of severity and the *system supports* required to ensure adequate infrastructure. The following system supports are considered here:

- funding
- planning and policy
- performance measurement and information management
- implementation of evidence-based practices (EBPs) and knowledge exchange/translation

Each of these system supports is worthy of its own synthesis of evidence-informed practices at the system level and have been identified as critical to the delivery of substance use services, and mental health services more broadly. The importance of

providing adequate funding in the context of well-defined, implemented and evaluated planning and policy processes are obviously important for the provision of quality addiction services. For purposes of this review we also emphasize performance measurement and information management as well as implementation of evidence-based practices and knowledge exchange. The latter touches on important issues related to workforce development and sustainability.

*Implementation of EBPs and knowledge exchange/translation:* Given the lag between the identification of new evidence-informed practices and their subsequent application in routine practice, several authors have noted the gap between the interventions with strong evidence of treatment effectiveness (i.e., what we know) and what is routinely delivered in practice settings (i.e., what we do). Some areas that have been highlighted as lagging well-behind the research literature are the implementation of continuing care interventions, and screening, brief intervention and referral to treatment programs.

Importantly, there remains a heavy reliance on "training" as the core approach to building individual and organizational treatment competency whereas the literature on implementation science is extremely clear about the limitations of relying on a training model alone (i.e., without additional supports) and the importance of an analysis of system-wide, organizational and professional drivers and incentives to build and sustain capacity. A recent review of the many models for implementation of EBPs showed that virtually all models argue for systematic approaches that recognize the complexity of the change process at the individual, organizational and community/system levels.

There are several important efforts underway to build capacity in substance use services and systems for the use of EBPs. In Ontario, this has been a priority for past and current DTFP work (e.g. EENet). The current DTFP work in Ontario for implementation of a common measure of client perception of care and staged tools and processes for screening and assessment is a notable exception to the routine training model. This work and several other knowledge exchange initiatives emphasize the need for strong measurement, structured implementation and change processes, as well as leadership and resources. Importantly, a significant warning has been sent by research leaders that the state of the infrastructure for substance use treatment in the US, including several workforce-related issues, is probably not strong enough to support significant advances in the implantation of EBPs. Thus, the "business" of substance use treatment is a critically important area of research.

Little is known about the current state of infrastructure of the substance use treatment system(s) in Canada, including workforce-related issues and the challenges and opportunities for enhancing EBPs, and quality improvement writ large. One might predict significant challenges in this area for Ontario since resources are strained due to flat-lined budgets for several years. This leaves little room for flexibility, pilot projects, experimentation with innovation and program

evaluation when the major preoccupation of service providers is essentially maintaining their service levels as costs increase and budgets remain the same.

*Performance measurement and accountability:* A matrix model for performance measurement and accountability has been advanced that requires system planners and administrators to distinguish between indicators of *need*, *process* and *outcome* and the level of observation—*client*, *program* or *the system* as a whole. Excellent process measures at the program or system level have been articulated for substance use services by a consensus panel known as the Washington Circle —for example, the allowable time of transitions between different levels of care, such as from withdrawal management to entry into treatment, or from assessment to treatment. Work is underway by Dr. Karen Urbanoski, a collaborating Scientist at CAMH, to map DATIS information on service delivery to these Washington Circle performance measures.

Measuring client satisfaction/perception of care remains an important element of a performance measurement framework, especially as new research identifies the link between perception of care and other indicators of client safety and clinical outcomes. In this regard, the provincial implementation of a common perception of care tool in Ontario addiction and mental health services (the OPOC-MHA) is noteworthy.

Concerning outcome measurement at the client level, considerable progress has been made in conceptualizing and measuring both within-treatment and post-treatment outcomes and can be further guided by an over-arching staged approach to screening, assessment and outcome monitoring (see Appendix 10). Importantly, both within-treatment and post-treatment outcome monitoring consider the follow-up of clients for evaluation purposes to be an extension of the treatment and support process itself. This process, referred to as "recovery monitoring check-ups", is conceptually quite different than a traditional "research" follow-up, and is much more likely to engage administrative and clinical staff, as well as clients themselves, in the outcome monitoring process.

At a national level, there has been considerable DTFP investment in outcome measurement, including client perception of care, and the work in Ontario is particularly notable. There is a need, however, to consolidate lessons learned to date, to keep pace with new developments in the field (e.g. maximizing the potential of Internet and mobile technology) and to support further capacity development in Canadian jurisdictions. Some individual organizations are investing in outcome monitoring (e.g., Homewood Research Institute) and furthering work in this area not only by demonstrating the value-add of the resulting outcome data but also by testing the feasibility of various methodological options such as phone or email contact for client interviews. An important DTFP project is underway to build capacity for outcome monitoring within a network of youth service providers in Ontario. Ontario Works has initiated an outcome monitoring process using the GAIN-SS screening tool. Work in the costing area undertaken within the Ontario DTFP portfolio is important both for interpreting outcome data (i.e., case mix

adjustment) and for allowing better comparison of operating costs across addiction service providers.

Lastly, it is important to note that performance measurement for addiction and mental health services is receiving considerable attention within the work underway implementing the current phase of the Ontario Mental Health and Addiction Strategy. The aim is to develop and implement a small number of common indicators across mental health and addictions as well as the community and hospital sectors. A complementary DTFP-funded project is developing a set of indicators more specific to addictions and which are derived from a broad conceptual framework and literature review that covers both mental health and addiction services.

#### *3.2.4.2 What We Learned from Participants*

*Funding -Strengths in the region:*

Based on information provided by the NE LHIN, it is estimated that about $22.5 million is invested annually in addiction services. This is a minimum estimate since some addiction services are embedded in mental health services (e.g., CD workers) and in global hospital budgets. It is considered, however, to be the majority portion of the funding and representing about 25% of the overall mental health and addiction portfolio. Of course the total does not represent the total funding for addictions services in the region as there are significant resources allocated by other Ministries, government departments and community-based services (e.g., MCYS, Health Canada, municipalities).

Participants gratefully acknowledged the financial support provided by the LHIN (and other sources), funding which has typically been targeted to specific populations or types of services (e.g., youth, concurrent disorders, pregnant and parenting women, opiate related support, and supported housing). There have also been some recent investments such as the Harm Reduction Home in Sudbury and support to Benbowopka in Blind River, now with 50% LHIN and 50% federal funding.

*Funding - Challenges in the region:*

Expressions of gratitude for these investments notwithstanding, there were several dimensions to an almost universal, concomitant expression of needs and challenges related to funding. As mentioned earlier, the most notable among these concerns was the length of time that funding levels have been frozen in contrast to rising costs related to union-related wage increases, utilities, rent, and transportation, for example. The

> *"You can only invent the wheel so many times until it's not a wheel anymore".*

most recent freeze was said to be about 6 years in duration and this following a freeze of 12 years duration a few years prior. The end result has been a net decrease in service levels and many examples were cited of lost or reduced positions and service reductions. This stands in marked contrast to the picture painted of increasing case complexity and requests for service. Frustrations were also expressed about the need to frame proposals for service enhancement to fit new funding priorities rather than deal with the core issue of lack of increments in base funding for so many years.

Another aspect of this broad funding theme was the noted contrast in funding levels and salaries with other sectors, particularly mental health. The resulting challenge is difficulty recruiting and retaining staff. This was said to be exacerbating other recruitment challenges already faced in rural and remote areas of Ontario, including challenges related to hiring Francophone managers and staff.

Lastly, the concern was noted about the provincial funding model and the need for a new model such as the current approach for problem gambling where a portion of provincial gaming revenue is dedicated to prevention and treatment. The potential legalization of cannabis was seen as an opportunity to lobby for such a funding model, based on cannabis sales, and perhaps use this as an opportunity to extend the model to alcohol sales. Such a model has been advanced previously by addiction experts in Ontario (in particular Wayne Skinner at CAMH) and it was suggested that the LHIN could take a lead role in advocating for consideration of this approach (for alcohol at present) in the context of current work on the provincial Strategy.

*Planning and policy - Strengths in the region:*

Several regional strengths in this area have already been noted earlier. A few, however, are worthy of repeating: specifically, the value of the LHIN support provided through Mike O'Shea and Sylvie Guenther; the generalist role of the LHIN regional outreach officers with respect to the MSAA agreements and support for proposals regarding service enhancements; and the strong multi-sectoral nature of local planning tables focused on addictions issues in their sub-region or local area and the important work these groups have achieved.

Value of local planning: Although there are several aspects of the environmental scan that point to the need for regional-level planning, it was noted by some participants that there are advantages to retaining localized planning within the context of a regional plan. Two points were emphasized. Firstly, that the more "local the planning table" the more engagement of people in a position to make decisions, as opposed to having only managers participate without significant decision-making authority. The second point was the need to consider local adaptation and variation

> "*…making services required there [speaking of communities in the Coast sub-region] fit into all the neat and tidy boxes and expectations – it's never going to work*".

of wider initiatives when it makes sense to develop such adaptations. A case in point is the Web app developed by addiction and mental health services in East Algoma to increase awareness and facilitate access to services in the area. It was developed in lieu of participation in an Algoma-wide 1-800 information line, which was said to have subsequently received few calls for addiction services. Regional planning that aims for more commonality will need to allow room for considerations of adaptability.

*Planning and policy - Challenges in the region:*

Need for more region-level planning**:** There has been no region-wide plan to guide funding decisions over a significant period of time, with most efforts being at the sub-regional level. Further, there are several examples of historical funding decisions and past integration efforts that are impacting some current collaborative efforts (e.g. trust between hospital and community in some areas; mental health and addictions in others) and related client trajectories and transitions. The DATIS, ConnexOntario and ICES results all show movement across the region for services by people living in another area. Migration trends are noted in several other sources of information and key informant opinion. In short, the NE LHIN region as a whole could benefit from more region-level planning, information sharing and cross-sub-region projects to complement, support and provide direction to local sub-region-level planning. While there have been some such cross-sub-region initiatives (for example, the Common Referral Form), information provided in subsequent sections highlight the need for more region-level planning. (See Section 4 for recommended elements of a regional plan for addiction services).

> "*…. ability to see the big picture… direction is needed from the LHIN and the province that looks out 5-10 years and that is supported.*"

> "*I am not aware of what is going on in other areas of the region. Being divided into hubs presents challenges*"

> "*District and provincial networking is not as evident as it used to be for a variety of reasons- a lack of trust created in recent years, lack of funding, lack of opportunities*"

Perceived disparity in support for FNIM services: Participants noted that LHIN funding is provided to some FNIM services in the region, and that this funding was greatly appreciated. However, there were many other instances encountered where FNIM services had no relationship at all to NE LHIN staff and where a small boost in services (e.g., an additional outreach worker, an intake worker) was said to make a significant difference to scope and quality of services that could be provided. Some additional funding was also seen as a way to increase the level of participation of FNIM services in regional and local planning.

> "We *have done this before. We are exhausted from studying it. It's always about money. No new money so [they say] you guys have to figure it out - do it*".

Too much planning and not enough action: Several participants commented at length on the extent to which addictions (and mental health) services have been studied in the region and decried the lack of action. The response to the present review was a mix of skepticism and optimism that something concrete would be done with the results, especially the funding levels in relation to needs and requests for service.

In addition, there is an immediate need to integrate, and where possible, reconcile results from three separate reviews – the present review focused on addictions and concurrent disorder services in the overall NE LHIN; a review initiated in early 2015 by the NE LHIN and which was focused on community mental health and addiction services in the Sudbury area; and a third review completed just prior to finalizing this report, commissioned by the North Bay Regional Mental Health Program and Health Sciences North with the stated aim to produce a region-wide strategic plan inclusive of both mental health and addiction services. Among these inter-related activities, the present environmental scan provides the "deepest dive" regarding addictions services across the entire NE LHIN. In this regard there were concerns expressed by several participants about potential overlap between the present environmental scan and these other reviews and, further, that it was sign of apparent disconnect between addictions and mental health planning in the region.

> "*Why the exclusive focus here on addictions? It's a sign of siloed thinking with a lot of potential for duplication*"

Challenges with local-level planning*:* Not all sub-regions currently have a local planning table - it was felt that these should either be developed (Coast region) or re-instated (Sudbury). In addition, some members of current planning groups noted the absence of key players in their local system, for example, from the education sector, given the number of positions recently funded for mental health and addictions nurses in the schools. Representation of FNIM services was also not uniform. Another challenge noted for local planning was the lack of community data on alcohol and drug use, raised for example, by participants from the Noojmowin Teg Health Centre on Manitoulin Island.

> "*…. not a lot of funding for addiction compared to other parts of the system – as a result [they] don't get a lot of attention*."

Perceived low priority for addiction services*:* Several participants considered the lack of funding and many other challenges in meeting local needs to be a reflection of a lack of priority at multiple levels, including the provincial, LHIN and local levels. The long delay in developing a new withdrawal management service in Sault Ste. Marie was cited as but one example. The situation of Parry Sound was another example, it being cited as "*a no- man's land for planning and resource allocation given its geographic location within the LHIN structure."* Also, while advantages were recognized of the LHIN outreach officers being "generalists" (as noted earlier under

the "systems" approach), the flip side was sometimes expressed by participants that addictions as a whole was not getting the attention that it needs. This was sometimes linked to the relatively small part of the health care budget devoted to addictions, but also to the sheer scope of work of the LHIN outreach staff and immediate priorities attached to issues specific to hospitals (e.g., ALC, ER visits, deficits) or other sectors such as long-term care. The reported siloed nature of LHIN funding, and the related siloed thinking, was also cited as a challenge, despite LHIN staff being generalists.

Policy disconnects and work-arounds*:* Participants working in youth services noted the disconnect between the provincial policy of "no wrong door" and the apparent and reportedly confusing position of MCYS, at least in their jurisdiction, reflected in the statement: "*they don't do addictions*". It was noted that the age of onset of substance use and many related challenges is typically between ages 12-14 and that youth can be criminally charged at age 12. However, age criteria for addiction programs start at age 14 to 16. This was said to present challenges for access and continuity of services for those in their young teens or younger.

> *"So the route is to children's mental health services first, or justice, and then wait to age 14 for addiction treatment. What is that if not sequential treatment?"*

Several participants noted the extent to which addictions managers and staff do "*work-arounds*" regarding policy. This was summarized succinctly as "*we are dysfunctional until we are caught - that is, policy frameworks don't make sense, put up barriers, but we make it work somehow.*"

Residential treatment and methadone: Participants cited the need for provincial policy and direction regarding mandating residential treatment centres to provide access to their services for those on methadone or Suboxone. The restrictive policies of some large provincial resources (primarily in other parts of the province) were said to be putting pressure on other residential treatment centres with a provincial mandate and who are otherwise open to the provision of these types of services and supports.

*Performance measurement - Strengths in the region:*

Participants tended to be much more focused on challenges rather than strengths with respect to performance measurement.

With respect to outcome monitoring, the laudable practice of Monarch Recovery Services to conduct 6-month follow up on all clients sets it apart as a leader in this area in the NE LHIN region.

With respect to information management, a prerequisite for good performance measurement, the shared electronic record among the diverse mental health and addiction services under Health Sciences North (crisis services, withdrawal

management, inpatient, outpatient, youth and adult services) is highly laudable for facilitating client pathways of care as is the emerging shared electronic record among a range of service providers on Manitoulin Island, including FNIM service providers. Also worthy of mention in this regard is the arrangement among providers within the North Shore Tribal Council for shared information. Importantly, this includes shared information between the Blind River Hospital and the Benbowopka Treatment Centre, with recording and linking health interventions provided by an in-kind nurse practitioner to the hospital information system. Another good example is a shared information management system among a range of providers in East Algoma and yet another is the integrated charting system and shared clinical notes among WAHA-affiliated services in Moose Factory (physicians, the EMS and WAHA-sponsored addiction and mental health services).

These are examples of the kind of information transfer that is needed to facilitate client transitions and related performance measurement. Much more, however, needs to be done in this regard, and progress in this area is challenged by the diverse information systems at play in the mental health and addictions sector, a diversity that has actually been supported by the MOHLTC, at least with respect to community mental health services. That being said, the OCAN is included in the provincial integrated health record (IAR) and this is an important development.

*Performance measurement - Challenges in the region*:

There are several gaps in the current measurement of performance of the LHIN-funded addiction system. Importantly, the limitations noted below by participants are not unique to this region of the province or to this sector of health services (e.g., limited outcome data; lack of comparable cost data; diverse information systems that do not "communicate" well with each other).

> *"…it's all a big black hole, no one is using any of the data for decisions. The OCAN is not accessible".*

Lack of feedback: A number of concerns were expressed with both the OCAN and DATIS in that both were often noted as returning insufficient information to the programs submitting the information. In the case of the OCAN, it was reported as very challenging to implement any reporting function. DATIS returns considerable information for planning purposes, including for this review, and has report generation functions built into Catalyst. Thus, additional training and support in that area may be needed.

Need for evaluation and proper metrics: Reference was made not only to the general need for more evaluation, but also to the need to match required performance metrics with program logic and expected outcomes and to give time for results to be achieved in complex environments.

> *"It's all so willy-nilly. Everyone does their own thing. its apples and monkeys, not even apples and oranges – the same in mental health".*

Lack of data comparability: The lack of comparable costing and other operational data for addiction services (and no doubt mental health data) was reported as a major barrier for planning and system enhancement using actual program and service utilization data. The principle challenge noted by participants is the variable interpretation of functional centres and other definitions in the reporting systems including "administration". One example to take forward into next steps in this area is to avoid using the number of clients as an indicator. As one participant running a residential treatment centre noted: "*basing a performance indicator on service volume just rewards programs with a high non-completion rate*". In this case the indicator should be the percentage of residential clients who successfully complete the program (or the cost per successful completion).

> "*We can't use any of the data, for example, residential services, and we are as much in the dark as anyone*".

*Evidence Informed Practices and knowledge exchange/translation - Strengths in the region:*

With respect to evidence-based practices, it was not an intention in this review to drill down into the specific clinical and counselling practices within the region's addiction services (e.g., motivational interviewing, CBT, group versus individual counselling, psychoeducation, medication management for withdrawal). Doing so is well beyond the scope of this and similar environmental scans. That being said, several participants commented on specific aspects of the work in addictions in the region that do connect to this topic. Strengths with respect to evidence-informed practices include:

- Increasing use of trauma-informed treatment.
- Progress with respect to culture-based treatment for FNIM people.
- The high value placed on supported housing which has been made increasingly available, although more is still needed in many areas.

Strategies for improving evidence-informed practice*:* With respect to how to transfer, upgrade and/or sustain evidence-informed practices participants offered few comments beyond the need for, and heavy reliance, on training. High value was placed of sessional fees particularly with respect to training on concurrent disorders and managing complex client profiles. A high value was also placed on OTN access for distance education and seminars. There was little mention of CAMH/EENET or the Canadian Centre on Substance Abuse as sources of support for accessing evidence-based practice (aside from training). Nor was mention made of the value of structured approaches based on implementation science to complement and sustain training, although more than

> "*… skilled workers will become more and more of a challenge. People are looking for full-time work and reasonable wages.*"

one participant acknowledged the need for enhanced change management processes in general.

Staff recruitment, self-care and wellness: Another issue related to the uptake and sustainability of evidence-informed practice is the skill level and health of the workforce, and the organizational support offered to them. Almost without exception, participants spoke of the passion and dedication of the front-line staff, often coupled with concerns about wellness and burnout in the face of workload and the complexity of clients being served. Support is needed for training as well as a healthy work environment, including organizational support for self-care and wellness. These are necessary pre-conditions for implementation of new practices and change management generally.

Research and evaluation: In terms of research and program evaluation, some participants noted the importance of Health Science North as well as CAMH. The META-PHI project in Sudbury (see below) was cited as a laudable example of research partnered with strong system enhancement goals.

*Evidence Informed Practices and knowledge exchange/translation - Challenges in the region:*

Challenges noted by participants included:

- The need to review practices within selected residential facilities in the region to ensure sufficient concurrent disorder capability and up-to-date program content.
- The need for medical (nursing) supports in withdrawal management services.
- The obvious disconnect concerning provision of methadone or Suboxone without concomitant counselling supports.
- The need for highly integrated treatment for the most complex concurrent disorders; that is, matching the level of integrated care with the level of severity and complexity.
- The need for more mental health supports within Health Canada-funded FNIM treatment centres, which connects to the need for trauma-informed care and complexity.

### 3.2.5 Principle 4: Unique Strengths and Needs of FNIM Peoples

**FNIM peoples have unique strengths and needs with respect to substance use and related problems, and benefit from services and support that blend principles and practices of non-indigenous people with those based on traditional healing.**

#### *3.2.5.1 What the Evidence Says*

In Canada, the needs and strengths of FNIM people are unique in many ways and call for broad cross-sectoral action including, but by no means limited to, collaborative delivery of mental health and substance use services and supports. The poor health status of FNIM people in Canada, indeed internationally, is well-documented, as are the poorer conditions related to the social determinants of health (e.g., employment, income, housing). Income disparity is well-documented and underlies many other challenges related to the social determinants. Alcohol and other drug use are particular concerns that are also well-documented and linked to high rates of morbidity, such as accidents, and mortality, including suicide. The economic burden of such health issues are enormous.

There are many root causes of these differences in health status and risks of poor health, not the least of which are the inter-related impacts of colonization, the residential school experience and inter-generational trauma. As noted earlier, the remoteness of many communities also presents many challenges to accessing health services, including substance use services.

FNIM people and their traditional culture bring many strengths to the planning and delivery of substance use services, including a traditional focus on the whole person, a wellness rather than disease orientation, and a strong role for the family and community. Outcomes of health and other social supports are considered in the context of the whole family and community and not just the individual. Efforts to review and renew substance use services in Canada and elsewhere have emphasized the need to offer more choice with respect to culture-based or mainstream approaches and to incorporate more culture-based healing practices into these mainstream services. Recent work in Canada has focused on measuring the nature and impact of culture-based supports. This work, and other national and international projects, have highlighted the different cultural understanding of "evidence", for example "community-based evidence" and "practice-based evidence" as well as the need for different evaluation paradigms that are consistent with a FNIM world view.

A current DTFP project aims to develop a culture and trauma-informed assessment tool that will complement the new staged screening and assessment package being rolled out across Ontario, and which will include implementation within FNIM services as it is deemed appropriate. There is also a need to address the challenges

of stigma and discrimination and ensure a welcoming environment and culturally appropriate environment for all health services, including substance use services.

### *3.2.5.2 What We Learned from Participants*

*Strengths in the region*

There are significant strengths across the region including increased recognition of culture-based approaches to addiction treatment and key treatment and support services in the region. Several healers associated with these services contributed their perspectives and experiences to this environmental scan.

> *"If you don't follow the rules, don't worry. We have lots of people on the waiting list and you can be replaced"*

Acceptance of culture-based services (but still a ways to go): A very positive feature of the current network of specialized addiction services is the wide acceptance of culture-based treatment for FNIM people. There are many instances where this is extremely well-operationalized in FNIM as well as in non-FNIM services (many of which reported having 30-40% FNIM clients). However, some key informants recounted experiences with certain staff, working in otherwise well-regarded programs, who adopted quite an insensitive approach to FNIM clients. This highlights the need for managerial vigilance and ongoing staff training in cultural safety.

Some key programs and resources: The NE LHIN is rife with outstanding FNIM services with a strong focus on addictions. The list here is not meant to be exhaustive but rather to highlight some key programs and individuals encountered during the program and a brief note about their services that deserves recognition:

- North Shore Tribal Council for its integrated service delivery model, including the N'Mninoeyaa Aboriginal Health Access Centre for its wide variety of counselling services and educational workshops, including individual client-centered counselling, family and group therapy.
- The Native Friendship Centre in North Bay for the outstanding, and largely unrecognized, community contributions of Amanda Dokis, and the Timmins Native Friendship Centre for its significant support for traditional healing.
- Benbowopka Treatment Centre (Blind River) for the scope of its program renewal and leadership, both of which reflect a harm reduction approach
- Ngwaagan Gamig Recovery Centre (Manitoulin Island) for the continuum of services it offers.
- The keeping Women Empowered (KWE) aftercare program for FNIM women coordinated by Charlaine Skinner-Stahan at Monarch Recovery Services in Sudbury which includes traditional teachings.

- Sagashtawag Healing Lodge in Moose Factory for its family program, one of only three in Ontario.
- B'saanibamaadsiwin Aboriginal Mental Health Program for its integrated work on prevention, as well as the integration of mental health and addiction services, including outreach.
- Misiway Milopemahtesewin Community Health Centre in Timmins and the commitment to outreach over significant distance, in challenging circumstances, and with limited resources.
- The Shkagamik-Kwe Health Centre in Sudbury for its Youth Cultural Camp run by Brian Nootchtai.
- The work of Gary Martin in Timmins; Jules Tapas, Bob Sailor and Stella Schimmens in Moose Factory; and Brian Nootchtai and Angela Nahwegahbow in Sudbury; and others who are carrying and/or practicing their traditional medicine in addictions-related work but who are also seeking to build local systems of treatment and support wherein these practices and more mainstream approaches complement each other.

*Challenges within the region*

We also highlight several challenges remaining in the delivery of addiction services for the FNIM population of the NE LHIN region.

> "*Non-Aboriginal programs have nice words but is the content appropriate? When in need and have choice Aboriginal people will turn to their own community*"

Stigma and discrimination*:* We have previously highlighted the significant challenges reported by FNIM participants with respect to stigma and discrimination, particularly with respect to accessing services in hospitals (e.g., emergency rooms) and related to child custody issues and the CAS. Participants in some communities noted that the situation with CAS was improving but that training needs to be ongoing (for example due to staff turnover).

Choice is critical: More than once during the course of interviews with FNIM participants, the issue of *choice* was advanced, namely the need for FNIM people with challenges related to their substance use to have the option to seek service either in their community/region or elsewhere, a choice that is available to the vast majority of Ontarians. While participants spoke of the choices many FNIM people make to seek services outside their community for reasons of confidentiality and safety, others spoke just as strongly about the value of healing in their own community.

> "*It begins with exposure. We need more materials, pamphlets, and videos outlining what the kids should be learning. People need to be exposed to their culture."*

Choice was also said to be important in terms of selecting a culture-based or a more mainstream approach and in this regard the need was expressed for educational resources to educate and expose FNIM people to their traditional culture and healing practices. Such education was seen as an important first step in making an informed decision.

Access, transitions and the need for a community network of support: In the Coast region, and other remote areas in the region, the process for Health Canada prior-approval, transportation and other significant challenges accessing withdrawal management and/or residential treatment were described as extremely challenging. This included the need for rapid medical clearance for residential treatment (which may require an X-ray that can only be obtained in another community assessable only by air); other transportation and weather-related challenges, many opportunities for relapse (e.g., the sale of alcohol on the train to Cochrane as well as the lengthy wait at the bus station - itself a high risk environment for alcohol and drug use) and the small window of opportunity when a bed comes available in a residential treatment facility. Wait time for many FNIM and non-FNIM treatment centres was reported to be 3-6 months or longer.

*"When 25 people in your family and community have abused you where do you go for help?"*

*"It's not like people really plan to go into treatment"*

The challenging situation in the Coast communities is really just at the far end of a continuum of challenges related to accessing and transitioning between services that were reported during the environmental scan throughout the entire region. In addition to difficulties with access and service-related transitions, the transition back to First Nations communities after withdrawal management or treatment was noted as particularly challenging. FNIM participants were particularly attuned to the need for a continuum of services within a reasonable distance that included pre-treatment (withdrawal management, stabilization and support), treatment (residential, day and community) and post-treatment counselling and support for relapse prevention and longer-term recovery. Investment in a collaborative network of community support services was seen as critical to maintaining gains made during treatment, whether it be undertaken in or outside the community. The collaborative network of services developed by the North Shore Tribal Council was cited as exemplary in this regard and can serve as a model for other communities in the region.

*"With Health Links we are investing in people with the most complex needs. We need a parallel to Health Links for Aboriginal people."*

Land-based and family recovery: Several key informants spoke of the need for land-based recovery services as an important part of the continuum of services after

withdrawal management and treatment in a residential facility. The need for family treatment in this and other treatment contexts was also widely endorsed among FNIM participants.

Gambling–related challenges: Several FNIM and non-FNIM participants noted challenges related to gambling, including ready access to casinos and bingo venues. One noted that many FNIM people did not view this as a problem as they saw gambling as "*just giving back to my community*". The service providers interviewed, however, had a different perspective as they were engaged in supporting people with financial, family and other challenges related to problem gambling.

### 3.2.6 Principle 5: Age, Development, Equity and Diversity Issues

**Age/developmental considerations and a range of equity and diversity issues are critical for effective treatment system design.**

#### *3.3.6.1 What the Evidence Says*

*Older adults:* Much of the literature on the design of integrated health services, including collaborative shared care, emerges from the field of older persons' care, a field that has extensive experience with the management of chronic illnesses, such as stroke, cancer and diabetes. The need for collaborative care is almost self-evident in these instances. In the substance use field, and mental health broadly, the needs of older people can also be chronic and complex and require a special focus in both prevention and service delivery. For older adults, the aging process increases vulnerability to high physical and mental co-morbidities, including cognitive impairment. This is often coupled with a diminished social network and loss of financial resources. Older people are also more susceptible to the impacts of alcohol and other drugs and there are increased concerns for safety (e.g. falls, fire prevention), housing stability, and suicide risk. Services need to be tailored in many ways to the older adult population—for example, reduced use of reading materials; more focus on safety; fostering self-advocacy and medication management; treatment sessions of shorter duration due to older adults' tendency to fatigue earlier than others; and a larger role for a spiritual component as values shift towards this area at a later stage in life.

*Children and adolescents:* The needs and resiliency of children and adolescents are also particularly salient in the addiction and mental health field. Evidence shows, for example, that most adult substance use problems have their onset in adolescence and, indeed, there is considerable evidence concerning the link between early childhood mental health problems (e.g., behavioural challenges such as conduct disorder) and subsequent substance use problems. Therefore, treatment for mental health problems in children is a critically important preventive action for the onset of problematic substance use in adolescence and young adulthood.

There is large body of literature on the need for well-integrated collaborative systems of mental health and substance use services for children and youth. Frequently children and adolescents have a very complex profile of needs and challenges that bring them into contact with multiple service delivery systems. The consequences of missed opportunities for early intervention and poor continuity of care may be lifelong and extremely costly in terms of human suffering and economic burden. The significant challenges that youth experience when transitioning to adult services are also well-documented.

Is substance use treatment for adolescents effective? A major review of the large literature on adolescent treatment concluded with a strong statement of its effectiveness (e.g., 42% in age-specific treatment were in sustained recovery compared to 47% for adult studies). Also a recent comprehensive meta-analysis of the comparative effectiveness of outpatient treatment for adolescent substance use confirmed that: (a) almost all forms of outpatient treatment improved substance use outcomes compared to no-treatment control conditions; and (b) comparatively speaking, the best outcomes were derived from family therapy and mixed and group counselling.

Work on screening and brief intervention for youth is promising but more needs to be done. Developmental stage, an important determinant of health, is a core element of the conceptual framework for screening and assessment (see Appendix 10) and important for the choice and delivery of treatment interventions. For example, adolescents may be more susceptible to influence from peers than their older counterparts. Further, because of their smaller body size and developmental stage, they may be more vulnerable to adverse effects of substances and experience greater long-term cognitive and emotional damage.

Developmental stage, and the consideration of service delivery settings that may be unique to specific stages, are important factors for determining ***when*** during the engagement, treatment and support processes to ask different types of screening questions. For example, for young people being seen on an outreach basis in their school or street environment, it is generally not advisable to begin asking screening questions about sensitive topics such high risk sexual behaviour, trauma experiences, or illegal behaviour before a trusting relationship has been initiated. This is also the case for the adult population, including seniors, and is dependent on the specifics of the situation.

It is important to recognize that, for adolescents and adults alike, treatment may be used as a form of social control, as evidenced by the large percentage of people in treatment who are mandated or otherwise pressured to seek help. For youth, this may partially account for the significant percentage of the treatment population whose primary problem substance is cannabis and who may be "referred" for treatment but who may only require brief advice and counselling in order to effect a change in their drug use. Other youth may be dependent on cannabis and also experiencing co-occurring mental health problems (e.g., depression, anxiety, conduct disorder, psychotic-like symptoms) and require more intensive treatment,

perhaps even residential treatment. Thus, there is an important role for screening and assessment to determine the appropriate use of treatment resources for adolescents.

*Gender:* It is widely understood that there are unique gender-specific needs and considerations with respect to substance use treatment. Women are reported to have a faster trajectory from non-problematic substance use to hazardous use and substance related problems. Moreover, the vast majority of women accessing substance use services report histories of trauma. Trauma-informed treatment is therefore, critical, as are many considerations related to safety in facilities serving both women and men, and other aspects of treatment such as dealing with stigma and discrimination, mixed group therapy, child care and transportation. In this regard, outreach services are also critical for women, as are either women-only facilities and well-designed withdrawal management and residential facilities.

Men make up about 2/3 of the treatment population in Ontario and are also increasingly recognized as having special needs and considerations, including trauma-informed therapy.

*Francophone population:* I There are 125,085 Francophones in the NE LHIN region comprising almost 22 per cent of the total population. The largest proportion of Francophones in the North East is in the Cochrane region, with Sudbury, Nipissing and Temiskaming also showing significant numbers. In the NE, there are a total of 41 HSPs designated under the French Language Services Act. The Francophone population is another population with unique strengths and needs that is important for both regional and sub-regional planning.

*Other population sub-groups*: While our interview process and complementary survey were open to feedback on the strengths and needs associated with other population subgroups, it is beyond the scope of the research synthesis to focus on the many important groups, such as those defined by other gender identities (e.g., transgendered), sexual orientation, and racial, ethnic, immigration and/or refugee status. That said, in addition to the Francophone population, it is critical to attend to differences in language within our Canadian multi-cultural context, to cultural meaning attached to substance use and addiction, and to program-specific needs.

Population characteristics play a large role, and are especially important, with respect to potential stigma and discrimination, treatment access and treatment content. In general, research supports the application of an equity lens over all work with respect to collaborative service delivery and system design for substance use.

### *3.3.6.2 What We Learned from Participants*

*Strengths and challenges with services for older adults in the region*

While not identified by participants as a major priority in the region as a whole, the needs of older adults was raised on several occasions. Given the demographic trends in the region, and in particular some sub-regions such as East Algoma/Elliot Lake, one can only assume that challenges in this area will only increase over time (often referred to in the health care literature as the "*grey tsunami*"). In general, gambling-related problems tended to be identified in concert with challenges related to alcohol use. Both were linked to the lack of social and recreational opportunities and illustrates the close link between community health and health promotion and individual wellness and addiction related issues. Also with respect to gambling, it was reported that older adults with gambling-related challenges are the fastest growing clientele seen by debt counselling services.

> *"There is just not enough to do – we lack social opportunities for older adults".*

> *"They are not getting to the specialized door and we are not getting to their door".*

*Youth-specific strengths and challenges in the region*

<u>Strengths in youth outreach and community services:</u> There are several pockets of strength in the region with respect to community treatment for youth with substance use challenges - indeed too many to identify them all here. We do note several, however, primarily to illustrate some of the strengths upon which to build and share lessons learned from across the region.

- The outreach services provided through South Cochrane Addiction Services are a notable and major strength of this agency, as are the youth services provided by North Cochrane Addiction Services.
- Youth services provided through Sudbury Health Sciences Centre are noteworthy for the smooth transition offered from youth to adult services in the context of the same program. These transitions are normally very challenging. The Sudbury-based services are also noteworthy for the close integration of mental health and addiction services, as are the services offered through Algoma Family Services, including the Genesis day program.
- The three youth addiction workers within Algoma Family Services is a good example of very close and functional relationships developed between designated addiction staff and other workers who are designated as mental health staff.

- Another program of note is the Youth Cultural Camp run by Brian Nootchtai at Shkagamik-Kwe Health Centre in Sudbury.

These are but some of the excellent youth services in the region and the omission of others is not meant to downplay their importance.

Service gaps: The need for youth treatment and support services was endorsed by many key informants and does stand out as a gap in the system as a whole in the region. This was cited most often within Sault Ste. Marie and Sudbury and specifically with respect to the need for a youth withdrawal management service and residential treatment program. Also with respect to residential treatment, and Francophone youth specifically, the region hosts Maison Arc-en-Ciel, a long term treatment facility in the Cochrane sub-region. It is a provincial designated resource and provides limited, albeit potentially important, treatment for Francophone youth in the region and beyond. We say limited support only in so far as the length of stay is quite long and the facility sees a very small number of youth per year.

As will be noted below with respect to residential services generally, a recommendation from this environmental scan is for a more in-depth assessment of costs, client retention, occupancy rates and other operating characteristics of these programs. Maison Arc-en-Ciel should be included in this more in-depth review so it can benefit from a broader provincial perspective than is possible in the present environmental scan. For example, differences in strengths and needs of youth accepted into the longer-term services of Maison Arc-en-Ciel should be compared to clients receiving the shorter-term residential services offered by Maison Fraternité in Ottawa.

Representation on local planning bodies: In some sub-regions there was a lack of representation on local planning tables of the addiction and mental health resources working in schools, and funded through MCYS.

*Women-specific strengths and challenges in the region*

There are several major strengths in the region with respect to women's services. We highlight here the long-standing services offered through both Monarch Recovery Services in Sudbury and Breton House in Sault Ste. Marie/Algoma. These services anchor the whole region in the delivery of a wide range of services for women along the treatment continuum. In addition to residential treatment (Monarch) and longer term recovery support (Monarch and Breton House), they offer child care and outreach services. Both have a high percentage of FNIM women, and in the case of Monarch Recovery Services, a specific one-week aftercare program is offered for FNIM women and is open to clients in recovery from any treatment program. Both Breton House and Monarch, as well as a wide range of other addiction services in the region, have benefited from funding through the Early Childhood Development Program for Pregnant and Parenting Mothers, as well as funding for opiate-related services. Both funding opportunities have been used,

for example, to support case managers who provide significant outreach services—including court support, home visiting for emotional support, and transportation assistance, such as for accessing groceries and other necessities for children. A good example of such outreach services are those provided through the Community Counselling Service in North Bay. Another noteworthy development in the region is the development of a First Nations foster care system under the umbrella of the North Shore Tribal Council, in response to the often cited challenges with CAS and foster care for First Nations children.

The main challenges identified in the region with respect to meeting the needs of women with substance use challenges were:

- Issues of trauma, child care and transportation challenges.
- The significant challenges reported for FNIM women regarding CAS and child custody (already highlighted earlier). This is linked to larger issues of stigma and discrimination for the FNIM population in general and the need for outreach support to emergency and other hospital based services.
- The high number of babies born to women addicted to prescription opioids; in some outlying communities this is reported to occur with as many as 2/3 to 3/4 of the total number of births.
- The need for transition/recovery support homes for women that accommodates live-in children, as well as homes specifically designed to help women in recovery transition back to their community with recently returned children from foster care.

*Men-specific challenges*

When participants highlighted the need for men-only services, they were often speaking to the needs of men along the housing continuum. This continuum ranged from the need for shelter housing (e.g., Elliot Lake) to a male-only transition home (North Bay), the latter reflecting the need among FNIM people in particular.

Two specific funding gaps related to men were also noted:

- Additional financial support/beds for the ¾ way transition home offered under the auspices of the Ken Brown Recovery Program in Algoma/Sault Ste. Marie;
- Sufficient funding needed to fully operate the men's residential treatment program that was transferred from the Salvation Army in Sudbury to Monarch Recovery Services.

*Francophone-specific strengths and challenges in the region*

As noted earlier there are a total of 41 HSPs in the NE LHIN designated under the French Language Services Act and the Francophone population has unique strengths and needs that are important for both regional and sub-regional planning. The region is home to a small cadre of Francophone addiction services in areas with a high Francophone population (Maison Renassiance, Maison Arc-en-Ciel, and Sudbury Counselling Services). The region as a whole appears to have a diverse range of French language-designated addiction services, many with excellent capacity for delivering services in French.

Challenges reported by participants are that addiction services are not always available in French and are not always actively offered in French, even by designated health service providers. While it was reported that more and more service providers are asking the language of preference of clients, it was also reported that few determine the client's linguistic identity.

That being noted, the main challenge identified by participants in this environmental scan concerns the hiring and retention of French-language speaking staff. In this regard, the availability of trained candidates, as well as salary levels in addiction services, were cited as the main barriers.

Other challenges noted included access to French-speaking psychiatrists for support with people with concurrent disorders and the availability of French-language speakers/presenters for staff training and community capacity building.

*Other population-specific strengths and challenges in the region*

In the participant interviews and complementary survey responses there was little mention of other population subgroups, aside from FNIM people and Francophones. One participant noted the LGBTQ community and their strengths and needs. The Algoma Public Health addiction program noted the need for an "equity lens" to be adopted for all planning and delivery of addiction services in the region. This is a view endorsed by the consulting team preparing this report (see earlier) as it would embrace not only "other populations" but in fact would include many of the issues already identified with FNIM people and other groups in the region affected by challenges accessing and transitioning between services.

### 3.2.7 Principle 6: The Continuum of Care

**Since a significant number of people with substance use problems are in contact with helping agencies and professionals who do not identify their problems, proactive systematic screening is necessary to improve detection and access to required services. This should be followed by assessment of strengths and challenges and development of an individualized treatment and support plan, starting with placement matching along the continuum of care.**

There are several elements to this key principle. In this section we will address three of these elements separately, reflecting specifically on the evidence and the feedback from participants. The elements are:

- Screening, assessment and placement matching
- Withdrawal management services
- Residential and community treatment services
- Access, outreach and transitions

#### *3.2.1.1 Screening, Assessment and Placement Matching – What the Evidence Says*

It is widely recognized in Canadian and international research that only a minority of people with mental health and substance use-related concerns seek help from either community professionals or less formal services. Reasons for not seeking help are many and varied across communities and include:

- Limited access to services.
- Knowing how/where to seek help.
- Stigma and discrimination that challenge people to seek help or are reflected in the attitudes and behaviour of the helping agents they encounter.
- Feeling able to manage on their own; and
- Personal challenges related to responsibilities such as work, school and child care.

Research in Canada and elsewhere has also informed us for some time that, among those who seek help, the largest proportion will first access a primary health care provider or other health and social service professional and *not* a specialist provider.

*Screening:* Screening refers to the use of evidence-based procedures and tools to identify individuals with problems, or those who are at risk for developing problems. The goal of screening is to detect these problems and to set the stage for subsequent assessment and treatment – not to provide a detailed description of

problem areas or to make a diagnosis. Screening is part of a larger staged approach that also includes assessment and outcome monitoring (see Appendix 10 for a conceptual framework that guides the planning of screening and assessment processes and the selection of appropriate tools).

The research data highlight the importance of generic community services, such as primary care, hospitals (including ED), social services, education and justice-related services, being proactive in asking questions about substance use and related issues, such as mental health. There is considerable advantage to different providers using the same screening tool that quickly covers a small number of domains, for example, the GAIN Short Screener (GAIN-SS – CAMH Modified) which covers substance use problems, problem gambling, a variety of mental health challenges and crime and violence. That being said, there is often a need to adapt the screening tool to the setting, for example, busy emergency departments may need a tool with 1-2 well-validated questions.

The aim of systematic screening is to identify concerns, increase opportunities for early identification and intervention, provide access to more in-depth assessment and other services and supports, and link the person to more specialized services when needed. Since the evidence shows that many people will likely be identified who require more than a brief intervention that can be provided on site, it is important to assess the extent to which the specialist substance use providers have the current capacity to treat a large number of new-found cases. This may require system re-design as well as new resources in the specialist programs and/or additional training and capacity building within the sector where the screening will occur. Importantly, substance use treatment need not be delivered in specialist agencies via external referral.

Screening (and assessment) must also be seen as a process that continues over time as more information is shared and therapeutic relationships strengthen. Consistent with the staged approach to screening and assessment, screening can commence with a short instrument that begins to identify key issues that can be further explored in a longer, more specific screening tool. A collaborative, longitudinal approach is particularly critical for the screening and assessment of complex, co-occurring disorders, given the need to disentangle etiological sequencing (e.g., depressive symptoms induced by heavy alcohol use). In a collaborative, multi-provider approach to screening and assessment, the sharing of screening and assessment results across service providers is also critical; this of course requiring client consent. Ideally, information should be shared through e-health technology, if available.

People who are identified as having substance use related challenges as a result of the screening process require more comprehensive exploration of strengths and weaknesses in order to connect the person to the right services and supports appropriate to their situation (sometimes referred to as the right "level of care"). This staged approach helps operationalize the "any door is the right door" principle for system design as well as a "stepped care" approach to system design.

*Assessment:* In the staged framework, assessment is conceptualized as involving two stages. Stage 1 assessment is focused primarily on information gathering across multiple bio-psycho-social-spiritual domains, including health and mental health status, family/social situation, and environmental risk factors. The aim is to support and direct the client to the most appropriate service setting in a stepped care framework (i.e. level of care). Upon engagement in the appropriate setting, Stage 2 assessment then goes much deeper into strengths and needs, typically with further program-specific tools and assessment processes.

One helpful way to conceptualize the distinction between Stage 1 and Stage 2 assessment is the difference reflected in the language of "placement" versus "modality" matching.

> *Placement matching* refers to initial client assignment to a treatment setting with a given resource intensity and, therefore, has critically important cost implications. This stage is especially important for ensuring the most efficient use of scarce resources, particularly community residential and bedded hospital resources.
>
> *Modality matching* refers to individualized treatment planning and engagement on the basis of the full profile of strengths and needs and includes decisions regarding the optimal clinical approach and mix of intervention(s). This may include, for example, the balance of group versus individual treatment; the level of integration needed for concurrent mental health treatment and supports, level of engagement of family, as well as goal orientation such as reduced substance use versus abstinence.

For substance use services, Stage 1 assessment also includes a determination of the need for withdrawal management which may be initiated in one of three levels of care: home/mobile, community/medical or, in the case of complex co-occurring mental and physical problems, a hospital-based service with comprehensive medical and psychiatric supports. The CIWA-Ar is an assessment tool that further supports determination of the need for withdrawal management services. There is a parallel tool for determining needs with respect to withdrawal from opiates (Clinical Opiate Withdrawal Scale (COWS)). Withdrawal management often needs to be accompanied by a period of stabilization prior to formal engagement in treatment during which time further assessment is typically undertaken.

Aside from needs for withdrawal management, a Stage 1 substance use assessment should also determine the need for community or residential treatment at varying levels of duration and intensity. These levels of care are articulated in considerable detail in the criteria of the American Society of Addiction Medicine (ASAM) for placement/referral to substance use services, and have been tailored for the purposes of needs-based system-planning in Canadian jurisdictions (see below). The placement model developed by ASAM specifies the dimensions across which a clinician should explore strengths and needs in order to make the appropriate placement match. These dimensions include:

- acute intoxication and/or withdrawal potential
- biomedical conditions and complications
- emotional, behavioural, or cognitive conditions and complications
- readiness to change
- relapse, continued use or continued problem potential
- previous treatment history and recovery environment

It is highly recommended that these areas be examined with a semi-structured or a structured interview approach, facilitated by the use of validated instruments that support the initial placement/referral. There is a strong role for clinical experience and judgement and the validated tools are meant to complement, not replace, this judgement and experience. Clinical supervision is also important.

*The continuum of care and stepped care:* The concept of the "continuum of care" remains a useful planning tool that fits within the broader tiered framework for treatment system planning. The levels of care may be defined somewhat differently in different jurisdictions but are intended to serve similar purposes including: (a) efficient use of the most costly resources; (b) an appropriate level of risk management; and (3) optimal treatment outcomes.

A list of pan-Canadian service categories are provided below and are more fully defined in Appendix 7.[11]

*Withdrawal Management:*

- Home-based/mobile
- Community/medical residential
- Hospital-complexity enhanced

*Substance Use Community Services*

- Minimal
- Moderate
- Intensive

[11] These categories approximate Ontario functional centres and commonly used descriptors but are not identically as they represent a national consensus. They do, however provide a useful template for planning and gap analysis in Ontario, as elsewhere. Further, the pan-Canadian definitions include Internet-based mobile services, mutual aid, housing, and harm reduction.

*Residential*[12]

- Supportive recovery
- Residential treatment
- Complexity-enhanced treatment

Expert opinion and conventional practice wisdom hold that individuals experiencing higher levels of risk and harm, who have more complex substance use-related problems, and whose environment presents significant challenges for relapse prevention, will probably have better outcomes in residential treatment services compared to non-residential services. Similarly, expert opinion and conventional practice wisdom maintain that the same holds true for non-residential services that vary in duration and intensity of interventions and program structure: the more intense, structured programs such as day/evening programs are required for those with a higher degree of severity and complexity, as opposed to non-residential services where the client attends weekly or bi-weekly appointments, or a small number of very brief treatment and support sessions.

Referral criteria for the more intensive day/evening and residential services typically include severity of dependence, social stability, including housing challenges, environmental risk for relapse (e.g., heavy alcohol or drug use in the home or immediate social network), mental health and physical co-morbidity, and previous attempts at less intensive community treatment.

In a stepped-care model, treatment and support are initiated at the most appropriate, but also least intrusive, level of care, while accounting for other factors such as the person's previous treatment experience in various types of settings, service availability and accessibility, and immediate preferences. Depending on the resulting outcome, one is "stepped up" to a higher level-of-care if required and "stepped down" on the basis of progress toward the individual's goals. At moderate to high levels of severity and case complexity, this typically requires considerable transition support, including case management and shared e-health information. It also requires monitoring of outcomes, both within and post-treatment and, as noted above, adjusting the level of care accordingly.

Also with respect to transitions, withdrawal management services should aim to support not only the safe withdrawal of substances but also short-term stabilization of co-occurring challenges and facilitation of *engagement in treatment*. Similarly, community treatment and support helps maintain the gains from the more intensive phase of treatment. The critical point is that people should have access to this continuum of services and that services along it should work together to facilitate the person's successful treatment trajectory.

[12] Revisions to these definitions are likely, based on recent applications. Most important is the need, under the broad residential service category, to include "stabilization services," which provide a flexible bridge from withdrawal management to residential or other treatment.

### *3.2.7.2 Screening, Assessment and Placement Matching – What Participants Told Us*

*Strengths in the region:*

Compared to other areas of strength and challenges regarding addiction services in the region or sub-regions, there were comparatively few comments related to screening, assessment and placement matching. Among the strengths noted were:

- The common use of the GAIN-SS among addictions and mental health services in the Timmins-Cochrane area and many other regional services.
- The ADAT tools, but typically in the context of agencies sharing resources for ADAT assessments, commitment to the ADAT processes for accessing residential treatment, and training among selected providers. The implementation of the new staged screening and assessment package was welcomed by those aware of the new tools and processes; participants encouraged careful regional and sub-regional implementation planning for this initiative.
- The "Common Referral Form", which has been developed by a collaborative region-wide process; some noted that the implementation of the form now needed to be coordinated with the implementation of the new screening and assessment tools.

*Challenges in the region*

The main challenges noted with respect to current screening, assessment and treatment placement processes were related to:

> *"We need to review the residential criteria in ADAT, there is a lot of slippage there."*

- The provincial criteria and process for accessing residential treatment; participants noted the need to review and update the criteria based on the ADAT tools. They also noted that these criteria, and adherence to them, should be further examined during the implementation of the new screening and assessment package.
- The reported wait time in some programs to get an ADAT completed; in one instance in a LHIN-funded program this wait was reportedly over 3 months.
- The relationship between the new screening and assessment tools and the OCAN; programs offering completely integrated addiction and mental health services anticipated challenges as they may be required to complete the new package of tools as well as the OCAN.

### *3.2.7.3 Withdrawal Management – What the Research Says*

With respect to withdrawal management, a body of evidence exists supporting a range of options, depending on the severity of the intoxication, the duration of heavy use, and other factors, such as co-occurring mental health and physical health conditions and stability/safety of the home and community environment for relapse potential. These options range from a high level of medical and psychiatric care (referred to as "hospital complexity-enhanced" or "medical" withdrawal management) to a non-hospital "social" model of residential withdrawal management to a non-residential "home-based/mobile" alternative. In Ontario, each of the withdrawal management programs that operate on a social residential model (almost all of Ontario's WMS programs) are required by legislation to be sponsored by a hospital. However, as will be discussed below, they also have varying degrees of functional integration with the hospital for medical support – many being almost totally independent except for emergency cases. In many jurisdictions, both the social residential model and the home-based/mobile model of withdrawal management include some supports for medical management, although in Ontario this is much less common than elsewhere.

Many parts of Canada, including Ontario, are challenged by two important issues with respect to withdrawal management: (1) keeping standards, protocols, staff competencies and infrastructure up-to-date with evolving program objectives and client profiles, in particular with respect to the trend toward increasing levels of physical and mental health co-morbidity as well as poly-drug use, including opiate dependence; and (2) planning and implementing home-based/mobile alternatives.

On the first point, withdrawal management services in Canada have embraced the evidence that "detoxification" alone provides short-term symptom relief and rest but that it rarely leads to intermediate or longer-term recovery without subsequent treatment. To that end withdrawal management services should include motivational and other preparatory efforts aimed at further treatment and support. This also requires flexible lengths of stay to help stabilize the individual and improve treatment readiness. In short, adopting a "trajectory" approach for withdrawal management within a chronic disease model means provision of a basket of services aimed at stabilization, medical/psychiatric screening and management and psychosocial supports for future treatment engagement.

In Ontario, the need for medical/psychiatric screening and management has become an area of increasing concern since the provincial network of social model - residential withdrawal management services was initially designed as an alternative to public drunkenness. Although, this social model may have been effective in dealing with alcohol intoxication, with occasional medical back up from the required sponsoring hospital, it is no longer a functional model that matches the complex needs of today's clientele.

There are calls for increasing involvement of nursing staff and this is being put in place in some jurisdictions. In Toronto, for example, the TC LHIN funds a nurse practitioner who provides medical supports across the network of Toronto's withdrawal management services[13]. In Ontario, a new research project known as META-PHI, being led by Dr. Mel Kahan, is evaluating a collaborative care model between hospital emergency departments, local withdrawal management and other community services, and rapid access to medication-assisted withdrawal and treatment of opioid addiction in an addiction medicine clinic. Such models that engage emergency departments are absolutely critical as they are often the first point of contact for heavily intoxicated individuals, for example, if there is no local WMS or if they have been involved in an accident. Also, the local emergency department may be called upon by the community withdrawal management service to provide a medical clearance indicating that the person can be safely treated outside the hospital. In short, there is considerable involvement of emergency department services in managing intoxicated individuals. Issues related to stigma and discrimination are also commonly reported.

The picture across Ontario and in some other provinces, with respect to medical and psychiatric support for withdrawal management, is not a uniform one as some communities have developed highly functional liaisons for such support. That being said, the issue is salient enough to occupy much of the discussion among meetings of Ontario's managers of withdrawal management services and supporting organizations such as Addictions and Mental Health Ontario (AMHO) which has worked on withdrawal management standards for several years.

In Quebec, a project is being planned to develop and validate a measurement tool to efficiently signal the need for more medical support among clients presenting for withdrawal management. In BC and some other provinces and territories, this issue of securing medical support is a "non-starter" since all withdrawal management services include nursing staff and close liaison with physicians through a variety of means. While a non-starter for BC and elsewhere, it is currently a very delicate situation for risk management in Ontario.

With respect to home-based/mobile options for withdrawal management, the research literature unequivocally supports a variety of approaches. A few such programs operate in Ontario (e.g., London/Thames Valley, Manitoulin Island, Halton region). However, the current scarcity of such options in the province and elsewhere represents a major opportunity for knowledge exchange and implementation of evidence-based practice. This knowledge to implementation gap is no doubt due in part to factors common to implementation failure - factors such as resistance to change among key opinion leaders, lack of leadership and implementation and evaluation support among policy makers and funders and, in the Ontario context at least, the added barrier of funding needs in a time of fiscal restraint in health services. Funders, however, need to consider the existing evidence that home-based/mobile services have the potential for larger reach than

[13] Currently St. Michael's Hospital WMS does not participate.

bed-based options and have been shown to reduce ER visits and hospital utilization. Thus, they score highly in both cost-effectiveness and cost-benefit.

Models for home-based/mobile withdrawal management are varied and there is not a substantive body of research investigating the pros and cons of different approaches in varying community contexts. Undoubtedly the model needs to be tailored to the community and include a developmental evaluation embedded in planning and implementation. Models, singly or in combination, include:

- Mobile teams, such as the Riverside Model in Fraser Valley, BC, whereby, a small travelling team comprised of a nurse and social worker, with dedicated physician and psychiatrist back-up, provide service in people's home community (e.g., the person's home or agreed upon alternative -a dedicated "safe" site in the community). There are specific teams for First Nations communities, recently added on the basis of positive evaluation results. The Riverstone Model also includes provision for access to STAR beds (Short Transitional Access to Recovery), which support clients whose homes are not safe for supervised withdrawal management.

- Provision of distance support by a system of tele-health (e.g., by OTN, Skype) with appropriate pre-screening of home/community risk and support.

- Outreach workers from existing bed-based services; such workers can also provide a range of other harm reduction and supports for treatment engagement.

- Screening, stabilization and basic medical monitoring by trained community health workers or primary care nurses with a protocol for specialized distance support (e.g., OTN), and transportation as required.

Developing increased capacity for home-based/mobile withdrawal management requires a "total system" response including, but not limited to, standardized screening and assessment tools for determining level-of-care needs (including home and community risk and supports) and service/accountability agreements for back-up support from residential withdrawal management services and hospitals, including transportation protocols. In some rural and remote communities, building local capacity for home-based/mobile withdrawal management is the only viable option to costly and often risky transportation, from a medical management point of view. Increasing access to support by OTN and the Internet also increase the alternatives that can be explored, adapted and evaluated in the Canadian context, including in Ontario. No doubt these various models can also be combined with the provision of support for screening, assessment and opioid substitution treatment and thereby present an opportunity for more collaborative work between the

currently quite separate systems of treatment for opiate dependence and other substance use treatment and support services.

### *3.2.7.4 Withdrawal Management - What Participants Told Us*

*Strengths in the region*

Themes related to current strengths with respect to the region's withdrawal management services include:

Current capacity: While there are some organization-specific challenges, a significant capacity for residential withdrawal management services exists within (or near) each of the region's major population centres, with the exception of Moose Factory/Moosonee, and the distance and associated transportation challenges between the WMS in Smooth Rock Falls and the cities of Timmins and Cochrane. In addition to these residential services, there are two examples of community withdrawal management services: one long standing program on Manitoulin Island, and the community addiction program affiliated with the primary care service within the North Shore Tribal Council.

Flexible length of stay and transition supports to treatment: The Smooth Rock Falls WMS stands out with respect to its flexible length of stay and demonstrated commitment and expertise to transitioning clients to treatment, supported for example by stabilization and comprehensive assessment. These services and supports for service transitions serve as a model for others regarding client engagement.

Enhanced medical supports: Although not a strength throughout the group of withdrawal management services in the region as a whole, there are noteworthy examples of enhanced medical support in some of the WMS services. This includes the availability of a methadone nursing position in North Bay WMS and a variety of collaborative arrangements with hospital and/or community physicians (as in Sudbury Health Sciences North, Oak Centre, Sault Area Hospital WMS and Smooth Rock Falls).

Use of safe beds: In Timmins, where the need for withdrawal management services continues despite the existence of the program at Smooth Rock Falls, "safe beds" have been incorporated into Jubilee Centre to meet some of the local needs and take

pressure off the ER department. While other challenges were noted with this situation, in particular the lack of year round availability due to Jubilee's full closure in the summer months, this is an innovative use of a funding opportunity to meet local needs and enhance medical supports in a community-based service. When stabilized medically, clients are often referred on to Smooth Rock Falls WMS for additional stabilization and preparation for treatment.

Intersection of alcohol withdrawal management and opiate substitution treatment: Many participants noted the intersection of alcohol dependence and withdrawal and opioid dependence and withdrawal within the region's emergency departments. The research and development project at Health Sciences North, known as META-PHI, and led provincially by Dr. Mel Kahan from Toronto, links hospital ED services, community withdrawal management and other services, and medication-assisted treatment for opioid dependence. This is very high need area for the development of collaborative care and needs to be monitored carefully for lessons learned that can be transferred to other parts of the region.

*Challenges in the region*

These many strengths notwithstanding, there were several gaps and challenges related to withdrawal management services in the overall region and within the various sub-regions. The various themes identified below should be considered in the context of the need for a region-wide plan for withdrawal management services.

Need for enhanced medical capacity: Consistent with trends across Ontario, several participants commented on the need for increased medical staffing/competencies in the region's withdrawal management services. The need for increased medical support was primarily connected to a perceived need for supports from nurses and/or nurse practitioners, again reflecting provincial trends. This feedback also reflected a need for enhanced medical supports for the region's safe beds

> "*There are not a lot of criteria on who is coming in. No medical assessment, no vitals, no nursing staff. Staff at the detox use their judgement whether someone needs medical clearance coming in or being dropped off by the police. If a concern then they go to emerg in a cab."*

Enhanced crisis/safe beds: In some areas, participants noted the need for additional crisis/safe beds to allow a better transition from withdrawal management to treatment. This was highlighted, for example, by Camillus Centre in Elliot Lake.

Enhanced support for outlying communities via OTN: While the call for enhanced use of OTN services was echoed across the region as a whole, it was particularly evident in terms of offering more support for withdrawal management services in

outlying communities, including the more remote communities in the Coast sub-region. There is a close connection between the need for enhanced medical supports and this call for increased utilization of OTN. Specifically, OTN resources could support people in immediate crisis of alcohol/drug intoxication in the more rural/remote communities, as well as help meet the potential need for opioid agonist treatment.

More focus on treatment engagement and transitions*:* Several participants noted the importance of a flexible length of stay in residential withdrawal management services. In at least one of the region's WMSs, a defined length of stay followed by automatic discharge was reported as an ongoing practice. Flexible stay and other client-centred approaches for treatment engagement should be considered a core feature of all WMSs in the region. Similarly the provision of transition and follow-up supports should be a core element of services provided by the region's WMSs.

Specific service gaps related to withdrawal management services:

- *Top-up funding for Smooth Rock Falls WMS*: During the review the annual funding shortfall at the Smooth Rock Falls WMS was duly noted and this shortfall is typically managed by transfer of surplus from the local CMHA. The shortfall at the WMS was said to result from an initial funding deficit for service operations. Given the longstanding and important role of this facility in the region, some means should be found for permanent resolution of the funding shortfall.

- *Community withdrawal management:* There was an expressed need for enhanced community withdrawal management, including the use of OTN for home/community supports when the home/community situation is appropriately cleared for medical safety through screening and assessment processes. As noted in the evidence review, there have been important advances in community withdrawal management services in recent years in Ontario and elsewhere in Canada. However, this progress has not been recognized by some opinion leaders in the region's treatment system despite evidence that home/mobile WMS is cost-effective and can reduce utilization of hospital emergency departments. The most apparent opportunity for enhanced community withdrawal management services in the region is associated with the recent retirement of Barb Deschamps from the community withdrawal management program on Manitoulin Island. This departure may provide an opportunity to re-purpose some funding to expand the reach of the service and assist in capacity building in other areas of the region.

Some participants also noted the synergy between models of supportive housing and community withdrawal management. A natural place for a pilot project is in Timmins given the existing collaboration between CMHA (supported housing and nursing capacity) and the South Cochrane Addiction Services (which is very strong on outreach services).

- *Moose Factory/Moosonee:* One of the initial drivers underlying this environmental scan was a question about the need for a WMS in Moose factory/Moosonee. Considerable feedback on this question was obtained from participants in the Coast sub-region, including physicians, program directors, mental health and addiction workers, cultural workers and traditional healers. All acknowledged the need for withdrawal management services while noting several critical aspects of local context, including the following points:

    - Participants reported a high use of the WAHA hospital emergency department service, other departments of the hospital, and community health services throughout the region related to alcohol and drug use.
    - The longstanding and valued relationship with the WMS at Smooth Rock Falls was noted, while also acknowledging the significant challenges with travel approvals and arrangements, including language challenges for those speaking only Cree, and the high risk of relapse and other medical complications while in transit.
    - The opinion was frequently expressed that even with a local WMS resource in place many people in the area needing substance use treatment prefer to go out of the area for purposes of confidentiality. A strong counter-argument was, however, offered by other participants that this is not necessarily the case for withdrawal management services as long as they also offered stabilization and active referral/engagement to treatment. Important feedback also came from workers, who had experienced their own process of recovery, that healing was stronger and more sustainable if undertaken in the home community rather than externally.
    - All participants with a point of view on this subject felt that the location of any new service should be in Moosonee, as opposed to Moose Factory, given transportation issues across the river. These participants also felt that the new service should be planned in concert with current plans for a new hospital to be sited in Moosonee.
    - The WAHA hospital was seen as the logical sponsor for the service but closely affiliated with the current mental health and addiction program. It was also noted, however, that the service should not

necessarily be within a medical unit, but rather be situated within a more community-oriented setting funded and sponsored by the hospital and with a strong focus on FNIM culture, including involvement of traditional healers and in-house medical support through nursing professionals (ideally one or more nurse practitioners). Participants also felt that such a hospital-affiliated service would need to be supplemented with a small number of beds set aside in the hospital for management and stabilization of medical complications and guided by protocols for transitioning the individual to the community setting.

- Lastly, participants noted that a stronger and more coordinated network of community services was needed to support a new WMS in Moosonee to help stabilize and prepare people for treatment and to successfully transition them back to the community. This community network, and transition protocols in particular, needs to be strengthened in concert with any concrete plans for a new WMS.

*Sault Ste. Marie:* Participant feedback, as well as the perspective afforded by an on-site visit made during this review, strongly supports a new location/facility for the WMS in Sault Ste. Marie. The physical condition of the building, as well as safety concerns related to the co-ed nature of the program and the building's physical layout, reflect the need that has been expressed locally for quite some time.

During the review, discussions were well-underway about where to locate the building. This was not a subject of this review *per se*, and considerable local feedback will be needed for this decision (e.g., to explore implications related to available public transit). It is important that the need expressed in this review regarding enhanced medical supports within the region's withdrawal management services NOT be misinterpreted as support for locating withdrawal management services *within* the region's hospitals, including in Sault Ste. Marie. This is not cost-effective as, while a percentage of WMS clients will need some medical and psychiatric supports, experience elsewhere suggests that these can be well-managed with an appropriate model of collaborative care that includes nursing support in the community-based WMS and good cooperation with hospital-based and other community physicians.

- *Parry Sound:* Participants from this area noted the challenges experienced with being between two population centres with withdrawal management services and the ensuing transportation challenges. It is unknown if Parry Sound and the surrounding area would have sufficient withdrawal management cases to warrant a residential WMS facility. This should be studied more carefully than was possible in this review. That being said,

participants considered the possibility of community withdrawal management given the strong cadre of community addictions and mental health services embodied in the local CMHA.

### *3.2.7.5 Residential and Community Treatment Settings – What the Evidence Says*

Of considerable relevance to discussions concerning cost-effectiveness of options for allocation of resources for addiction treatment services is the evidence regarding the role of residential treatment compared to community treatment. In the research literature, community treatment is typically referred to as "outpatient" or "intensive outpatient" treatment due to the use of these terms in the United States, where most of the research has been performed. The question about relative cost-effectiveness in favour of community treatment has been settled definitively in the research literature and to the satisfaction of major treatment providers and funders internationally. However, most experienced clinicians and addiction service researchers consider that some level of residential service (i.e., supportive recovery, residential treatment, intensive/complexity enhanced) is optimal for people with a certain profile, such as severe dependence and co-occurring disorders, severe social marginalization, and earlier attempts at community treatment as per the stepped care model. This is true also for youth substance use treatment services, although the data are less convincing. It is challenging to summarize this large and complex literature here but the following points are particularly salient for treatment system planning:

- The evidence underlying community treatment programs (outpatient) is excellent for the vast majority of people in need of treatment and support, including adolescents; and for intensive outpatient (e.g., day or evening treatment) which can be seen as an alternative for many people who may otherwise be directed to residential treatment.[14] There is also strong evidence that the effectiveness of community treatment can be enhanced by community case management.

- There are many "levels" and types of residential treatment and support that have been studied in the research literature and they fall roughly into the three categories noted above for the Canadian Needs-based Planning Project. That said, there are many nuances in the delivery of residential services as well as in the target populations served that make it very challenging to summarize the research literature into cogent summary statements. While experts agree that residential services have an important role to play in the

[14] The evidence for intensive outpatient treatment (i.e., day treatment) is less conclusive for youth services compared to adults

treatment continuum, they also agree that more evidence is needed on the profile of people best suited to these services, including youth.

- An important Canadian review undertaken in support of the (then) Ontario Addictions Treatment Rationalization project concluded that the best designed research studies either favoured community treatment services or showed no difference in outcomes compared to residential treatment. At that time there was also little evidence that length of stay made a major difference to treatment outcome, nor did the severity of the client profile, with the possible exception of co-occurring mental health challenges. The recommendation was for residential treatment to be used very selectively and in a stepped care model, for example, preparing the person for extended community treatment and support. The recommendation was also made for open treatment cycles of flexible, rather than fixed, duration and tailored to individual strengths and needs.

- The most recent syntheses of research on residential treatment have concluded that the strength of the evidence is "moderate" for both supportive recovery and shorter-term, more structured residential treatment. While the evidence is not as strong as for community treatment, the reviewers concluded that it was strong enough to recommend that decision-makers continue to support selective use of residential treatment as part of the continuum of care, while also highlighting the need for more research on matching criteria. The same can be said for youth residential services.

- Therapeutic communities (TCs) are a long term residential treatment model characterized by a longer length of stay (usually 6 to 12 months) and a unique program structure that utilizes the program's entire community – including residents, staff and the social context- as active components of treatment. So-called "modified TCs" have evolved and many now use more professional staff and tailor services to special populations such as people with severe co-occurring disorders, the incarcerated, or homeless, to name a few examples. The most recent research review concludes that the evidence, in terms of effectiveness of TCs is "moderate". As with other types of residential treatment, more research was said to be needed due to methodological challenges, and in the specific case of TCs, the very high drop-out rates. Results tend to be better for modified TCs focused on people with co-occurring disorders and those focused on incarcerated populations with a continuing care component.

To summarize, virtually all the research evidence points to the selective role of residential treatment in the care continuum. When utilized, it should be one component of a person's pathway in and through the treatment system, and not expected to serve as a stand-alone treatment experience. Residential treatment may be a necessary option for some people but is rarely a <u>sufficient</u> component of the

treatment trajectory. It must, therefore, be used judiciously to ensure appropriate use of scarce resources. The lower cost-effectiveness of residential compared to community treatment also means it is especially important to routinely and systematically monitor outcomes in these services. This includes both recovery-related outcomes as well as performance measures related to adherence to criteria for admission, retention and follow-up continuing care.

#### *3.2.7.6 Residential and Community Treatment – What Participants Told Us*

*Strengths in the region*

Strong current capacity: As with the region's withdrawal management services, there is a strong foundation of residential and community treatment services. With respect to *residential treatment*—both short-term treatment (typically 3-5 weeks) and longer term supportive recovery (typically 3 months or more)—the region hosts a cadre of highly regarded services. These services are part of the larger provincial network of residential programs and, as such, accept referrals from anywhere in the province, and sometimes beyond. These residential programs are located in major population areas of the region (i.e., North Bay – North Bay Recovery Home North Bay Regional; Timmins - Jubilee Centre; Cochrane - Maison Renaissance and Arc-en-Ciel; Sudbury - Monarch Recovery Services; Sault Ste. Marie – Breton House and Ken Brown Recovery Home; Elliot Lake - Camillus Centre). The region also hosts several FNIM treatment centres funded wholly or in part through the First Nations and Inuit Branch (FNIB) of Health Canada. This includes Wikwemigong on Manitoulin, Benbowopka in Blind River[15], the Healing Lodge in Moosonee, and Garden River Healing Centre. Some of the residential services, such as Monarch Recovery Services, Maison Renaissance, and Maison Arc-en-Ciel specialize in services for particular sub-populations, namely women, Francophone and Francophone youth, respectively, and this requires additional consideration in regional planning.

Although some participants expressed concerns with individual centres (e.g., cultural safety for FNIM clients, wait times, program length or content, underlying philosophy, concurrent disorder capacity), the overall thrust of the participant feedback was positive and acknowledged the important role the residential centres play in the local, regional and provincial treatment systems.

The strong, current capacity in the region with respect to *community treatment* services also came through clearly in participant feedback. This included services offered in larger communities and their surrounding area (e.g., Sudbury - Health Sciences North; Sudbury Counselling Services; and Sudbury CMHA; North Bay - Community Counselling Services; North Bay Regional Mental Health; Sault Ste. Marie – Alternative for Youth (Genesis Program); Algoma Public Health; and the

[15] The program at Blind River is not exclusively for Aboriginal people but this is clearly the primary target population.

Addiction Treatment Clinic at Sault Area Hospital; Timmins/Cochrane - South Cochrane Addiction Services and North Cochrane Addiction Services; Moose Factory/Moosonee – WAHA Mental Health and Addictions Program) as well as agencies in smaller communities (e.g., Elliot Lake, Chapleau, Sturgeon Falls, Parry Sound) and mentioned earlier in the context of their well-integrated mental health and addiction services.

In addition, there are a host of other service providers engaged in community treatment and affiliated with a wide range of providers and sectors, including Native Friendship Centres and First Nations reserve-based programs such as in Sagamok, Community Health Centres, Community Care Access Centres/schools, etc. Further, some of the region's residential services have significant reach into the community through their outreach and treatment engagement services (e.g., Monarch Recovery Services).

As with the region's capacity for withdrawal management and residential treatment there exists a strong network of community treatment services on which to build.

Concurrent disorder (CD) capacity: The regional network of residential and community treatment has been enhanced significantly over the past several years with a designated MOHLTC CD-funding opportunity several years ago. Enhancement in concurrent disorder capacity has occurred with both designated CD positions (e.g., Timmins CMHA; North Bay Regional Mental Health) as well as through enhanced training and staff competencies (e.g., Jubilee Centre in Timmins).

Harm reduction: Several participants commented positively on the general support for harm reduction as a guiding principle underlying the region's treatment services as a whole. This principle was played out, for example, with respect to access and support for people on opioid maintenance treatment as well as active involvement in local Harm Reduction Committees; leadership for development of "Patch for Patch" programs; needle exchange programs; and recent funding of the Harm Reduction Home in Sudbury with a managed alcohol program, to name just a few examples.

This general support for harm reduction does not mean that there was no variation in key aspects of this construct, for example abstinence versus moderate use goals – this being a matter of program-specific philosophy and principles. Importantly, the issue of abstinence or moderate use treatment goals tended to be viewed along a continuum of goals rather than as an either/or choice and dependent on the person's situation and current trajectory. For example, Monarch Recovery Services reported explicit goals of abstinence while in program but which can change after discharge and depending on the person's goal achievement and overall well-being.

Culture-based treatment: As noted earlier, participants highlighted the wide acceptance of culture-based treatment for FNIM people within the regional network of programs. While concerns were occasionally noted about particular treatment programs with respect to the depth of the commitment to principles and practices of

culture-based treatment, the general thrust of the feedback was that a bridge had been crossed in terms of philosophical acceptance and, in some instances, strong-culture-based practices. A related strength, although limited to the Healing Lodge in Moosonee, is the availability of treatment for family members in the context of their culture-based treatment for addiction.[16] This is one of only three such programs in the province.

Other strengths in the system: Many other strengths in the region's community and residential treatment services are highlighted in other sections of this thematic analysis and will not be repeated here in detail. Noteworthy, however, are innovations in access and engagement, wait list management, comprehensive assessment and referral, support in the area of opioid-related treatment and outreach services.

> *"We do a lot here (community program). We see a need, we create a program"*

*Challenges in the region*

Notwithstanding the many strengths in the region's treatment network, there were a number of challenges and gaps noted.

Funding challenges: An earlier section highlighted the significant challenges with respect to funding; these challenges driven in large part by the long-standing budget freeze, increased demand, and annual increases in operational costs. Although this funding issue cuts across the entire regional network, we highlight here only those issues specific to the delivery of community and residential treatment services:

- Several examples were cited of significant staffing and corresponding service reductions due to the funding freeze. Among community agencies it was reported that the impact was proportionally greater for small compared to larger agencies.
- Funding shortfalls in the region include Jubilee Centre in Timmins and the need for additional funds to accompany the transfer of the Salvation Army Men's Treatment Program to Monarch Recovery Services in Sudbury.
- For historical reasons, funding for the youth program at Maison Arc-en-Ciel is currently flowing through Maison Renaissance. This limits LHIN oversight and program accountability.
- Most of the region's residential services are relying on outside service contracts to maintain services and address the chronic shortfalls. Renewal of these contracts is uncertain and the impact of losing these contracts on

[16] A family program is also offered at Camillus Centre with a non-Aboriginal focus.

the sustainability of the core residential services in the region has not been assessed at a regional level.

Unexplained variation in operations, cost and content: There appear to be significant outliers across the region's residential services in terms of cost of services provided, clients served, retention levels and occupancy rates, for example. A more detailed analysis of these data is required than was possible in the present environmental scan, due to challenges with data being recorded in an unstandardized fashion. However, enough data was reviewed to show the significant variation and raise concerns about a lack of explanatory factors, especially for important indicators such as program completion rates.

Challenges with access: Participants noted the significant challenges related to accessing residential treatment services in the region. While concerns regarding access were not limited to residential services, the most salient comments were specific to this sub-group of services. This included challenges with wait times, challenges meeting all the criteria for admission, including medical clearance in remote communities, as well as significant variation in admission criteria and processes. Most, but not all, services, for example, accept clients on methadone. There was also a fairly consistent call among participants regarding challenges with access and the need for more services in the region for "complex cases". Some participants raised the question as to whether a proportion of the current clients in the region's residential services could be equally well served by community treatment programs, thus freeing up capacity in the residential services for more complex cases.

*"It's the long waits. The system is hard to navigate and you lose that window of opportunity"*

*"There is just not enough here for the real complex""*

*"Admission packages to enter residential treatment facilities across the province are inconsistent, causing unnecessary pressures. Standardized medical forms would alleviate the pressure"*

Medical/nursing enhancements: Somewhat related to the above, and consistent with the participant feedback already reported for withdrawal management services, many participants noted the need for further investment in nursing supports in both residential and community treatment services. This was tied in part to the need for more collaborative managements for medication-assisted treatment (e.g., methadone), and/or concurrent mental and physical challenges.

In one illustrative case it was reported that South Cochrane Addiction Services had stepped up to host the community's Outreach Hepatitis Clinic, which was forced to seek a new location. They were unable to host the program, however, because of the lack of nursing staff. This remains a significant gap in the local community. Clients with Hepatitis C or HIV are now required to move to Sudbury for care or go outside

the community to die with dignity, as in a hospice. Lack of nursing staff also prohibited the program from participating in the local Health Links.

While some programs have developed solutions unique to their situation, such as a part-time nursing position (e.g., Jubilee Centre), coordinated care with a local physician (e.g., Camillus Centre), or collaborative arrangements with a local hospital (Blind River), there is a need across the board for an enhanced role for nursing in the region's residential and community treatment services.

Transitions and building community supports around residential treatment: Participants consistently reflected on the need to consider residential treatment as only one element of the region's continuum of services, and called for priorities to be established to build more capacity for community supports, including transition supports upon discharge. This, in effect, calls for the stepped care approach to both system design and individual treatment planning.

> *"We need to re-conceptualize residential treatment. Most people have been through 3-4 times at least. It's one step…"*

Specific service gaps regarding residential and community treatment services:

- *Better management of summer closures*: More than one residential program in the region closes for a period of time in the summer due to lack of funds needed to allow for operation when key staff are on vacation. Program closure does not mean full closure of the facility, with the exception of Jubilee Centre in Timmins, which was raised as a significant concern locally and throughout the region. The expressed concern was in part related to the significant period without community access (approximately 8 weeks every summer), including access to other services offered by Jubilee, such as the safe beds, but also due to the pressure it put on other parts of the regional residential treatment network that remained operational. Participants suggested that processes be put in place for all residential services in the region that currently close for all or part of the summer months to ensure maintenance of basic administrative services, for example, responding to calls, bookings for future admission, and facilitating access to support elsewhere if needed.

- *Day/evening treatment:* Among the gaps in the local or regional treatment system, one of the most frequently cited was day or evening treatment services, especially in Timmins, Sault Ste. Marie and Sudbury. Some participants noted that not all parts of the region have the population base to support day/evening service options, although the three communities identified above would likely have sufficient cases and could take the load off some of the region's residential programs.

- *Youth residential treatment:* Youth residential treatment was also cited as a gap in the system. Enhancements in this area would have to be prioritized carefully, based on a more detailed analysis of severity profiles, costs, completion rates, etc. for the one existing program for youth – Maison Arc-en-Ciel. Its role in the regional and provincial treatment system needs to be considered in relation to reported under-utilization of the Francophone youth residential program in Ottawa- Maison Fraternité.

- *Transition/land-based residential recovery services for FNIM people:* A consistent aspect of the feedback regarding residential treatment for FNIM people was that the program duration in most treatment centres (3-5 weeks, including FNIB-funded programs), was just too short to successfully deal with the impact of the trauma experienced by the vast majority of clients. This included consideration of the residential school experience, inter-generation trauma, and individual personal experiences of sexual or other physical and mental abuse. In addition to more flexible length of stays and enhanced capacity for treating concurrent disorders in many programs, some called for more transitional recovery support, including land-based residential support in remote areas to assist in reintegration with traditional culture and planning a sustained recovery in high risk community environments. This resonated with FNIM people interviewed across the region, but was most salient among those interviewed in the Coast sub-region. An option was presented for further investigation as participants from the Moose Cree Health Services noted a property they owned that could be re-purposed.

  *"we need to connect the dots - create a seamless system"*

- *Other residential transition needs*: A number of specific gaps/needs for service enhancement were noted for FNIM and non-FNIM clients alike and which are consistent with the theme of ensuring effective transition support after discharge from residential treatment. For some clients, this means transition support to residential recovery support services. Needs for additional long-term recovery beds or enhanced facilities were noted by several such providers including Ken Brown Recovery Home in Sault Ste. Marie (for ¾ beds), North Bay Recovery Home and the men's and women's supportive recovery programs at Monarch Recovery Services in Sudbury. It is important that this part of the treatment continuum continue to receive the attention it deserves to facilitate community re-integration and longer term recovery, often for more marginalized populations.

#### *3.2.7.7 Access, Outreach and Transitions – What the Evidence Says*

Many experts argue that the need for direct treatment resources notwithstanding, priorities for overall treatment system enhancement should focus on improving access to available services, continuity of care and program completion.

*Access to services:* Planning a seamless treatment continuum requires consideration of how people access the overall network of services in such a way as to minimize wait times and maximize treatment engagement, retention and completion. It is widely recognized that client engagement can be enhanced by ensuring a welcoming attitude among all program staff, as well as the creation of a welcoming physical environment (e.g., non-institutional look-and-feel; physical layout; or posters with content reflecting a diversity of people—e.g., age, gender, sexual orientation, cultural and ethnic heritage). Engagement is also impacted by the overall length and efficiency of the treatment entry process, including the intake, screening and assessment tools and processes. Generally speaking, treatment systems should be planned to facilitate withdrawal management and/or treatment as quickly as possible in order to take maximum advantage of whatever factors brought the person to the threshold of seeking professional help. There is a large literature on facilitating factors related to the help-seeking decision, for example, accumulation of negative consequences and related encouragement from family or health professionals. There are also well-recognized barriers to treatment entry and participation (e.g., child care, transportation).

It is important to use this research information to design processes for treatment entry and engagement. Trained "engagement specialists" may be employed and incorporated into the intake process of all or specific programs to assist in providing supports to treatment entry, such as transportation, child care, work commitments, appropriate clothing for appointments, and basic necessities such as toiletries and clothing for overnight stays in residential programs. There are also many forms of "outreach" services to enhance treatment access, all of which share the feature of extending the point of service contact into the client's (or prospective client's) natural environment. These can include street services for marginalized youth or homeless populations; engagement with parents in the home to support participation of youth in treatment; or co-located substance use workers in schools or health care settings—for example emergency and departments of the hospital.

In jurisdictions with a small number of specialized services, or where one multi-functional organization provides all or most levels of care under one administrative umbrella, it will be easier to design systems and processes for treatment entry that can be clearly communicated to the community, including other service providers who will be engaged in making and/or receiving referrals. Even in these instances, however, it is important to take into consideration the perspectives and past experiences of service users and family members and consider such things as hours and location of service, including maintenance of some minimal level of information and referral service during required program closure; transportation challenges, such as lack of public transit or bus/taxi service; telephone systems (e.g., live response versus recordings); and capacity to respond to complex needs, for

example, severe co-occurring disorders. Issues related to system access are, of course, more complicated in jurisdictions with many services (e.g., Toronto) and/or where programs are dispersed over a large geographic area (e.g., northern Ontario). Many of these challenges can be minimized in a treatment system heavily invested in community outreach services.

*Centralized/coordinated access:* Of particular interest in many jurisdictions, including Ontario, are considerations for the design or re-design of treatment entry processes based on so-called "centralized access" or "coordinated access" models. There are many different versions of these models, some of which seek to streamline treatment system access by creating a "single entry" point through which people seeking help must pass to be screened and/or assessed and matched to the most appropriate local or regional services. A single point of access is an example of a "funnel approach" to healthcare system management and it has been tried with varying degrees of success for substance use services in Canada and elsewhere.

In Ontario, a provincial program to create "assessment and referral services'" in the 1980s and 90s was severely challenged by the lack of available community (i.e., non-residential) treatment options and the majority of the programs gradually evolved into community treatment services while retaining a strong commitment to comprehensive assessment and referral when needed. The original assessment tool used by these assessment and referral services, known as the ASSIST, was eventually replaced by a common package of tools and decision criteria for client placement (i.e., a decentralized model of common assessment processes). This included a common set of criteria for referral to residential programs. The tools were known as ADAT – Admission and Discharge Criteria and Assessment Tools. This effort at standardization met with some success, and is still used as intended in some programs in the province. However, an evaluation in the late 1990s found considerable organizational drift from many aspects of the assessment process, including core principles of treatment placement, especially to residential programs. In many instances the "completion of the ADAT tools" actually followed the decision to refer to residential treatment, rather than to precede and justify the decision in the first place. Sustainability and fidelity were challenged by turnover in the workplace as well as by the evolving research literature that presented new options for the assessment tools themselves, including screening tools for concurrent disorders. The implementation of the new staged screening and assessment protocol in the 2015-17 Ontario DTFP initiative is renewing the suite of tools for standardized addiction assessment in Ontario, this time with more up-to-date tools as well as an evidence-based approach to implementation that will better support sustainability.

A major factor driving the resurgent interest in centralized or coordinated access in some parts of Canada, and Ontario in particular, is the movement toward integration of mental health and substance use services. Centralized access models are being developed, or are under consideration, that will include substance use as well as mental health services, including, in at least one instance in Ontario, crisis

intervention services. The new suite of screening and assessment tools are being implemented in the respective jurisdictions with these centralized or coordinated access models. The importance of paying close attention to the needs of individuals with substance use challenges with and without significant co-occurring mental health problems is also acknowledged. There are also issues related to the current capacity of local treatment systems to take on a major influx of new cases, as well as to provide quality of care, if the "doorway" to treatment is opened substantially without a concomitant increase in treatment capacity. These potential complications are likely to become more acute with the trend towards even broader integration/collaboration efforts (see Principle #2). These efforts are also likely to raise further challenges and opportunities in some jurisdictions already engaged in mental health and addictions integration, or perhaps impacted by previous attempts at integration with varying degrees of success. A review of the Ontario experience to date and lessons learned with centralized and coordinated access is currently underway by Dr. Brian Rush on behalf of the Addiction and Mental Health Ontario (AMHO) and the Centre for Addiction and Mental Health (CAMH).

*Access to mental health services:* Among the challenges in the Canadian mental health system today that impact service accessibility for people with co-occurring substance use and mental health challenges are the strict criteria and limited access to specialized mental health services, namely severe and persistent mental illness. At this high level of severity and case complexity, and for those with challenges that are more moderate in terms of severity, there is a strong role for collaborative arrangements with substance use services, primary care and other community services, such as emergency response teams, for purposes of screening and assessment, as well as subsequent treatment and support. It is important to work with local resources as best as possible, while advocating for additional resources.

*Tele-psychiatry/OTN:* In rural and remote areas where resources may be limited, options like tele-psychiatry and OTN in Ontario can be pursued to facilitate access to treatment and support. Therapist-assisted screening, assessment and interventions via the Internet or mobile technology, including Web apps, are also an area of burgeoning research and development and are particularly applicable in rural and remote communities. This is discussed further below.

*Mandated treatment:* The large literature on "compulsory treatment" is also relevant to the discussion of treatment access as a large percentage of people in the treatment system (about 30-40% in many Ontario programs) participate under some formal legal mandate (e.g., condition of probation, child custody) or pressure (e.g., condition of employment). Legal mandates, in particular, may be used as a form of social control of marginalized people. The evidence is not very strong that compulsory treatment is effective in ameliorating substance use-related outcomes or criminal recidivism. Since mandatory clients may have priority for treatment access, processes are needed to ensure these clients receive a type and level of service appropriate to their level of motivation upon treatment entry, and then services stepped up accordingly based on the individual's level of engagement.

*Program retention/completion:* One of the strongest predictors of positive treatment outcome is program completion, namely retention and exposure to treatment-related activities of sufficient duration and intensity to have some likelihood of success.

*Transition support*: The need for transition support between providers is an area of consistent feedback from people with lived experience with the substance use treatment system, and the mental health system broadly. Linkage can be operationalized formally via case management or "wrap-around" services that support clients by linking them with other formal and informal services in the community. Some treatment systems have created specific positions, referred to as "linkage managers", "transition coordinators" or "system navigators," recognizing the difficulties many clients have accessing services and experiencing continuity across multiple service providers. Transition challenges are also an area of particular concern for older adults as the complexity of health and mental health conditions increases with age and, for a variety of reasons, the capacity to successfully advocate and navigate multiple services and sectors diminishes at the same time. Transition supports are also critical for the challenging transition from child and adolescent services to adult services and are supported by good evaluation evidence.

*Continuity of care*: Service transitions also include post-treatment continuity of care or "stepped down" care. These extended interventions are grounded on a chronic care paradigm that acknowledges the likelihood of variable stages of recovery (e.g., "relapse") and often multiple service episodes over time. This chronic care model is especially appropriate for individuals at higher levels of severity and, as with other chronic, relapsing conditions, there is a need for some level of service to continue after an official termination of treatment. There are many terms applied to these continuing services, for example, continuing care, aftercare, and more recently, recovery monitoring checkups. The term "extended interventions" is a catch-all term to apply to post-treatment interventions longer than six months in duration. The evidence on the effectiveness of continuing care is strong but also points toward more work needed on adaptive protocols that can be adjusted up or down in response to changes in symptoms and functioning over time (as in a stepped care model).

Examples of continuing care services include connection to self-help groups such as Alcoholics Anonymous, telephone or periodic face-to-face contacts, regular "alumni" meetings, and more recently, e-mail, text messaging or other Internet/mobile-based interventions such as a Web forum with or without therapist support.

#### *3.2.7.8 Access, Outreach and Transitions – What Participants Told Us*

Participants provided a wealth of feedback relevant to access, outreach and transitions; this broad topic being eclipsed in frequency only by feedback related to funding, and funding related challenges. There were several concerns raised about the need for increased awareness of services in the community and a more seamless flow of clients in and through a continuum of services. Transfer of care was cited as a major challenge across the region as a whole.

*Strengths in the region*

Strengths in this area included program-specific solutions and innovations, sub-region or community-level solutions and innovations, as well as region-wide strengths.

*Individual program-specific solutions and innovations:*

Selected examples include:

- A strong commitment to outreach among many specific providers (several already noted above), including some examples of outreach and addiction liaison within emergency departments[17].

> *"We are fortunate to have outreach services in our local area which meet the needs of people more rapidly."*

- The seamless transitions across multiple levels of care within the mental health and addiction program(s) offered by Sudbury Health Sciences, including youth to adult services.
- The Connections Program at Monarch Recovery Services, which employs a dedicated engagement staff to get in touch with clients who have been given a bed-date and to help solve engagement challenges such as transportation and child care. This same staff member also helps plan discharge and keeps in touch with clients every two weeks for six months post-discharge.
- Shifting an addiction counsellor from the Camillus Centre to the Oaks WMS to support staff in building a therapeutic relationship. This was said to have created a climate whereby clients begin looking at possibilities for assistance within the continuum of care sooner rather than later.
- Walk-in counselling offered by North Bay Community Counselling Services
- Clearly defined priority levels for accessing services within the integrated mental health and addiction program in Sturgeon Falls.

*Sub-region or community-level solutions and innovations:*

[17] One such program was terminated in Sudbury because it didn't meet the metrics for reducing emergency department utilization. Consistent with evaluations elsewhere, different performance criteria would have illustrated the value of this type of outreach program in the hospital at improving service access and penetration to undetected populations in need of treatment.

Selected examples include:

- Availability of community crisis lines or a warm line and, in some instances mobile crisis teams.
- Community Mobilization Hubs (or other similar processes by different names) in several of the region's major communities, which help people access and transition effectively across services. Importantly, these multi-agency case conferencing tables aim to improve access and transition support for selected high need clients of the partnering service providers. They are not intended to improve access to services or transitions for all people in the community seeking help from mental health and addiction communities.
- The "Be Safe" app developed by the Sudbury-Manitoulin Service Collaborative to support youth transitioning from youth to adult mental health and addiction services.
- The "Session at a Time" program planned collaboratively and recently launched by a group of Sault Ste. Marie addiction services providers;
- The computer/phone app (East Algoma Connects) developed by East Algoma mental health and addiction service providers and which provides a wealth of information to members of the public and service providers, including the police, to facilitate access to a wide range of addiction, mental health and many other types of services in the region.
- The North Shore Tribal Council and its multi-partner coordinated access process that functions much like a FNIM Health Links.
- A community protocol developed by North Algoma service providers that articulates the sharing of clients and responsibility for their treatment and support
- The new META-PHI research and development project in Sudbury which aims to identify people in the emergency department in need of withdrawal management and treatment for opioid and/or alcohol addiction. Program staff then facilitate rapid access and transitions to appropriate care in the community, including withdrawal management services and addiction medicine specialists.

*Region-level strengths:*

Four of the examples cited were:

- Well-established pathways to care across different parts of the region, a good example being the pathway from Coast communities to the WMS service at Smooth Rock Falls.

- The Common Referral Form (mentioned earlier) which aims to facilitate referral and transitions across a wide range of mental health and addiction service providers.
- Funding for "safe beds" that have been implemented in a flexible manner across the region so as to manage immediate crisis as well as provide transition support to withdrawal management and, subsequently, to treatment.
- ConnexOntario (a provincial resource) was frequently mentioned by participants across the region as a well-utilized resource by FNIM and non-FNIM services alike, although some commented on the need for keeping the wait time and other data more up to date. The process of booking clients with gambling-related problems directly into services via the ConnexOntario website or over the phone with ConnexOntario staff was also noted and highly appreciated by several participants.

*Challenges with respect to access, outreach and transitions:*

A host of challenges were noted in this area including, but by no means limited to, the following themes:

<u>Difficulties managing treatment entry processes and criteria:</u> Participants, especially those in the Coast sub-region, noted the challenges in planning and synchronizing a host of activities:

> *"It's not like people have a big plan to go to treatment – we need to make it easier".*

- Managing wait times and availability of a treatment slot.
- Transportation approval through Health Canada's Non-Insured Health Benefits Program for on-reserve residents.
- Access to a facility with an X-ray machine and/or qualified health professional for medical clearances to access treatment.
- Availability of space on a plane, train or bus (or all three consecutively) and safe transitions in between.
- The potential need for a supportive escort, given language differences.
- Travel in severe winter weather conditions.

Workers interviewed in communities in the Coast sub-region noted these almost daily challenges, all in the face of varying levels of motivation and health status of the people who have asked for their help in accessing treatment.

Knowing what is available and where: Challenges were identified for both clients and program staff in knowing what services are available as well as where and how to navigate a host of admission criteria and processes, including admission rules for accessing residential treatment in the region and elsewhere. This theme also relates to stigma and discrimination (already mentioned above), particularly the perception of the prevailing belief among many service providers: "*when you are ready, you will have figured it out and you will probably succeed*".

> *"Providers meet but how seamless is the system? We need more wrapped around the person"*

Transportation and need for outreach: Challenges were noted earlier with respect to transportation, including having limited or no bus service throughout the region (e.g., one daily bus available late at night to Smooth Rock Falls from Cochrane) as well as difficulties within some communities, such as lack of transit or no taxi service available after 6:00 pm. Ontario Works was also said to be making it more difficult to access transportation to go outside of the local area for treatment. The need for outreach and navigation services was noted by many in the context of transportation challenges.

> *"more emphasis needs to be placed on reaching clients where they are at."*

Challenges accessing mental health services for clients with the most severe challenges: Many participants noted the challenges accessing mental health services to support integrated treatment of concurrent disorders, including poor access to designated regional resources (e.g., North Bay Regional Mental Health) and the fact that local ACT/PACT teams had limited access due to lack of flow through of clients (translating to extremely long waiting periods).

Centralized/coordinated access: The issue of centralized or coordinated access was identified primarily in Sudbury, as a system of common intake has already been worked out between the local CMHA and the Health Science North mental health and addiction program. In addition, a more comprehensive centralized access model was recommended in the local review of community mental health services. However, it was not clear if this model was intended to include local addiction services, most of which fall under Monarch Recovery Services. The pros and cons of a more comprehensive centralized intake model would need to be carefully assessed going forward.

A 1-800 information line for Algoma mental health and addiction services is operating through the Sault CMHA but with few calls from people seeking addiction services were reported in the early stages of operations - only 10 in the first year. In an attempt to better serve clients/public a small number of local addiction programs and the CMHA will begin to provide group schedules to the central access line so the information can be relayed directly to callers seeking information. Central access workers will also complete the initial intake form with basic demographic information if they are referring to the Sault Area Hospital Addiction Treatment Clinic or the addiction services at Algoma Public Health.

> *"It feels like we (managers) are signing papers all the time verifying that people are in treatment. How much of our investment is going to these people not really engaged?"*

Mandated clients: The high estimated percentage of mandated clients was noted by a host of program representatives, ranging from 30% to 50%. For some participants this was viewed simply as a reality of the system and they noted that their approach to work with this population included provision of the basics (e.g., a limited number of sessions, psychoeducation; focusing on relationships) and leaving the door open for the person to return for further treatment. Some noted that many people do return. For others, especially those interviewed with less experience in addictions (e.g., new managers with a mental health background), questions were raised about the overall benefits of treatment under mandated circumstances.

### 3.2.8 Principle 7: Mix of Evidence-Informed Psychosocial and Clinical Interventions

**Once an individual is placed in the initial level of care, the individualized treatment plan must include the right mix and duration of evidence-informed psychosocial and clinical interventions.**

An obvious assumption underlying needs assessment and treatment system design initiatives is that treatment services and supports "work"; that is to say, they accrue positive benefits to the people being treated, to their families and social networks, and to the community as a whole. ***This assumption regarding overall treatment effectiveness is unequivocally supported by research evidence.*** This being said, and as noted earlier, we do not yet know the precise criteria for optimal matching to various treatment modalities, for example, self-help, contingency management, motivational interviewing, family therapy, CBT, medication-assisted treatment etc. One possibility for this lack of consensus in matching clients is the potential that the precise model of treatment processes used by a given program (i.e., how and why their intervention(s) work) may simply have less explanatory power than other

factors, such as the process of treatment engagement, therapeutic alliance during treatment, and continuing care support.

For purposes of this abbreviated research summary there are four special topic areas with respect to evidence-based interventions that are summarized and contrasted with the NE LHIN region service delivery network.

- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Medication-assisted treatment for opiate/opioid addiction
- Housing
- Internet and mobile-based services

Additional topic areas are covered in a more complete research synthesis prepared separately from this report. These other topics areas include: treatment goal, therapeutic relationship, type of treatment/support intervention and cannabis-specific interventions

#### *3.2.8.1 Screening, Brief Intervention and Referral to Treatment (SBIRT) – What the Evidence Says*

SBIRT is comprised of several core elements including:

- It is brief (e.g., typically about 5-10 minutes for brief interventions; about 5 to 12 sessions for brief treatments).
- The screening is universal.
- One or more specific behaviors related to risky alcohol and drug use are targeted.
- The services occur in a "generic", that is, non-substance use, treatment setting.
- It is comprehensive (comprised of screening, brief intervention/treatment, and referral to treatment).

The rationale and evidence for SBIRT is very strong and it is based largely on the fact that there is a significant number of people who span the spectrum of substance use risks and harms that are currently in contact with a range of non-specialist services, but whose risks and harms remain unidentified. SBIRT interventions have the potential to identify many people with a range of risks and harms and provide opportunistic intervention. For some, the goal is to resolve the problems or reduce the risk/harm with a brief intervention; for others, the goal is to motivate and support the person to engage in more formal, specialized treatment services and supports.

We know from controlled studies that some sets of practices, called brief intervention, "work", statistically speaking, in certain populations. Specifically, we

have confidence from the literature that in research situations, brief interventions for risky drinking have a strong likelihood of good outcomes in terms of safer use patterns and reduced harms. This applies to only those who are non-dependent risky drinkers, that is, are drinking beyond the low risk drinking guidelines without major harms or dependence or concurrent disorders. However, results vary by type of setting and are less consistent for settings such as emergency/trauma and hospital inpatient services. A qualification about the nature of the health care setting concerns the fact that positive efficacy studies have largely involved brief intervention delivered in Family Medicine and GP primary care situations, and almost always by a physician, although there are now more studies using other health care professionals.

The mixed results in emergency department settings may reflect either the populations that frequent these services, the greater likelihood of concurrent disorders, or something about the nature of emergency department structures and processes. One might speculate that part of the issue is that investigators in this area have not yet found a practical way to implement brief intervention in busy emergency departments. Even in primary care settings where the evidence is very positive in controlled studies, researchers are still trying to sort out how to implement it in viable ways and improve uptake, given the already saturated work load of the health professionals in these settings.

In Canada, SBIRT is now formally embodied in the SBIRT protocol for family physicians that builds upon low risk guidelines for alcohol use and offers concrete advice on screening, brief intervention and referral to specialist substance use treatment services (see http://www.ccsa.ca/Eng/Priorities/Alcohol/Alcohol-Screening-Brief-Intervention-and-Referral/Pages/default.aspx ; http://www.sbir-diba.ca/contact-us and http://www.ccsa.ca/Eng/Priorities/Alcohol/Pages/default.aspx).

With respect to the effectiveness of SBIRT for drugs other than alcohol, the results are less conclusive than for alcohol but research continues. A recent review summarizes this literature for primary care settings and notes the greater challenges undertaking this work for drugs other than alcohol, for example, with respect to the range of substances that could be involved (including polydrug use), the corresponding need for validated screening tools, and the likelihood that a greater proportion of drug users will be dependent as opposed to at-risk, compared to the alcohol-using population. Currently, in the United States, SBIRT for drugs other than alcohol is supported by recent health care policy developments, including physician reimbursement, a move that many researchers feel may be premature based on existing evidence.

The more inconclusive findings for the application of SBIRT for drugs other than alcohol may be in part tied to the age factor, with studies on drugs other than alcohol more likely to be based on adolescents and young adults. We are not yet that confident that brief intervention works for youth for alcohol, let alone for other

drugs. As with adult populations, the results of SBIRT for adolescents seen in acute care settings are particularly inconsistent. We are, however, fairly confident that brief intervention works with young adults in campus settings and quite confident it can work with adults beyond the post-secondary age range. There is also some growing evidence from the literature on campus drinking that suggests that Web-based, partly self-guided, brief intervention can work with a young adult population.

Is the referral-to-treatment component effective? Here the evidence is quite strong that a well-structured and implemented SBIRT program will identify many people who may need more structured treatment of longer duration and intensity. In addition, the evidence suggests that many people will follow through with the recommendation for more intensive help if given an appropriate intervention that includes a well-implemented motivational component. Researchers suggest that the amount/intensity of the brief intervention may actually be less important in this area than duration of treatment and the inclusion of a component focused on treatment engagement and continuity of care.

More research is needed on who benefits most from brief interventions delivered outside substance use treatment services by trained health care and social services professionals, especially with longer term follow-up and drug abusing populations well-represented. More data are also needed on the persistence of related outcomes.

In sum, the existing data suggest that: (a) brief intervention for alcohol (BI or SBIRT) should be formally considered as part of the community's continuum of care and should aim to increase engagement in treatment when indicated. One important caveat in the Canadian context is that the optimal screening tools and brief interventions for FNIM populations are essentially unknown at present. Wide-scale implementation would also need to be accompanied by increased service capacity, including a shift to more cost-effective treatment system design (e.g., re-adjusting the balance of investment towards more cost-effective community treatment services).

#### *3.2.8.2 Screening, Brief Intervention and Referral to Treatment (SBIRT) – What Participants Told Us*

*Not on the radar:* This aspect of treatment system planning and service provision rarely got mention in the participants' feedback during site interviews or surveys. This fact mirrors the situation in most parts of Ontario, The one concrete example of screening and brief intervention noted in the region was a project underway in the emergency department at WAHA Hospital initiated by Dr. Dahl. He was using a short screening questionnaire in the emergency service and a brief intervention with an educational pamphlet.

Other related work that could be considered as connected with this type of intervention is the use of the GAIN SS for screening in mental health and addictions services. However, the intention was not really aimed at structured brief

intervention based on the results. There is a range of school-related work in the region that is aimed at "early intervention" but again this work does not appear to be organized formally as SBIRT. No SBIRT-related work came to our attention in the region's colleges and universities.

### *3.2.8.3 Medication-assisted Treatment for Opiate/Opioid Addiction – What the Evidence Says* [18,19]

Medications recommended for the treatment of opioid dependence include naloxone for the reversal of opioid overdose, long duration opioids such as methadone and buprenorpine (Suboxone) for both the treatment of opioid withdrawal and for maintenance treatment, clonidine/lofexidine for withdrawal management, and naltrexone for the prevention of relapse.

*Naloxone:* Naloxone is a short acting opioid antagonist used to prevent death from opioid overdose. The WHO has recently recommended the expansion of the availability of naloxone to include anyone likely to witness an opioid overdose, such as people who use opioids, their friends and family, and people who come into contact with opioid users through their work. Often naloxone is made available as a kit which contains instructions, a prefilled syringe, or a prefilled vial with an atomizer for intranasal administration.

*Medication-assisted treatment:* Because of the low rates of success with opioid detoxification alone, and the risk of opioid overdose with renewed opioid use after detoxification, opioid maintenance treatment is considered the more desirable treatment for the majority of people with opioid dependence. While opioid detoxification alone is not effective for long term treatment success, it can be the first step in attaining abstinence. Furthermore, the chances of maintaining abstinence post-withdrawal are increased if there is follow up with either pharmacological or non-pharmacological approaches. Counselling is widely recognized as a part of the package of evidence-informed interventions, although findings from research in this area are complex (e.g., results from controlled trials differ from field studies in terms of fidelity to concomitant counselling interventions).

The maintenance treatment of opioid dependence, with either methadone (an agonist) or buprenorphine (a partial agonist), is a highly effective approach to reducing illicit opioid use and preventing opioid-related mortality. Both medications are recommended by the WHO in the most recent guidelines and in recent research

[18] While there are many medications available for treating alcohol and drug dependence, the focus in this review is on medication to assist with the treatment and support for opioid dependence

[19] Technically the term "opiate" applies to substances derived from the opium plant (e.g., opium, heroin) whereas "opioid" applies to synthetic formulations that are chemically quite similar and which achieve much the same effect, including addiction potential. In this report we will use the term opioid to cover both classes of drugs as addiction to these synthetic formulations is more common in Ontario than the natural opiate substances.

syntheses. Buprenorphine has recently been identified in British Columbia as the first line medication approach. The optimal approach for either medication is to match the level of tolerance with a stable level of opioid medication (thus providing neither intoxication nor withdrawal) and thereby avoid the typical cycle of intoxication and withdrawal associated with the use of short acting opioids. The goal is to reduce the effects of any additional opioid use by providing a more stable, safe alternative.

Both methadone and buprenorphine carry some risk that is dose dependent, particularly abuse and diversion to non-treatment populations. However, the risk for buprenorphine, including abuse and diversion, is widely considered to be significantly lower. Importantly, methadone carries additional and significant risk of harm through overdose and resulting death. While both medications come with guidelines for supervision of use, in the case of methadone the guidelines are significantly stricter because of the risk of overdose.

Burprenorphine is now widely available in the United States through primary care settings and is being safely managed and administered by nursing professionals with physician back-up as needed. Research has been highly supportive of this cost-effective approach using nursing professionals. In Ontario and elsewhere, "medical directives" are giving nurse practitioners the authority to prescribe and administer buprenorphine. This approach is rapidly spreading in the province, including in remote First Nations communities in the NW LHIN and recently in the NE LHIN (Hearst area). There is high interest emerging in this approach given the scope of opioid addiction in these and many other northern communities, the comparatively low cost of nursing compared to physician supports, and the increased "reach" of buprenorphine versus methadone assisted treatment.

#### *3.2.8.4 Medication-assisted Treatment for Opiate/Opioid Addiction – What Participants Told Us*

Although not originally specified as a topic within the call for proposals for this addictions review, there were significant issues and challenges identified that required close attention as the review proceeded. These issues included, but are not necessarily limited to:

- The high prevalence of opioid dependence in many communities, including many First Nations communities, and the fact that such use is often accompanied by harmful use of other substances which also require treatment. One addiction medicine expert estimated that only about 2% of his patients on methadone would not have been engaged at some point in illicit drug use; that is to say, only this small percentage were using opioids purely for pain management. He noted that these clients typically don't stay on the methadone program as it is too demanding, for example, requiring two months of clean urine tests to get to the first carry privilege.

- The close association between urgent help seeking for opioid withdrawal and the need for other addiction related treatment and support. This brings opioid-related cases and other substance–related cases into contact with many of the same service providers, including those in emergency departments, where individuals often encounter the same level of stigma and discrimination.

*Strengths in the Region*

Key addiction medicine providers and specialists: There are several addiction medicine clinics and individual physicians providing services to residents of the region, although these services may be physically located outside the region and connected using technology such as OTN or other telemedicine supports. There are also emerging examples of community induction to Suboxone in some First Nations communities. Within and alongside this network of providers there are strong individuals/experts in the region who are doing significant training and capacity development, including Drs. David Marsh, Jonathan Bertram, Ralph Del'Aquila and Mike Franklin.

Positive signs of collaboration and integrated care: Despite the challenges noted below in terms of communication and collaboration between many addiction medicine providers and LHIN-funded and other addiction service providers, there are examples of positive collaboration. These include, but are not limited to:

- Some methadone-trained nurses or other supports funded and co-located in individual programs (e.g., North Bay Withdrawal Management Service; contracted physicians as with Algoma Public Health; methadone case management workers with South Cochrane Addiction Services).

- Community-based collaborations that have integrated Suboxone-based treatment and supports, FNIM traditional healers and LHIN-funded addictions treatment. Specifically the model developed by the North Shore Tribal Council in collaboration with Dr. Del'Aquilla from North Bay can serve as a model for other areas. Suboxone was also reported to be much more accepted by many FNIM key informants compared to methadone – the former being seen as less of a "drug for drug" since it doesn't have the equivalent effects of intoxication and its use is accompanied by lower risks.

- The fact that the vast majority of the region's residential services accept clients on methadone. In some cases participation was limited to a certain percentage of total clients and in other instances significant individual supports were provided, such as daily transportation to access methadone at a local pharmacy.

- The META-PHI project in Sudbury, an integrated model involving the local emergency department, community withdrawal management and rapid access to addiction medicine, including medication assisted treatment.

- The community liaison staff, employed by Ontario Addiction Treatment Centre (OATC), whose function is to build inter-organizational relationships to provide linkage to counselling and other resources for their clients.

*Challenges in the region*:

The language of addiction medicine: Some participants commented on the challenges with the commonly used term "methadone substitution treatment" and the often polarizing effect of the language, implying for some people that the approach is to simply substitute one drug for another. Treatment approaches are now more diversified than methadone *per se,* yet that term is widely used to represent all options available. The term medication-assisted treatment was recommended by many participants as it was said to "*reinforce the need for counselling and case management*".

Another language issue that was raised related to the "medicalization" of addiction treatment that comes with medication management. Some participants reported that the clear articulation of addiction as a "disease" is not consistent with their perception and daily experience of addiction as a social and community problem, as opposed to an individual problem, as implied by the use of the disease construct and language.

Lack of reliable alternatives: There is a reported lack of alternatives available for opioid maintenance treatment in many communities, as well as unreliable availability of treatment and support, as in periodic situations that have arisen on Manitoulin Island. Situations such as these, with abrupt interruptions of methadone service provision, rapidly bring people into contact with LHIN-funded addiction providers and engage LHIN planners in finding solutions.

Lack of communication and coordination:
Negative views were often expressed by some addiction service providers about the perceived profit orientation of some addiction medicine providers. Some reported good communication and collaboration but many others reported virtually no communication with local providers despite obviously shared clients and close geographic proximity, in one case co-existing in the same building. Addiction

> *"They waited too long. She was in withdrawal and cranky and verbal. They discharged her for not conforming. It took 3 days to give her anything because of poor or no communication with her methadone doctor"*

medicine providers who were interviewed also reported poor communication and awareness of local addiction services on their part. Participation on local planning committees was very rare despite common interests and potential for synergy. This plethora of issues calls for closer communication between these various players, including the involvement of key individuals from addiction medicine in both region- and sub-region-level planning. A good start would be relationship and trust building through the sharing of information and experience and open exploration of opportunities for better collaboration.

Policy regarding access to substance use treatment: While the majority of LHIN-funded residential services accept clients on methadone or Suboxone this is not the case outside the region. This puts pressure on the regional resources to accept clients from other areas but this may not be reciprocated so easily for NE LHIN residents seeking treatment elsewhere. There is a need for provincial harmonization of this treatment access criteria.

> *"We have to prioritize within our own catchment but realize that not a lot of other organizations take people on methadone. We need to accommodate.*

Unanticipated demand for counselling services: There is a large and essentially unanticipated demand being placed on some LHIN-funded community treatment services by addiction medicine providers for provision of psychosocial treatment and support. In some areas this is being accommodated in a collaborative fashion and in other communities there were major challenges reported in meeting the demand.

#### *3.2.8.5 Addiction-related Housing – What the Evidence Says*

Stable, affordable, supportive housing is increasingly recognized as essential to good health and well-being and has been linked to positive outcomes for those with mental health and/or substance use problems, outcomes that include reduced substance use, improved mental health, and reduced use of costly health services. There is a continuum of housing models to support people with substance use and/or mental health issues. These models range from short-term, low threshold shelter, to supportive housing that offers case management and counseling, to more independent living. A report by the Canada Mortgage and Housing Corporation describes the housing continuum as follows.

***Housing Continuum***

| Shelters | Transitional Housing | Supportive Housing | Subsidized Housing | Market Rental Housing | Market Homeownership |
|---|---|---|---|---|---|

The first three, shelters, transitional housing, and supportive housing, can be seen as an active part of the mental health and addiction treatment and support system.

Homeless shelters typically offer free, short-term residence for individuals and/or families who are in crisis. Shelters offer a place to sleep and varying degrees of support, food, clothing, and other basic needs. This temporary place to stay is intended to be a short stop on the way to more permanent, stable, safe housing.

An emerging practice is "managed alcohol programs", which "*provide regulated doses of alcohol to residents in supportive accommodation to address seemingly intractable health and social problems experienced by people with alcohol dependence, use of non-beverage alcohol and unstable housing*". This type of program can be implemented in emergency shelters, supportive housing, residential settings, and hospital settings.

A small-scale evaluation of a managed alcohol program in a supportive housing program in Vancouver showed promising results in a number of areas, including high retention rates, improved well-being and positive change in participants' lives, improved access to services, reduction in frequency and quantity of non-beverage alcohol consumption, and reductions in severe alcohol-related harms. Some potential risks were also identified and recommendations made to improve managed alcohol programs as a promising intervention within shelters.

"Transitional housing" is conceptualized as an intermediate step between emergency crisis shelter and permanent housing. It is more long-term, service-intensive and private than emergency shelters, yet remains time-limited to stays of three months to three years. It is meant to provide a safe, supportive environment where residents can overcome trauma, begin to address the issues that led to or sustained homelessness, and begin to rebuild their support network. A report by the Canadian Mortgage and Housing Corporation concluded that transitional housing programs are more effective than services alone, and permanent housing and community services are critical to their success.

Permanent supportive housing is defined as "*direct service that helps adults who are homeless or disabled identify and secure long-term, affordable housing. Individuals participating in permanent supportive housing generally have access to ongoing case management services that are designed to preserve tenancy and address their current needs*". Although there is a lack of studies showing the effectiveness of supportive housing, there are promising results from what does exist. In an assessment of the evidence, one recent comprehensive review found that positive results include increased length of time housed and decreased visits to emergency department and admissions to hospital. The review also reported that clients rated the supportive housing model more positively than other types of housing.

"Housing First" is one approach that has recently been advanced as an evidence-informed practice. This is a rights-based approach and described as "*a recovery-oriented approach to homelessness that involves moving people who experience homelessness into independent and permanent housing as quickly as possible, with no preconditions, and then providing them with additional services and supports as*

*needed*". Studies have shown positive results from this model, in particular, the At Home/Chez Soi trial protocol: a pragmatic, multi-site, randomized controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian cities. This study found that Housing First participants increased housing stability, improved substance use and mental health symptoms as well as quality of life, and improved outcomes related to community functioning. The Canadian Homelessness Research Network, although recognizing this approach as promising, suggests caution in considering this approach as best practice as they have assessed the evidence and feel that it is premature to rate the evidence as strong enough for best practice. Further, with respect to the evaluation of the Vancouver site for At Home/Chez Soi, the evidence regarding outcomes related to substance use and related challenges was limited.

### *3.2.8.6 Addiction-related Housing – What Participants Told Us*

*Strengths in the region*

Although challenges with respect to housing were among those most frequently cited by participants across the region, three important strengths were identified:

- The recent funding for supportive housing was seen as a major system enhancement and one which brought mental health services and addiction services closer together in many parts of the region; often the local CMHA managing the housing aspect and a local addictions service providing the counselling support.
- Funding for safe beds was also seen as having enhanced flexibility in the system.
- The Harm Reduction Home in Sudbury which provides a managed alcohol program and a range of other services.

*Challenges in the region*

<u>Lack of affordable housing stock</u>: The lack of affordable housing in the community was frequently cited as a major challenge for clients and one which significantly impacted treatment participation and success. This included rents that were too high for decent accommodation, with the monthly income from Ontario Works being barely sufficient to cover the costs of basic accommodation. These factors were said to converge to result in less than ideal accommodation – accommodation with a high risk of drug use in the building and, therefore, relapse potential.

> *"There is not enough residential support service beds to answer the needs. Investment in safe housing may be a good option."*

A range of housing options still needed: Depending on the community, a wide range of needs were cited including men's shelter; transition or supportive recovery housing (both men and women) and additional supported housing (men and women). A related challenge noted was the lack of consistency in criteria for provincial funding, for example for safe beds and supported housing (*"Is it permanent or temporary?").*

More (flexible) support needed: The increasing severity of clients noted earlier was seen as linked to the need for an additional level of support in supported housing, for example, requiring clients to be checked every day. In addition, several participants noted the challenges with overly rule-laden policies, in particular with respect to alcohol use. More options with harm reduction flexibility were cited as being needed.

> *" We need wet housing to stay topped up with 1-2 drinks for the day, for example, if needed to get from one place to another to get a form*

### *3.2.8.7 Internet and Mobile Services and Support – What the Evidence Says*

As with the addition of brief intervention services to the traditional continuum-of-care, there is another "new kid on the block" in the provision of substance use services and supports; namely those based on Internet and mobile phone technology. There are several ways in which Internet and mobile technologies are being used to assist people with health problems, including substance use and mental health problems. The evidence base around these applications is advancing rapidly. As yet, there is no widely accepted categorization of these applications, but the following broad grouping is helpful in a treatment system planning context:

- Mobile telecommunications, in particular text-messaging (SMS).
- Internet-based applications, including websites.

The kinds of services and supports that can be offered through either of these technologies (or in combination) include:

- Unassisted access to health information including information on available services (e.g., a website (or portal to other website); a web app with local program information and perhaps the functionality for direct contact or bookings).

- Self-completed screening or diagnostic tests, or structured interventions, such as CBT, with automated feedback.
- Therapist-assisted counseling (e.g., questions may be posted and a professional responds confidentially i.e., e-counselling; distance telecommunications such as OTN).
- Chat lines, open forums or social networking (e.g., Facebook, Twitter) for mutual aid support or sharing of information with or without therapist mediation.
- Text messaging or emailing to deliver health-related messages, encourage adherence to interventions being delivered by traditional means, provide follow-up support, or obtain evaluation feedback.
- Mixed methods, for example, using text messaging in conjunction with a manual, diaries, brief telephone support and/or weekly counseling appointments.

Several reviews of the literature have been conducted in recent years focusing on various intervention alternatives and populations. Some reviews have synthesized information for people at risk of, or experiencing, alcohol problems, and others have focused more broadly on a population using/abusing various substances (including tobacco). Still others have focused on problems related to gambling. While reviews are broad enough to include "computer-delivered" interventions, which may include use of self-administered on-site interventions administered using computer programs within treatment facilities, the norm is for studies of online or mobile interventions for external contexts.

A "bird's eye view" of this overall body of research is that it holds considerable promise but much more work needs to be done. One of the challenges in this area of research and development is that it is difficult for researchers to keep pace with technological advances in the design of interventions, for example, how to make good use of social media. That being said, the body of work holds the alluring promise of significantly extending the reach and impact of the overall treatment system by engaging people who may never otherwise engage in formal treatment in a helping (or self-helping) process of reflection and change in substance-related behaviour and cognition. In short, these technologies take the treatment to the community in need rather than vice versa.

It is also important to note that the "small" to "medium" effect sizes reported across this growing literature would have a large population impact on at-risk substance users (i.e., the lower part of the population health pyramid). Effect sizes for reduction of alcohol use comparable to that of face-to-face brief intervention are reported in the literature. Interestingly, results show that effective Internet-based interventions that utilize much reduced or no therapist support not only save on

program costs but can also increase engagement of the person accessing the service (e.g., homework between sessions; direct communication with a therapist).

Major challenges exist, however, in the current research base concerning on-line interventions, in particular concerning individuals' engagement and participation once presented with the on-line intervention. Lastly, while there are many innovative ways in which to engage participants (e.g., making it entertaining, graphics) one review found these factors did not make much difference on treatment outcome. This is reminiscent of the earlier reference to the "common factors" discussion underlying substance use treatment in general. In this regard, client satisfaction is high when these innovations are incorporated into treatment processes and, for therapist-assisted options, therapeutic alliance seems to be as strong as found for non-computer or non-Internet-based treatment alternatives.

In summary, while investigators encourage more research in this area they also stress that there are many options that can now be offered and evaluated in the field while this area of treatment systems development continues to rapidly expand.

#### *3.2.8.8 Internet and Mobile Services and Support – What Participants Told Us*

As with Screening, Brief Intervention and Referral to Treatment (SBIRT) the topic of Internet and mobile support was infrequently mentioned by participants. Some noteworthy examples include:

- The "presence" of ConnexOntario in the region as a whole in terms of being a provincial resource heavily used by many participants to help locate the most available treatment bed. ConnexOntario also has developed and implemented the facility for online booking to some of the services to which it is connected (e.g., access to problem gambling treatment).
- The extensive and increasing use of OTN connectivity.
- The Safe App and the East Algoma Web site mentioned above.

# 4.0 Summary and Regional-level Implications and Recommendations

The significant health and social burden associated with substance use and addiction argues strongly for continued investment in the regional substance use treatment system(s) in the NE LHIN, as is the case provincially and nationally. The economic costs associated with this burden, coupled with strong research evidence that treatment is effective, and that it returns an economic benefit, makes investment in substance use treatment systems a wise use of public funds.

Ontario's Comprehensive Mental Health and Addictions Strategy "Open Minds, Healthy Minds" reinforces the need for this investment and calls for a multi-sectoral and multi-Ministry response. The NE LHIN has identified mental health and substance use as a priority in its 2013-2016 Integrated Health Service Plan, in particular access to treatment services. A second closely related priority is that the NE LHIN address the community needs in relation to the cultural diversity of the region including the needs of the significant proportion of Francophone people and the FNIM population.

In setting its priorities the NE LHIN considered local evidence that regional/local addictions services are struggling to operate with the resources and funding currently available to them, and that service demands continue to grow. In response to this pressure on the addiction system, the LHIN commissioned the present environmental scan and literature review of best practice for addiction service delivery. The overall goal of the project has been to determine strengths and challenges within the current network of services in the NE LHIN as a whole, and within each of five sub-regions, and to identify in what ways these networks of services can be enhanced.

The following is a synthesis of the findings of this environmental scan including a summary of the main implications and a set of specific recommendations going forward. The focus in this section is on the regional level results and implications which is consistent with the initial objectives for a regional environmental scan and through a regional lens. This region-wide lens also reflects one of the key study findings that more regional-level focus needs to be brought to planning and priority setting to complement and set direction within each of the five sub-regions. Appendix 1 details strengths, challenges and implications of the findings for each of the five sub-regions.

By way of introduction to this regional-level synthesis, it is important to first highlight that many of the strengths and challenges identified regarding the regions addiction services mirror the situation at the provincial level. Examples include significant funding challenges in the face of increasing need and complexity, barriers to accessing services, specific gaps in service delivery in relation to evidence-based practice, and challenges with respect to data quality for performance measurement

and quality improvement. Undoubtedly these challenges are also shared by partner mental health service providers, again at the regional and provincial level.

While there are also many unique challenges faced by the planners and addiction service providers in the NE LHIN there are also several unique and innovative solutions that will be of high interest to important stakeholders outside the region. Several provincial-level initiatives are currently underway that are associated with the implementation of the Ontario Mental Health and Addiction Strategy and, therefore, it is a very opportune time to finalize this report and develop a communication strategy that includes provincial-level stakeholders and the key messages for them.

In the ensuing communication plan the strengths of this environment scan need to be highlighted as this is the "deepest dive" into a region's addiction services that has been undertaken for some time in Ontario, perhaps ever undertaken. Inputs to the process included:

- Feedback from 100 planners and service providers representing over 40 direct service providers;
- On-site visits and interviews with the majority of these participants/programs supplemented by an on-line survey of additional stakeholders;
- Significant engagement with important non-LHIN funded services including many FNIM service providers and traditional healers as well as physicians engaged in the provision of addiction medicine, primarily methadone;
- Consultation with out-of-region experts, in particular consultation related to withdrawal management, nursing and medication assisted treatment (i.e., methadone and Suboxone);
- A wide range of secondary data that were accessed and/or developed for the project including the most comprehensive set of regional data compiled to date on health service utilization associated with substance use;
- An intensive qualitative analysis of themes developed and contrasted to a Best Practice Template that was based on the extant literature on best practices for substance use treatment services and systems.

While feedback was not obtained directly from people in the community who need and/or who have accessed addiction services in the region, the project did draw upon several relevant sources such obtained in the project's on-line survey opportunity; locally derived input through the recently completed RHOC and Five Views project; information from ConnexOntario which supports people from across the province in accessing services; and input from front-line staff faced with the daily challenge of supporting people in their struggles to access and transition through a complex network of services and admission criteria. It will be important to include people with lived experience in the next stage of planning and

implementation, for example, validating and prioritizing the themes and service gaps that are of most relevance to their experience and that of family members.

### 4.1 Highlights of the Quantitative Data Gathered

*Key facts related to demographics of the population and other contextual factors:*

- The region covers a vast geography and hosts a diverse mix of urban/rural/remote communities (e.g., 19% of the population lives in urban areas compared to 69% for the rest of Ontario). There are many very remote communities that experience significant difficulties accessing services of all kinds and other challenges related to isolation.
- The regional population as a whole is declining and getting older at a faster rate that the rest of Ontario.
- There is significant diversity in the population mix, overall being 9-11% FNIM and 22% Francophone with both population groups showing significant sub-regional variation.
- Unemployment is high and again with significant sub-regional variation.
- Health status of the population is poorer than reported by the rest of the province and substantially lower in First Nations communities.
- There are significant challenges with recruitment and retention of qualified staff in part due to the rural/remote nature of the region and the population mix.
- There are significant transportation challenges such as lack of bus service to many communities or no/limited public transit within communities. Weather conditions in the winter impact travel in all parts of the region.
- There are significant migration patterns with the region, for example, for work, school, justice-related reasons such as court appearances or detention and in response to natural disasters.
- There is a significant shortage of affordable housing/rental options in many communities.
- Economic disparities, transportation and other challenges related to the social determinants of health are extremely high among the region's First Nations communities compared to non-First Nations communities.

*Key facts concerning substance use and addiction in the community:*

- The general population survey data for adults and youth in the NE LHIN suggest about equivalent rates of alcohol and drug use as the rest of the province. However, the data are severely challenged by the sampling procedures and survey inclusion/exclusion criteria (e.g., First Nations

communities, homeless people and those living in institutions including hospital and prison are excluded).

- Substance abuse, mental health challenges, and personal experiences of violence and trauma are typically intermixed among people in the community who express the need for services as well as those who have sought services in the past.
- Survey data and the observations and opinions of diverse stakeholders suggest extremely high rates of prescription opioid addiction in the FNIM population – on and off reserve - rates described as epidemic proportions in some communities. Some communities have declared a state of emergency.

*Key facts concerning utilization of other health services related to substance use:*

- Utilization of all types of health services related to substance use, including physicians billing through OHIP, mental health and non-mental health hospital bed discharges, use of emergency departments and publically funded prescriptions for methadone or Suboxone are all between 1.5 and 2.5 times higher than provincial rates. This will be an underestimate due to the well-established lack of recording of substance use involvement in health care episodes.
- While there is significant variation in health service utilization across the sub-regions all areas of the region are substantially higher than the provincial average.
- Over 4800 adults residing in the NE LHIN region (approximately 1% of the adult population) received a prescription for an opioid substitution medication through ODSP in the last year data were available (2012). This amounted to over 500,000 service encounters (i.e. prescriptions being filled) in the one year study period.
- While it was not possible to cost all health service encounters due to lack of available data, the OHIP billing alone is conservatively estimated at $24.2 million and emergency department use is conservatively estimated at $2.2 million annually.
- There are many other high system-level costs are not represented here – Ontario Works, police, probation, incarceration, family and children's services

*Key facts concerning those seeking specialized treatment in the region and the services they received:*

- Over $22.5 million is invested annually by the LHIN in addiction services, including some combined funding for mental health services in integrated programs. A significant amount of funding for addiction services comes from many other sources, for example, Health Canada for FNIM treatment centres

and other services.

- Problem substances reported by clients are largely alcohol, cannabis, cocaine, and prescriptions opioids. Clients typically report multiple problem substances.
- FNIM people are significantly over-represented in the treatment population (30-35% compared to about 11% of the general population.
- With respect to withdrawal management, the vast majority of cases are in residential versus community withdrawal management.
- Combining community and day/evening treatment, this represents a ratio of 3304/1399 or about 2.4:1 relative to short-term residential and supportive residential treatment. A ratio closer to 4 to 1 is suggested by a national needs-based planning model.
- There is very limited use of day/evening services due to lack of availability of this level of care in the entire region.
- A significant portion of the treatment population accessing services in the region come from outside the region – about 15% overall but much higher for residential services – about 40%.

The main implications of these quantitative data for treatment system enhancement include:

- The data suggest a community need for substance use services significantly higher than the provincial average. Therefore, using a strictly population-based formula for funding at the provincial level would significantly disadvantage the NE LHIN.
- The vast geography of the region impacts access to services as well the cost of service delivery. Related to this is the need for strong outreach services within the treatment system, including consideration of the aging population, as well as transportation challenges.
- While alcohol remains the most significant substance of concern, needs related to prescription opioids must also be considered in the same treatment system planning. The main implication is to include leaders in addiction medicine in regional and local system planning.
- FNIM people are significantly over-represented in the treatment population – one implication is that leaders and healers among this community need to be more engaged in regional and local planning. There is also a high need for culturally appropriate services and cultural safety training. FNIM-oriented programs should be consistently supported with NE LHIN funding policy.
- The data suggest an imbalance in residential versus community and day/evening treatment options suggesting that new investments go to the latter to better balance the continuum of care. Residential treatment must be used only when indicated by careful assessment, agreed upon admission

criteria across the system and in a stepped care model. In the qualitative data (see below) slippage was noted in these criteria.

- A high degree of collaboration among service providers, including but not limited to primary care is needed to deal with case complexity such as evidenced by mental health, addiction and violence/trauma.

## 4.2 Highlights of the Qualitative Data Gathered

The approach was to contrast stakeholder feedback regarding policy and practice in the NE LHIN against the current knowledge base so as to identify system gaps and to support recommendations for system enhancement. For each key principle, we summarized "*what the evidence says*" and then highlighted key themes that emerged from the interview and survey data that relate to the same principle and associated evidence - that is "*what participants told us*".

Tables 16a-h below briefly summarize the key themes that were identified in relation to each of the seven key principles as well as a small number of cross-cutting and highly relevant themes.

**Table 16a.** Regional summary of universal themes related to system strengths and challenges and implications for treatment system design

| ***Universal Themes*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| Highly valued workforce functioning in difficult circumstances and managing despite funding challenges and wage disparity. | | Acknowledge and articulate the value addiction services and the workforce. |
| Importance of self-help organizations within the treatment and support continuum | | Acknowledge the contributions and value of organizations such as AA, NA and Women For Sobriety and support their continued participation in the regional and local treatment and support systems. |
| | Variability across the region and within sub-regions in local context, as well as system strengths and challenges. | Acknowledge the need for local planning and adaptations in the context of a broader regional plan. |
| | Challenging context for planning and service delivery, for example, the large geography and its mix of | Ensure sufficient time is allowed for undertaking key pieces of planning, including |

| *Universal Themes* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| | urban/rural/remote areas; transportation challenges and severe winter weather. | local expertise, prevention, and health promotion planning. |
| | System challenges: No base funding increases, HR retention issues, and wage disparities. | Acknowledge the need for quality improvement re: system efficiencies.<br><br>Acknowledge wage disparities and staff retention issues and aim for resolution in the regional plan.<br><br>Where and when possible increase and/or reallocate funding. |
| | The demand for substance abuse services is significant in the NE LHIN. | Appreciate the pressure the system is under to provide needed addiction services. |
| | Community need is high and at epidemic proportion in several First Nations communities. Case complexity among people seeking services is increasing. | Managing this level of complexity demands community collaboration, as well as trained and competent staff using evidence-informed practice.<br><br>While the medical model is needed with a small portion of those with substance abuse issues, the majority can be treated by other models of care.<br><br>Consider the needs of First Nations communities and make substance use treatment for FNIM people in the region a major priority for the next phase of planning |
| | There is a high need among FNIM people for services (about 30% of addiction clients in the region are of FNIM background although this group only comprises approximately 11% of the overall population. | Ensure the FNIM community is significantly engaged in the process of implementing the recommendations emanating from this report. Seek advice from the LHIN Aboriginal Health Committee on how best |

| *Universal Themes* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| | | to engage community leaders, including health leaders and planners and competent traditional healers. |
| | Significant tensions exist among providers in the region. | Leadership needed from the LHIN as well as collaborative leadership locally. |

**Table 16b.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 1

| ***Principle 1: System approach needed*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| High endorsement from study participants of the key principle underlying treatment system design<br><br>More than the specialized services are needed to meet the need, for example, collaboration is needed with mental health, primary care, education, justice etc. | | The burden of substance use and addiction requires the participation of multiple partners from the broader health and social service systems. Key representatives from these sectors also need to be engaged in regional planning.<br><br>. |
| Participants also gave high endorsement for prevention and health promotion.<br><br>Addiction service providers are contributing significant activity to their communities for prevention and health promotion as well as early identification work in schools | Funding for health promotion, prevention and early identification appears to be a lower priority in the region than provision of treatment.<br><br>Prevention work does not appear to be strong enough to reduce incidence and prevalence of substance use challenges in the community at large | Acknowledge the value of the prevention and health promotion work being undertaken. Ensure this work is acknowledged in MSAA agreements with service providers.<br><br>Recognize and acknowledge the value of community wellness in supporting and maintaining recovery from addiction.<br><br>Explore potential for new opportunities with new LHIN funding relationship to public health departments. |
| | Stigma and discrimination is a huge challenge across the entire region, as in other areas of the province and is exacerbated for FNIM people. | Community and service provider training and education on substance use and addiction is needed.<br><br>Where possible enhance the relationships between addiction service providers and other health and social service providers.<br><br>Enhance addictions outreach services to support people in settings where stigma and |

| *Principle 1: System approach needed* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| | | discrimination are most challenging, (e.g., emergency services, court). |
| The LHIN has a mental health and addiction lead, as well as outreach officers who provide support. | Competing demands on outreach officers that extend well beyond their role in addictions. | The LHIN needs to evaluate the effectiveness of the outreach officers' support role in addiction services.<br><br>Brainstorm ways in which work in the addiction sector can be supported.<br><br>Ensure training in addiction (and mental health) for all new LHIN outreach staff. Also ensure FNIM culture-based approaches are part of that education. |

**Table 16c.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 2

| **Principle 2: Collaboration improves accessibility and effectiveness of services** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| High endorsement of principle for collaboration and many examples of strong collaboration at the sub-regional/local level. | Change management is a major challenge. | Participants in system planning tables need support and perhaps training in change management. |
| The concept of co-location (organization located in same building) of services is valued by system partners. | | Ensure LHIN support for co-location efforts where appropriate. |
| Generally high support for mental health and addiction collaboration and integration. Many strong examples, especially among agencies in the smaller communities. | Work is still needed on building concurrent disorder capacity in selected programs including those with previous designated CD investment.<br><br>There is a perception that there is a lack of access to mental health services for the more severe as well as difficulties accessing regional specialized mental health services.<br><br>Some leftover tensions from past integration efforts.<br><br>There are different mental health and addiction needs assessment and planning processes. | Maintain CD work as a priority in the region.<br><br>Where needed conduct formal CD capacity assessments.<br><br>Review policies and services/supports provided by North Bay regional Mental Health Program for regional residents with concurrent disorders.<br><br>Examine funding streams for mental health versus addiction and ensure funding is in line with provincial policy aimed at integration.<br><br>Reconcile the results and recommendations of this review with that of two other recent reviews (which were more mental health focused). |
| Many strong examples of community and hospital collaboration that can be built upon, modelled, and scaled up based on evaluation results. | In some sub-regions, in particular North Bay and Algoma, these community-hospital relationships are far from optimal. | Communicate the effective models of collaboration that are underway in the region and elsewhere<br><br>Build medical capacity in community-based programs via |

| Principle 2: Collaboration improves accessibility and effectiveness of services | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| | Pressures exist for significant investment in complexity-enhanced services (i.e., medical/psychiatric based services) that may be less than ideal for overall system.<br><br>Challenges exist with respect to cultural safety for FNIM people in many of the region's hospital services. | enhanced nursing capacity and competencies and focus on collaborative care models for delivery of services to those with the most complex needs.<br><br>Focus on investment in community services including outreach and transitional support.<br><br>Institute cultural safety training. Across all addictions and mental health services in the region, including those sponsored by hospitals. |
| There are several good examples of collaboration and communication between addiction medicine providers and LHIN-funded providers. | In some communities there are quite distant relationships between addiction medicine providers (e.g., methadone clinics) and LHIN-funded providers throughout the region.<br><br>Addiction medicine providers are not engaged in regional and sub-regional planning. | Communicate the effective models of collaboration that are underway in the region and elsewhere.<br><br>Engage leaders in addiction medicine in regional and sub-regional planning. Ensure availability of counselling supports in a seamless manner for those accessing addiction medicine services.<br><br>Encourage the education of system partners and clients on the relative advantages of different approaches to medication-assisted treatment (e.g., methadone versus Suboxone). |

**Table 16d.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 3

| ***Principle 3: Systems supports are needed to facilitate effective service delivery*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Funding:***<br><br>Investments over the years have been appreciated and include funding for services for youth, people with concurrent disorders and pregnant and parenting women as well as opiate related and supportive housing services. | Lack of increases in base budgets has put significant pressure on service capacity. Wages in the addiction services are lower than counterparts particularly in mental health services. In addition, there are more part-time positions resulting in recruitment and retention challenges. | Where and when possible increase and/or reallocate funding. |
| ***Planning:***<br>There are good examples of local planning tables and productive work.<br><br>The LHIN has a mental health and addiction lead and outreach officers who provide support.<br><br>Perceived value in local planning and flexibility.<br><br>LHIN strategic plan has identified addictions as a priority, as well as the need to provider culturally appropriate services to FMIN and Francophones. | Sudbury and the Coast do not have a formal planning table, unlike other parts of the region.<br><br>Some local planning is good but there is a need to balance this with more regional level planning.<br><br>Some providers perceive that addiction programs are a low priority, given the competing priorities and the need to achieve performance indicators.<br><br>Multiple reviews occurring within a short time frame have caused concerns that too much planning has occurred with not enough concrete action.<br><br>Perceived disparity in LHIN support for FNIM programs and more engagement needed. | Encourage the development of local planning tables in these areas.<br><br>Develop a NE LHIN regional plan for addiction services but in that context continue support for local planning.<br><br>Declare addiction services a priority. Initiate a process to implement the recommendations of this report.<br><br>Consider the unique needs of Francophone and FNIM populations in the development of a regional plan. Ensure appropriate representation in regional and local planning processes. |

| *Principle 3: Systems supports are needed to facilitate effective service delivery* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Performance measurement:***<br>There are some good examples in the region of the easy flow of health information across providers.<br><br>Work at the provincial level (MOHLTC) on system performance measures has potential to improve consistency across the NE regional providers in due course.<br><br>Drug Treatment Funding Program investments are increasing regional capacity for screening and assessment, as well as performance measurement/quality improvement. | In general, multiple information systems used by providers challenge sharing of health information.<br><br>Wide variation in interpretation of definitions for service use and cost leading to an inability to assess cost efficiencies or effectiveness using reliable and valid indicators.<br><br>The historic lack of feedback from mandatory data reporting systems continues to challenge enthusiasm for data submission/participation which in turn impacts data quality.<br><br>Concerns with performance metrics and lack of outcome data. | Encourage common electronic sharing of information. Aim to harmonize as many of the disparate systems as possible.<br><br>Synchronize regional work in this aspect of systems enhancement with relevant work at the provincial level that is developing a common performance measurement framework for mental health and addictions.<br><br>Support implementation of the new provincial screening and assessment tools, and the Ontario Perception of Care Tool (OPOC).<br><br>Improve the current data capture on program costs, completion rates, care transitions, and type/amount of service provided to allow for valid comparisons across LHIN-funded providers.<br><br>Apply new costing protocol being implemented and supported by CAMH DTFP implementation resources. |
| ***Support for enhancing evidence-based practices:***<br><br>Investment in training by service providers is supported by current funding agreements.<br><br>Some provincial resources to support enhancement in this area.<br><br>Availability of provincial resources with respect to | There is a wide variability in treatment practices.<br><br>Staff wellness and recruitment challenges are issues that challenge the uptake and sustainability of new treatment and support practices.<br><br>Some of the clearest gaps in evidence-based practice | Support, and where possible, enhance training budgets<br><br>Tap into provincial and national resources available for enhancing evidence-based practices, recognizing that training alone is very limited in terms of sustained outcomes.<br><br>Conduct a program and workforce assessment of |

| *Principle 3: Systems supports are needed to facilitate effective service delivery* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| implementation science and mental health and addiction. | include: the need for medical supports for withdrawal management services; need for counselling in the context of medication-assisted treatment (i.e., methadone/Suboxone); evidence based treatment for complex co-occurring conditions including trauma informed therapy; and day/evening treatment. | capacity for embracing and sustaining more evidence-based practice.<br><br>Support provincial implementation of new evidence-informed screening and assessment tools.<br><br>Support enhanced capacity for trauma-informed therapy.<br><br>Explore models that meet the needs of high-need populations (FNIM people with severe trauma from residential schools) including longer treatment duration. |

**Table 16e.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 4

| ***Principle 4: Strengths and needs of FNIM people*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| There is a general acceptance of principle of culture-based treatment and the need for choice. Many examples of this being operationalized. | There is a need for resource materials that help educate people, young people in particular, about their culture and traditional healing. | Develop a FNIM regional addictions component within the regional LHIN wide plan.<br><br>Consider ways of funding and supporting programs in the region whose target population is primarily FNIM. Even small contributions in some instance can sufficiently increase capacity and reach, especially outreach.<br><br>Support FNIM agencies to develop resources to educate FNIM people about choices available, including traditional healing and culture.<br><br>As per priorities set out in the LHIN's strategic plan, ensure there is access to both traditional and mainstream services for FNIM people. |
| In the region there is a strong network of FNIM-specific services including specialized addiction programs, as well as more generic services such as friendship centres and community health services. | Stigma and discrimination towards FNIM people is amplified by addiction and mental health challenges.<br><br>More cultural safety training is needed in some addiction programs. | More investment is needed in community-based services to build strong community networks that support recovery.<br><br>Invest in outreach services.<br><br>Encourage providers to invest in cultural safety training for all staff in all programs.<br><br>Utilize Ontario Perception of Care (OPOC) questionnaire as a feedback tool where appropriate. |

| *Principle 4: Strengths and needs of FNIM people* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| Excellent examples of collaboration in building integrated models of care that cut across mainstream addiction service provision, addiction medicine and traditional healing (e.g., North Shore Tribal Council) | Access to treatment and transitions across providers within the treatment continuum is challenging– especially in preparation for treatment and follow-up support when transitioning home | Focus on funding community-based addiction services to facilitate access for FNIM people and also supporting transitions to their community after intensive residential treatment. |
| Strong individual leaders and traditional healers in the region to draw upon for resource development, capacity building, and planning. | | Support culture-based planning by including FNIM leadership and expertise in the regional addiction planning process. |
| | Many FNIM people needing and/or considering treatment experience complex family and community challenges<br>Problem gambling is reported as a major concern. | Provide support for family and community wellness, recognizing that they are important for encouraging and supporting treatment engagement.<br><br>Prevention and health promotion, including economic investment and employment opportunities, should be acknowledged as fundamental factors underlying treatment success. |

**Table 16f.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 5

| ***Principle 5: Age, development, equity and diversity issues*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Older adults:***<br>Some services in the region's community treatment programs are aimed at older adults, including community outreach services. | Lack of social opportunities and isolation contributes to gambling related challenges.<br><br>The other challenge is stigma and discrimination. | Integrate addiction and gambling service planning.<br><br>Encourage providers to provide outreach services and coordination with credit counselling and other services as needed<br><br>Monitor trends in aging and related health and social needs of older adults in the general population and look for collaborative opportunities (e.g., Public Health Departments, CCACs). |
| ***Youth:***<br>There are several pockets of strength in the region for youth services, especially noteworthy are community treatment services.<br><br>Long-term residential services are available in the region for Francophone youth.<br><br>CCAC nurses are also delivering addiction support in school across the region. | Youth withdrawal management services and residential services are gaps in the region.<br><br>CCACs are not typically represented on local addiction and mental health planning committee.<br><br>Francophone treatment service admission numbers are low. | Review the needs for youth-specific residential and withdrawal management resources, including regional and sub-regional projections for demand for these service options.<br><br>The Francophone residential treatment service is available but needs to be more closely examined in context of its low annual utilization and other available services in the province (i.e., Maison Fraternite in Ottawa).<br>Engage CCAC in local and regional-level planning. |
| **Women:**<br>The region has several pockets of strength for women's addiction services including Monarch Recovery Services and Breton House. | There are challenges related to child care, trauma and transportation.<br><br>Additional challenges exist related to babies born to | Review the needs for enhancements to the region's women's residential services.<br><br>Enhanced services/supports need to be planned and implemented for neo-natal |

| *Principle 5: Age, development, equity and diversity issues* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| Other services for women are also available and typically as co-ed services or services embedded in community treatment programs such as outreach for pregnant and parenting mothers or opiate-related case management. | women addicted to opioid medication.<br><br>Need for transition/recovery home that accommodates children or for temporary accommodation of children, as women with child custody challenges transition back to community.<br><br>Appropriate co-ed services challenging in some WMS services (e.g., Sudbury and Sault Ste. Marie). | addictions care. This issue needs to be included in the regional plan.<br><br>Priority should be given to transitional recovery supports as opposed to additional short-term treatment. |
| ***Men:***<br>There is strength in the region for men's services which are typically in co-ed programs. | Increased shelter housing and transitional housing needed specifically for men across the region.<br><br>There are challenges operating men's treatment programs related to insufficient funding (Sudbury). | Review need for enhancements to the region's men's residential services. Priority should be given to transitional recovery supports as opposed to additional short-term treatment. |

| *Principle 5: Age, development, equity and diversity issues* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Francophone population:***<br>The region has organizations providing services in French and a significant number of other services have achieved designation under the French Language Service Act.<br><br>Some Francophone specific services closely involved in addictions and mental health work in the Cochrane district. | Addiction services not always available in French language when needed in all parts of the region.<br><br>Active offer is not always employed.<br><br>Few providers reported to ask clients what is their primary language (as opposed to language preference for service).<br><br>Hiring and recruitment of French-language speaking managers, staff, and access to French-language speaking psychiatrists is a challenge, as is access to French-language speakers and presenters for training and other capacity building purposes. | Encourage more providers to seek FLS designation and those who are designated to continue to meet its requirements.<br><br>Support is needed to encourage routine reporting of linguistic identify above and beyond language of preference.<br><br>Service providers need to work with the RMEFNO to develop a regional "database" of French-language trainers and speakers. |

**Table 16g.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 6

| ***Principle 6: The continuum of care*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Screening, assessment and placement matching:***<br>The use of ADAT for assessment and treatment placement processes is a strength.<br><br>There is a "Common Referral Form" under development that will be implemented across the region.<br><br>New staged screening and assessment tools and processes being implemented across the province. Including the NE LHIN-funded addiction services. Common use of the GAIN-Short Screener across Timmins-Cochrane area and many other services in the region.<br><br>Some local FN programs in the region are engaged with CAMH in the development of a new culture/trauma-based assessment tool for the First Nations and Inuit population by CAMH, through provincial DTFP funding | Wait time for ADAT assessment too long in many instances.<br><br>It is time for refresh of the ADAT tools and referral criteria.<br><br>Work completed to date on the Common Referral Form needs to be synchronized with the new screening and assessment tools and staged protocol.<br><br>Relationship between the OCAN and the new staged screening and assessment tools for programs offering both mental health and addiction programs is challenging. | Support implementation of the newly mandated staged screening and assessment tools<br><br>Synchronize the previous work on the Common Referral Form with regional implementation of the new tools and processes.<br><br>Support development of new admission and discharge criteria for residential treatment. The need for and use of residential treatment services should be closely monitored with indicators derived from the new screening and assessment tools database.<br><br>Support provincial efforts to better synchronize new tools with the OCAN.<br><br>Engage in the development and pilot testing of the new culture/trauma-based assessment tool under development for First Nations and Inuit population. |
| ***Withdrawal management:***<br><br>There is strong current capacity within or near each of the region's major population centres with the exception of Moosonee, Moose Factory, Timmins and Parry Sound.<br>.<br>Some good examples of regional work in withdrawal management include: | The longstanding funding deficit at Smooth Rock Falls WMS<br><br>Lack of WMS options in Parry Sound sub-region.<br><br>Lack of WMS in Coast sub-region/Moosonee. | Examine funding options for Smooth Rock Falls WMS to deal with long-standing funding deficit.<br><br>Support development of a new WMS in Moosonee to be affiliated with new WAHA hospital but located in a community residential setting with close affiliation and |

| *Principle 6: The continuum of care* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| • Flexible lengths of stays that lend major support to treatment transitions.<br>• Good to excellent medical supports through strong collaborative care arrangements (e.g., Sudbury WMS, Oaks Centre in Elliot Lake, Smooth Rock Falls).<br>• Use of safe beds for added flexibility in transitioning to WMS upon medical stabilization (e.g., Jubilee Centre).<br>• Synergy between supportive housing and addiction outreach service facilitates pilot work re: community withdrawal management.<br>• Community withdrawal management service upon which to build larger regional capacity and competence (e.g. Manitoulin).<br>• Collaboration between hospital emergency department, Emergency medical Services (EMS) and community withdrawal management services (Sudbury)<br>• The META-PHI project in Sudbury is an excellent example of service provision that intersects withdrawal management from alcohol and opioid substitution treatment. | Condition of facility and co-ed safety concerns re: WMS in Sault Ste. Marie.<br><br>Co-ed safety concerns re: WMS in Sudbury.<br><br>Negative attitudes towards community withdrawal management by some opinion leaders in the region have limited innovation for community withdrawal management despite its strong evidence base.<br><br>Need for more crisis/safe beds.<br><br>Need for more support for withdrawal management via OTN to outlying communities.<br><br>More focus needed in the region on transitioning clients to treatment from WMS, including flexible lengths of stay. | collaboration for urgent care (i.e., some designated hospital beds are also needed for medical stabilization)..<br><br>Support the development of a Sault Ste. Marie WMS in a community setting.<br><br>Look at ways to enhance medical/nursing supports in all regional withdrawal management services.<br><br>Educate regional opinion leaders on the current evidence base for community withdrawal management and involve in model development.<br><br>Develop community withdrawal management options for Timmins and Parry Sound and with strong evaluation component. Identify lessons learned and potential for scale up in the region.<br><br>Closely monitor the EMS diversion project and META-PHI in Sudbury for positive outcomes and lessons learned that may support scale-up in other cities in the region. |

| *Principle 6: The continuum of care* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Residential and community treatment settings***<br><br>Several strong residential and community treatment services in the region<br><br>Many, but not all residential services in the region have concurrent disorder capacity.<br><br>The large majority of services are supportive of harm reduction approaches. Most of the residential services accept clients on methadone.<br><br>General acceptance of culture-based approaches to treatment of FNIM people. | There are several examples of significant funding challenges, many resulting in reductions in service capacity.<br><br>Lack of day/evening treatment options in the region.<br><br>Funding issues for Jubilee Centre and corresponding summer closures. Full summer closure effects service delivery locally and across the region.<br><br>Accountability difficulties between Maison Renaissance and Maison Arc-en-Ciel.<br><br>Residential services are relying heavily on external contracts to address increasing levels of budget constraints.<br><br>Unexplained variance in operations, cost, program content and completion rates among residential services.<br><br>Challenges with access to services, especially for the most complex cases.<br><br>Need for medical enhancements via nursing competencies within the community-based services.<br><br>Concerns regarding available supports for people transitioning back into the community from treatment<br><br>Lack of youth residential services | Priorities re: community and residential treatment are:<br><br>1) Enhance outreach services being provided through community-based programs.<br><br>Enhance transitions both to treatment and back to community.<br><br>Examine ways to enhance medical/nursing supports in all regional treatment and support services.<br><br>2) Establish day/evening treatment services in the region.<br><br>3) Review existing short and long term residential services prior to any enhanced funding for these services. This residential review should look closely at accurate cost comparisons within the region and across the province, as well as completion rates, occupancy rates, wait times and rationale, CD capacity/competency, and mechanisms for transitioning to community care.<br><br>4) In the context of the residential review noted above, examine the chronic. funding difficulties in the region including:<br>• Funding problems at Jubilee and ensure no further summer closures. |

| *Principle 6: The continuum of care* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| | | Any additional closure that is needed in this or other sites in the region should include provision of basic services such as referral and other onsite services funded separately on an annualized basis.<br>• Examine and resolve funding difficulties related to the transfer of the Salvation Army treatment program for men to Monarch Recovery Services.<br><br>5) Enhance transitional longer term recovery supports in the region, pending the aforementioned review of residential services to ensure services are currently are operating at maximum efficiency including matching criteria for access to this level of care are in place and being monitored. |
| ***Access, outreach and transitions***<br>Several excellent examples of a commitment to outreach services.<br><br>• Facilitation of treatment entry (e.g., Connections Program at Monarch recovery Services; walk in counselling at North Bay Community Counselling Services)<br><br>• Community-level solutions and innovations (e.g., community crisis lines; community mobilization hubs/tables; "session-at-a-time" program in Sault Ste. | Knowing what is available and where is a challenge. As well as difficulties managing disparate treatment entry processes and criteria.<br><br>Transportation challenges are significant throughout the region and there is a need for more outreach<br><br>Challenges accessing mental health services for clients with most severe difficulties in that area, including designated regional resources. | Enhanced outreach services through community-based programs.<br><br>Existing attempts at centralized access models in the region need to be carefully reviewed especially for value-add in terms of access to addiction services.<br><br>Explore opportunities and models through which transportation to addiction services, including withdrawal management can be formally |

| *Principle 6: The continuum of care* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| Marie; computer/phone app in East Algoma; North Shore Tribal Council and multi-partner coordinated access process; META-PHI project in Sudbury.<br><br>• Region-wide solutions and initiatives (e.g., well-established referral pathways such as to Smooth Rock Falls WMS from the Coast sub-region; Common Referral Form; safe beds, ConnexOntario including direct booking of clients | Coordinated/centralized access models between addiction and mental health have some challenges.<br><br>The treatment population in the region includes a significant percentage of clients who are under various forms of mandated treatment. | funded. Look to the transportation model offered by Westover treatment Centre in Southwestern Ontario for lessons learned.<br><br>Closely examine the Connections Program at Monarch Recovery Services, Single Session protocol in Sault Ste. Marie, and the walk in counselling services at North Bay Community Counselling Services for lessons learned and critical features that can be modelled and scaled-up in addiction services across the region.<br><br>Maintain pathways between the Coast and Smooth Rock Falls WMS.<br><br>Encourage the use of ConnexOntario across the region. Also encourage accurate and timely reporting of service availability data to ConnexOntario.<br><br>Continue investment in OTN supports as possible.<br><br>Ensure service provision to mandated clients is matched to their level of motivation and focused on subsequent treatment engagement. |

**Table 16h.** Regional summary of themes related to system strengths and challenges and implications for treatment system design – Principle 7

| ***Principle 7: Mix of evidence-informed psychosocial and clinical interventions*** | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| ***Screening, brief intervention and referral to treatment (SBIRT)*** | SBIRT is not on the radar in the region's primary care settings despite strong evidence in favour of this option for high risk drinking. | Solicit interest among primary care providers in pilot testing SBIRT with an aim of understanding costs and benefits and potential for regional pilot testing and scale-up. |
| ***Medication-assisted treatment for opiate/opioid addiction***<br>Several key addiction medicine providers and specialists in the region<br><br>Some positive signs of collaboration and integrated care.<br><br>General acceptance of clients on methadone by LHIN-funded treatment providers.<br><br>Increasing use of Suboxone, including community induction in First Nations communities and integrated model through North Shore Tribal Council in collaboration with Dr. Ralph Dell'Aquila.<br><br>META-PHI project in Sudbury that integrates withdrawal management and medication-assisted treatment for opioid dependence. | The language of addiction medicine (e.g., "*addiction is a disease*") is a barrier for some key stakeholders and a facilitator to others.<br><br>Lack of reliable alternatives to medication-assisted treatment in some communities (e.g., past experience with Manitoulin in terms of reliable access to methadone)<br><br>Lack of communication and coordination between LHIN-funded services, FNIM services and addiction medicine providers<br><br>LHIN-funded community treatment programs are experiencing a significant demand for counselling services. | There is a need to get past "terminology" and focus on client-centred principles that provide a more common ground for collaboration and communication when planning with multiple partners.<br><br>Communicate the effective models of collaboration that are underway in the region and elsewhere.<br><br>Engage leaders in addiction medicine in regional and sub-regional addictions service planning.<br>Work with providers to educate clients on different approaches to medication-assisted treatment (e.g., methadone versus Suboxone)<br><br>Monitor the implementation and evaluation of META-PHI in Sudbury for lessons learned for potential scale-up across the region. |
| ***Addiction-related housing***<br><br>Recently the LHIN has provided funding for supportive housing. In addition to meeting service needs, this has a positive effect on relationships between | Lack of affordable housing stock.<br><br>Range of housing options still needed, such as shelters, | Continue to invest in housing supports.<br><br>Support other housing options such as shelters, transition homes and others. |

| *Principle 7: Mix of evidence-informed psychosocial and clinical interventions* | | |
|---|---|---|
| **Strengths** | **Challenges** | **Implications for Consideration** |
| collaborating mental health and addiction partners.<br><br>The funding for safe beds enhances flexibility in treatment access.<br><br>Harm reduction home in Sudbury is showing promise in addressing needs of chronic users. | transition, or supportive recovery units.<br><br>Increased complexity of clients accessing supportive housing. | Need for more flexibility and resources to manage the increased complexity of clients. |
| ***Internet and mobile services***<br><br>Fairly heavy use of ConnexOntario helplines and website for determining service availability and booking appointments.<br><br>Extensive and increasing use of OTN connectivity.<br><br>A mobile device app has been piloted on Manitoulin for youth.<br><br>There is a local app and website for East Algoma service providers, including police. | Participants rarely noted needs and challenges in this area except for the importance on OTN and the supports sometimes needed for its set up and use (more in remote communities)<br><br>This aspect of system enhancement is weak compared to the burgeoning options available and growing evidence of utility for service access, direct treatment, continuing care, and evaluation | Ensure considerable attention in the regional addiction services plan is given to opportunities and potential risks associated with Internet and mobile services.<br><br>Building on what exists now in the region and the available literature strike a separate task group to report back to the planning committee. |

## 4.3 Recommendations

### 4.3.1 The Process for Moving Forward

Following the submission of this technical report, as well as a briefer Executive Summary, the LHIN Board should be briefed as to project completion and the reports then made available to key regional stakeholders[20]. Having consulted with the LHIN's Mental Health and Addiction Lead (Mike O'Shea) the following "next steps" are then envisaged:

1. *Prepare a communication plan*: A communication plan should be prepared that briefly describes the purpose of the project, the key messages going forward and the structure of the ensuing planning process.

2. *Structure the regional planning process:* Create an Integrated Regional Mental Health and Addictions Planning Committee to oversee two parallel but highly integrated planning processes:

    - one process focused on addiction issues and assessing the information, implications and recommendations for addiction treatment system enhancement put forth in this report; and

    - the other focused on the information, implications and recommendations emanating from the two more mental health-oriented reviews undertaken and reported on in 2015 – one concerning community mental health services in the Sudbury-Manitoulin-Parry Sound sub-region (commissioned by the NE LHIN) and the other at a more regional-level commissioned by North Bay Regional Mental Health Services and Health Sciences North.

    While the ultimate aim is to have ONE resulting mental health and addictions plan for the North East Region, such an integrated, two-track process would ensure sufficient attention is given to the substance use and addiction issues reported herein.

3. *Ensure representation*: Comprise the planning group so as to reflect the continuum of care within the various sub-regions of the LHIN as well as its diverse population make-up, in particular Francophone and FNIM people. Consideration should be given to appointing a FNIM co-chair at least for the

[20] Given the scope and depth of this review a separate executive summary with provincial-level implications highlighted will also be developed and taken to a range of provincial-level stakeholders.

addiction-focused planning group given their significant over-representation in the treatment population and limited involvement to date in both regional and sub-regional planning processes. One or more representatives of mental health services as well as addiction medicine should also be represented. Further, while the number of people on the committee needs to be managed, careful consideration should be given to representation from other sectors such as justice, education and primary care, for example.

4. *Present the findings*: Invite the Lead Consultant for the present project (Dr. Brian Rush) to present the findings related to the region's addictions services to this integrated planning committee and other invited stakeholders as appropriate. Participants should be drawn from various stakeholder groups identified above for the planning committee as well as participants in the mental health services planning track noted above under #1.

5. *Initiate hub-level planning*: Simultaneously to the above regional-level planning process the LHIN outreach officers responsible for each of the five hub planning areas should focus attention in their respective jurisdictions utilizing the hub-level summaries (see Appendix 1) as well as the main themes and quantitative data included in this more detailed technical report and the executive summary. This hub-level process should aim towards engaging local service providers and stakeholders in discussing, priorizing and fleshing out local action items for implementation. The evidence-informed set of treatment system planning principles can serve as a useful guide to this discussion and priorization process as well as the specific gaps in service that have been identified. For example, the recommendation for a new withdrawal management service in Moosonee will no doubt be helpful in the functional planning and design of the new hospital in that community.

   This work at the hub-level will be facilitated by re-instatement of the local planning group for the Sudbury-Manitoulin-Parry Sound area, and creation of such a group in the Coast hub.

6. *Invest in process management:* A recommendation from the current project team going forward is for the NE LHIN to dedicate a resource for process management related to the regional level plan, and to lend support as needed for local planning. Without this dedicated resource charged with moving the recommendations forward and helping to integrate the many findings and implications for addiction services identified in this report there is a risk of limited action in addressing many of the opportunities, needs and gaps identified here. We mention this in part to echo the concerns expressed by many of the participants in the present environmental scan that there have

been many previous reviews and studies that resulted in significant discussion but limited action and systematic change management.

### 4.3.2 Framing the Content of the New Addiction Services Plan

Aside from the planning process going forward the main albeit high-level recommendation emanating from this project is that:

- **the NE LHIN lead a process for the development of a <u>North East Regional Addiction Services Plan</u> as one part of an integrated mental health and addictions plan.**

The structure and content of the Addiction Services Plan should be guided by the quantitative results, the core themes that cut across the qualitative data and the themes that emerged under the seven key principles for evidence-informed treatment system design and performance measurement.

#### *4.3.2.1. Core themes with significant implications for the ensuing planning process*

***Variation across the region****:* Due to the variability within and across the region with respect to several key strengths and challenges it is very difficult to generalize the many regional themes identified in the report to all parts of this vast area of Ontario. This inherent regional variability needs to be taken into account in the planning process. In addition, while additional harmonization of addiction treatment practices and processes is desirable in the NE LHIN as a whole there should always be room for some local adaptations when well-supported by evidence and well- informed local stakeholder opinion.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the NE LHIN for several reasons noted in the report such as weather, remoteness of some communities, transportation and recruitment challenges, to name just a few aspects. The extent to which these contextual challenges impact access as well as the increased cost of service delivery needs to be acknowledged in planning system enhancements.

***Highly valued workforce:*** The managers and staff members who are providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. It is important that this be acknowledged in the planning process through good communication and meaningful engagement strategies.

***Changing nature of those seeking help*****:** There was strong, almost unanimous, opinion among those interviewed who are providing direct service to clients, that client complexity has increased dramatically in the last decade or so—the typical

presentation now including the use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health. To put it simply for planning purposes, the level and complexity of community need appears to be increasing.

***FNIM people and choice:*** It is conservatively estimated that FNIM individuals comprise 30% of the total client population in the region's specialized treatment services. While there is significant support in the region for culture-based treatment, experiences of stigma and discrimination in the regions' mainstream health services were commonly reported and much more needs to be done within many programs to ensure cultural safety and choice for people seeking help. The need was also commonly voiced for more support and engagement of FNIM leaders, organizations and traditional healers in planning regional and local treatment system enhancements.

***Importance of self-help organizations:*** Self-help groups are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. It is widely recognized, and supported by research, that involvement of clients with such organizations as AA, NA and Women for Sobriety are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system. This needs to acknowledged and supported in the planning process.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the *organization-level* (e.g., program managers seeking to avoid duplication of services) and *the individual -level* (e.g., front-line workers facilitating transitions across services). This affirmation notwithstanding, tensions exist in the sub-regions and many specific communities that significantly challenge collaboration and coordination, particularly at the organization-level. While to a certain extent such tensions are to be expected in Ontario's complex health and social service delivery system, the tensions are running very deep in many communities and strong leadership is needed at the LHIN-level, and collaborative leadership at the community level, to work together in the interests of the community as a whole. The ensuing planning process should be characterized by collaborative leadership for change management.

***Funding challenges****:* Participants commented at length on the funding challenges that present barriers to the delivery of quality services. These challenges are further described below but primarily reflect the lack of basic increases to budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Participants also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to other professionals and staff working within many community partner organizations, particularly community and hospital-based mental health services. Prioritization of the challenges and gaps in the treatment system will have to take

into account current funding realities while also using this report as a strong base for advocating for additional support.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** This report has shown the significant level of utilization of physicians and hospitals, including ED visits, for substance-related conditions, at a regional level that is about double the provincial rate. This doubling was also evident for utilization of physician support for medication-assisted treatment (primarily methadone). Planning needs to not only affirm the need to reduce costly health care utilization related to substance use and addiction but the process to do so needs to be a collaborative effort that engages *both* hospitals and community services in seeking solutions. This includes more sharing of strategies and lessons learned across the region and the province as a whole.

Evidence suggests that the costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals across the board; investing in models of addiction nursing liaison and collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

#### *4.3.2.2 Themes and Implications Related to the Key Principles for Treatment System Design*

In addition to the core themes that, at least to some degree, cut across the entire region, the content of the proposed addiction service plan should also be guided by the seven core principles for system design that structured the regional gap analysis. It will be the task of the regional and local planning bodies to prioritize the many challenges and gaps identified in the report and which are too numerous to reiterate or adequately synthesize and prioritize here. The focus in this closing summary, therefore, is to offer a small number of highly salient points under each principle so as to give some guidance to priority issues and principles for careful consideration in the next stage of planning.

Identifying these few points below is not intended in any way to diminish the importance of the many other areas of concern and need for system enhancement identified in the main body of the report or the sub-regional summaries in Appendix 1.

## Principle 1: Broad Systems Approach

### A broad systems approach is needed in order to address the range of substance use and related problems in the community, including severe substance use problems, and to achieve a population-level impact.

In the ensuing planning process it will be important to build upon participants' virtually universal endorsement of the system approach to addiction treatment planning and service delivery. Essentially this systems approach argues that since the societal challenges and costs related to substance use are shared across virtually all sectors of the public service, a broad, multi-sectoral approach is needed to identify, implement and evaluate solutions. The Tiered Framework (see section 3.3.2) is a helpful conceptual framework that articulates levels of service provision and organization appropriate to various levels of individual severity and need.

There are four main issues to ensure receive consideration in the upcoming planning process.

First, it will be important to bring the "systems with the system" together at the regional and local planning tables to build trust and concrete collaborations. Here we refer specifically to ensuring participation of both LHIN-funded and non-LHIN-funded addiction services including but not limited to addiction medicine and FNIM services.

Second, while there were many excellent examples of prevention and health promotion work in the region, and which need to be acknowledged as highly valued, more can and should be done to strengthen the relationship between prevention and health promotion and early intervention and treatment. This can be facilitated by using the tiered framework as a planning tool and by acknowledging that a healthy community (i.e., strong social capital) is critical to the success of treatment and recovery at the individual level (i.e. social capital becomes recovery capital). Concretely, it will be important to sustain current linkages with public health where they exist (e.g., Algoma Public Health) and explore building more such linkages regionally. The recent provincial move to bring funding for public health under the LHIN umbrella is an important opportunity to strengthen these linkages at a regional and local level in the North East LHIN.

Third, an important challenge at the systems level across the region that needs to be addressed in the ensuing planning process concerns stigma and discrimination. This is particularly a challenge for FNIM people with substance use (and mental health) challenges, but not exclusively so. This is discussed further below, for example, the need for sustained cultural safety training across all addictions services in the region as well as in key services/settings such as emergency departments, the justice system writ large and the CAS.

Lastly with respect to moving forward with this broad systems approach, the planning process needs to articulate very clearly the optimal relationship across the

region between mental health and addiction services. It is recommended that the overall strategy should be to proceed with collaborative work as well as opportunities for structural integration that make sense from the point of view of cost efficiencies AND improved outcomes for clients and families. This process of gradual integration is evident across the province with clear success in some areas and remaining challenges in others. That being said, experience elsewhere suggests there is a need within the regional plan for strategies to protect addiction capacity and competencies in the context of this gradual integration process. Leadership is also needed, however, to articulate the rationale and pros and cons for policy which covertly or overtly imply separate funding streams for one "sector" versus the other sector. If the vision going forward is in fact one integrated system then separate streams of funding and disparate wage levels, for example, are ultimately inconsistent with this highly integrated system view.

### Principle 2: Collaboration across Multiple Stakeholders

#### Accessibility and effectiveness of services for people with substance use problems are improved through collaboration across multiple stakeholders.

There is some obvious overlap between this principle and the system approach described above. So as to avoid duplication and also to emphasize the most salient themes under this principle of "collaboration" we focus here on the tensions between hospital-sponsored and non-hospital sponsored services that were evident in many communities in the region. Resolution of these tensions should be an important aspect of the planning process, largely through open and honest dialogue, but also through adequate exploration of the motivations and concrete pros and cons for investments in one direction or another and adequate exploration of collaborative care models that draw upon the strengths of both hospital and non-hospital services. Importantly, the pros and cons also need to be articulated for specific sub-populations from an equity lens while recognizing the overall distribution of needs in the community as a whole.

By way of providing some guidance to resolving these tensions, and using the population health pyramid and Tiered Framework (see section 3.3.2) as a conceptual aid, the advantages of investing in non-hospital based services for "Tiers 3 and 4" are the following:

- They are less costly and, therefore, offer greater service capacity per dollar spent.
- They are more flexible, for example, offering the promise of increased reach through outreach services.

- It is feasible to build in some medical supports (i.e., nursing expertise) into non-hospital services thereby reducing the need for transition to hospital for many cases needing some medical attention and monitoring.
- They are more compatible with and comfortable for FNIM people and others who are challenged by stigma and discrimination and who also need strong community supports to sustain recovery.
- They offer a stronger connection to prevention and health promotion work in the community.
- Experience is often reported that non-hospital based services are more accountable to the community at large and better protected from hospital deficit reduction needs.

Potential advantages of enhanced hospital-based services for Tiers 3 and 4 are:

- There is potentially a more immediate link to medical supports, including medication, when needed. This enhanced linkage facilitates and mitigates risk management.
- There is potentially enhanced wrap-around services that can integrate psychosocial and medical/psychiatric supports,
- Physicians are potentially more cooperative in working with external community partners if the core services are based in the hospital and the overall care plan is more under their control.

The points above are specific to Tier 3 and 4 services and, on balance, support investment in community-based services versus those sponsored by hospitals. However, while pressure to medicalize services in these tiers is to be resisted, it is important to acknowledge the need for hospital-based care for the small but still significant percentage of cases with highly complex needs. In some communities this will likely include a small number of designated beds for short-term acute care and stabilization in a closely medically monitored environment such as a hospital with transition/step down to less intensive and costly community supports. This requires close collaboration and understanding of the stepped care model and the role of different levels of care within it.

Lastly, with respect to this key principle of collaboration, we would recommend close attention be paid in the planning process to collaborative care between addiction and primary care, Primary care was noticeably absent from the core themes identified by project participants while at the same time collaborative care models between primary care and addictions services are very well supported in the research literature. While important relationships do exist at the community level overall this seems to be an area deserving specific attention in the planning process. Well-validated models of screening, brief intervention and referral to

treatment (SBIRT) were clearly absent however from local discussions and participant feedback. This model is clearly appropriate for Tier 2, and in many cases also Tier 3 depending on the level of substance dependence. Collaborative care is also helpful for Tiers 3-5 overall with a step down to primary care for monitoring and support following intensive treatment or integrated care with medication management.

## Principle 3: Wide Range of Systems Supports

### A wide range of systems supports are needed to support and facilitate the effective delivery of services.

The following system supports were considered in detail in this project's system-level gap analysis:

- funding
- planning and policy
- performance measurement and information management
- implementation of evidence-based practices (EBPs) and knowledge exchange/translation

*Funding:* To avoid repetition with the core regional theme discussed above related to funding we reiterate only briefly the need for the upcoming planning and priority setting processes to be undertaken in the context of the gradual but real and significant erosion of service capacity that has been underway for some time across the region. This erosion of capacity has occurred in concert with increasing community needs and case complexity. Considerations for enhanced funding also need to take into account the significant wage disparities that are contributing to recruitment challenges. In addition the current high level and cost of utilization of physicians and hospitals, including ED visits, for substance-related conditions are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example. Investment will be needed to reduce but also recover some of these exorbitant costs.

*Planning and policy:* In terms of planning and policy we have noted elsewhere but reiterate the need for reinstatement of the local planning table in the Sudbury-Parry Sound-Manitoulin sub-region and development of such a local group in Moosonee/Moose Factory in order to move the local planning process forward more efficiently with appropriate stakeholder involvement. We have also noted the needed for strong representation of FNIM on the addictions planning committee (ideally as a co-chair) and for key representatives from addiction medicine to also be closely engaged.

*Performance measurement:* This should be an area of high priority in the next stages of planning given the current inability to answer even the most basic questions related to access, cost, services provided and outcome achieved. A process is needed to "clean up" costing and other measures related to program operations so as to provide better benchmarking, planning and accountability data. The data collection and reporting protocol being advanced across the province by Dr. Garth Martin and through the DTFP implementation should be examined and used as appropriate. In applying this protocol the missing information in the agency profiles gathered herein should be collected.

Better tracking is needed of Francophone status and not just language of preference but also primary linguistic affiliation and identification of Francophone status. The new screening and assessment tools will accomplish this task as well as the OPOC-MHA Client Perception of Care tool being implemented across the region.

With respect to the regional roll-out of the OPOC-MHA tool specifically, as its use becomes institutionalized and routine comparative data become available across addictions and mental health services, as well as community and many hospital services, the resulting data will be of high value for performance measurement, quality improvement and evaluation purposes.

Models of outcome evaluation should be carefully considered, both within-treatment outcomes and post-discharge recovery monitoring. Guidance can be provided by others pursuing this work in the province building upon the foundation laid by Ontario and national DTFP work. The newly mandated screening and assessment tools provide a solid foundation for this work and pilot work or other steps in this direction within the region are to be encouraged.

*Knowledge exchange and evaluation: There should be more options operationalized* for more sharing of information and innovative practices across the sub-regions. There should also be region-wide evaluation activity, particularly around pilot projects with an aim to identify regional evidence-informed practices and scale up as appropriate (e.g., evaluation of community withdrawal management, transportation options, screening and brief intervention in primary care). Planning for regional scale up of such innovations as META-PHI, Harm Reduction Home, Single Session Therapy, Walk in Services are also critically important and the regional plan should include consideration of initial priorities and both scaling up and sustainability strategies. The resource at CAMH, now expert in implementation science can be very helpful in this regard.

Also in the context of knowledge exchange the next steps of planning should include a more complete assessment of strengths, needs and proposed solutions to the human resource challenges in the sub-regions. This should include identifying solutions, for example, to wage parity, enhancing nursing capacity in addiction services, challenging in recruiting Francophone and HR-related risks associated

with service contracts for the regional residential services (i.e., potential risk for major downsizing due to loss of key contracts).

Opportunities for cross training should also be identified as well as support for self-care and capacity building of staff and managers.

### Principle 4: Unique Strengths and Needs of FNIM Peoples

**FNIM peoples have unique strengths and needs with respect to substance use and related problems, and benefit from services and support that blend principles and practices of non-indigenous people with those based on traditional healing.**

As with many of the system supports such as funding and planning/policy the need to better address the needs of the region's FNIM people was salient across virtually all the sub-regional input and analysis. To that end we discussed above the general thrust of the input and implications above as one of the core regional themes. We will not duplicate but will reinforce again the obvious disconnect between:

(a) the high need in this population - in some communities at virtually epidemic levels of prescription opioid addiction layered on top of inter-generational trauma, alcohol and other drug abuse, suicide and many other health and social challenges;

(b) the obvious disparity between the estimated 30% of the total client population in the specialized addictions treatment services compared to about 10% of the regional population, not to mention larger disparities in the incarcerated population also closely related to substance abuse;

(c) the experiences of stigma and discrimination in the regions' mainstream health services, justice system and in isolated instances found in this project in the region's addiction's services;

(d) the declared priority of the NE LHIN with respect to addressing needs of this population; and, lastly

(e) the lack of current representation on regional planning bodies specific to addiction (and mental health) services.

The recommendation, noted earlier for co-chairmanship of the addictions planning committee is based primarily on these salient factors. Several, other noteworthy recommendations specific to the FNIM population include the need to engage

leaders drawn from the FNIM community, including traditional healers, in the development of educational materials that will help educate clients and families about traditional culture as one complementary option in support of their healing process[21]; the need for community outreach services into FN communities; the need for flexible and longer lengths of stay in residential services due to the lengthy healing process required for the significant trauma associated with the residential school experience and other forms of trauma; the need for effective transition supports to and from withdrawal management and treatment services away from their community; the need to support land-based healing opportunities; the need for family-based treatment options; and the need for sustained culture safety training within all addictions, mental health and other services utilized frequently by FNIM people in the region.

With respect to the latter (cultural safety), the planning body picking up on this report should look to the Southwest LHIN as being exemplary in this regard and particularly their adoption of a well-received program on cultural safety training developed in British Columbia. Another major strength to build upon is the deep understanding in the FNIM population itself of the need for community health and wellness on a broad scale in order to facilitate and strengthen the healing process for specific individuals and families. This speaks to above need to strengthen prevention and health promotion work at the community level, including education and employment opportunities, access to healthy food and clean water, housing, child care, etc.

Lastly, the ensuing planning process should examine the need and potential details for a clearer LHIN-level policy with respect to LHIN funding support for FNIM programs. Some programs are currently funded, at least in part, while others have no relationship with the LHIN at all. There is room for more clarity here and recognizing that small investments could make a significant difference in service capacity in several FNIM programs in the region, especially for intake/assessment or outreach workers. This clear show of support would also no doubt increase engagement of these services and their managers/staff in regional and sub-regional level planning.

[21] Importantly these materials need not be aimed solely at FNIM people as an increasing number of people accessing FNIM traditional healing approaches are non-FNIM (in one instance noted in the environmental scan as 50% of participants).

## Principle 5: Age, Development, Equity and Diversity Issues

### Age/developmental considerations and a range of equity and diversity issues are critical for effective treatment system design.

With respect to this key principle there is such a wide range of service gaps and challenges, as well as key strengths upon which to build it is very challenging to highlight a small number of issues of particular priority for the ensuing planning process. Sections 3.2.6 of the main body of this report as well as Table 16 in this summary sections shows the many strengths, challenges and planning implications with respect to older adults, youth, women, men, and the Francophone population. The planning process should draw heavily upon all this material.

In this summary we highlight the particular challenges and opportunities with respect to youth, highlighting in particular the need for enhanced support for transition from youth to adult services. This transition is made particularly challenging by age-related criteria for services and service entitlements and is no doubt challenged by local/regional context in the availability and accessibility of service alternatives. There is a literature of evidence-informed practice that the planning committee can draw upon as well considerable expertise garnered by CAMH and participating organizations in many regions of Ontario via the System Improvement through Service Collaboratives (SISC) initiative. In addition the planning committee can look to identified strengths in the region, for example, the app developed by partners in the Manitoulin service network and the transition processes developed by the addictions and mental health service at Health Sciences North in Sudbury as well as Algoma family Services.

Other youth specific needs to be reviewed and prioritized by the planning committee include expressed needs for youth withdrawal management services and residential treatment. With respect to the latter see section below on the continuum of care and the need for a wider review of residential addiction services in the region.

## Principle 6: The Continuum of Care

**Since a significant number of people with substance use problems are in contact with helping agencies and professionals who do not identify their problems, proactive systematic screening is necessary to improve detection and access to required services. This should be followed by assessment of strengths and challenges and development of an individualized treatment and support plan, starting with placement matching along the continuum of care.**

The report highlighted the many significant strengths in the continuum of care for the region as a whole as well as within each of the five sub-regions/hubs. In brief, there is a strong foundation of services upon which to build, albeit they are struggling to meet demand due to the gradual erosion of capacity noted earlier as a result of long-standing baseline funding increasing costs and increasing case complexity.

We specifically drilled down in four areas within the continuum of care and highlight below a small number of issues within each sub-area.

- Screening, assessment and placement matching
- Withdrawal management services
- Residential and community treatment services
- Access, outreach and transitions

Screening and assessment – In this sub-area the priority for planning should be to identify support needs and opportunities for regional and hub-level implementation plans for the new mandated screening and assessment tools (to replace ADAT). The Ministry-mandated tools are being rolled out at the present time with support by a CAMH implementation team and this process is well-underway in the NE LHIN, one of the designated "early adopter" LHINs. While there are strengths and challenges in each LHIN where the implementation process is underway some of the challenges are unique or exacerbated by the complexity of the NE regional and sub-regional treatment systems.

One of the particular challenges of note is the specific mandate and related staffing and resource base to support implementation of the new tools within LHIN-funded addiction services. This, of course, unintentionally prompts challenges and potential tensions among non-LHIN-funded services who have been using the now outdated ADAT tools as part of their assessment and referral process, including but by no means limited to referral to residential treatment. While recognizing the process of replacing the ADAT across the region will take several months, there are immediate challenges being identified by several organizations in the FNIM community who

have been using the ADAT and have expressed an interest in quickly adopting the new protocol. There may be some cases where this can be done relatively easily (e.g., where both the ADAT tools and the tools software platform in the DATIS/Catalyst system have been used) while in the majority of instances new resources and considerable planning will be required. It will be important for the ensuing planning process to be familiar with these and related issues and consider how best to secure resources and support widening the access to and training on the new screening and assessment protocol.

Further to this the planning committee needs to recognize that beyond the high clinical value for treatment planning/matching from the new screening and assessment package to replace ADAT these new tools will provide important and currently unavailable performance measurement data for the system as whole, including the ability to monitor severity of cases entering the region's residential and community treatment services as well as different levels of withdrawal management. The tools will also be able to monitor access to service by different sub-groups in the population from a health equity lens as well as track self-reported outcomes such as use of emergency department visits. In short, they are critical tools for ongoing system-level quality improvement.

Withdrawal management

The primary recommendation related to withdrawal management is for a rejuvenation of the work in the region on community withdrawal management, building upon the success of the Community Withdrawal Management service on Manitoulin Island as well as the solid body of national and international research evidence that has now accumulated on this cost-effective level of care. There are a number of potential communities in the region where community withdrawal management can be piloted (e.g., Timmins, Parry Sound) taking advantage of natural synergies that exist such as between the local CMHA with existing nursing and supportive housing capacity and local addiction services with a strong outreach capacity.

Another highly salient recommendation for careful consideration in the imminent planning and prioritizing process will be to enhance the level of nursing supports in the region's residential withdrawal management services. This will be a cost-effective approach to minimizing the current cross-traffic between the withdrawal management services and the local ER's often for an unnecessary medical clearance and/or medication management that could be easily; done in-house with nurses at an appropriate level of training and certification. This trend to embed nursing professionals in the province's "social detox" model is occurring across the province and is in fact as much a provincial as it is a regional issue. There is an opportunity for the NE LHIN to both build upon expertise from other communities in the province as well as show provincial leadership on this issue by addressing it at a regional scale.

Other aspects of withdrawal management services deserving particular attention in the planning process include considerations with respect to mandatory requirements for flexible length of stay to support subsequent treatment entry, ensuring a high level of concurrent-disorder capability in each of the region's WMS programs and exploring ways to maximize the use of OTN in outlying areas for WMS capacity development. This OTN-based capacity development for WMS should also be linked to enhancing capacity in the outlying communities for support with respect to medication-assisted treatment for opioid addiction.

The planning committee should also review the specifics related to withdrawal management services in the sub-regional summaries in Appendix 1 including addressing the deficit funding-situation at Smooth Rock Falls; a strong recommendation for a new WMS in Moosonee as well as a new site for Sault Ste. Marie and the aforementioned development of community withdrawal management options for Timmins and Parry Sound and with strong evaluation plans.

Residential and community treatment

While there are several outstanding strengths in both the community and residential treatment programs across the region, and some specific areas where community programs can be enhanced due to the challenges presented by the ongoing baseline funding situation noted in several places already, the main implication and clear recommendation for the next planning phase is for a deeper and more operationally-oriented review of the region's residential treatment services.

This review should aim to resolve several current situations that have been left hanging for some time and which need a resolution, including the chronic funding shortfall and related extended summer closure for Jubilee Centre the need for full funding to Monarch Recovery Services regard the operation of the men's treatment program that was transferred to them from the Salvation Army; enhanced funding needed for longer-term transitional recovery supports in some parts of the region and needs for residential treatment for youth and options for meeting these needs in the region given the existence and mandate of Maison Arc-en-Ciel as well as apparently under-utilized resources for youth residential treatment in other parts of the province. In short there is a wide range of issues to sort out but limited data to in fact do so without a more focused review and a review process that can develop cost comparators in the region and from across the province, review and validate existing data on program completion, policies related to access to clients on methadone or other medication, new criteria for access based on the emergent screening and assessment tools and the process for monitoring adherence, and program content and operating characteristics vis a vis retention and transition supports and the need for enhanced in-house nursing supports as per the withdrawal management services noted above.

This particular focus on the region's residential treatment sector is not meant to downplay their importance in the region which was reinforced on many occasions in the process of conducting this environmental scan. The recommendations comes from the spirit of ensuring that those services are being used to optimal efficiency given the large share of the resource base that supports them; the high utilization of these residential services by people outside the region; the extant research evidence that shows community (non-residential ) services to be the more cost=effectiveness choice for the large majority of clients (hence the need to match very carefully in the assessment and treatment planning and stepped care process); and finally and the poor status of even the most basic administrative and operational data by which one can describe the current state of affairs and make appropriate decisions.

Aside from this more in-depth look at the region's residential services the other important recommendation going forward is for enhanced day/evening treatment options in the region. This is a notable gap in many communities and can be considered in the context of the aforementioned operational review of residential services as it is likely that some (perhaps many) of the clients currently seen in the regions residential services could be more cost-effectively treated on a day/evening basis, again on the basis of individualized assessment and monitoring in a stepped care model.

The other important recommendation for enhanced community services is noted below with respect to enhancing the regions outreach services.

<u>Access, outreach and transitions</u>

Notwithstanding the many excellent examples of outreach services in the region and selected communities making enhancements to this outreach capacity is identified here as the number one priority for overall system enhancement in the region writ large. There are many dimensions to this high need for outreach services including but by no means limited to the following:

- The (rapidly) aging population and the recognized value of outreach services for this and other populations including marginalized populations
- The rural and remote nature of the region and the very significant transportation challenges;
- Supports needed by people affected by stigma and discrimination and the documented value of accompanying them on critical events such as an ER visit or court appearance;
- The need for transition supports between levels of care (e.g., withdrawal management to treatment; treatment back to community) that may or may not include the need for transportation.

In sum, the top priority for addressing gaps in the already reasonably strong continuum of care should enhanced funding for community-based outreach services including, if possible, transportation funds and other flexibility to support treatment access. With respect to funding for transportation it is recognized this has been a historic funding challenge across the province and in this regard the planning committee would do well to look to a well-functioning model funded by the Southwest LHIN through Westover Treatment Centre.
One other area of particular interest for the regional and local planning groups alike concerns efforts in the region towards more centralized/coordinated access. This is addressed most specifically in the sub-section on the Sudbury-Parry Sound-Manitoulin hub as Sudbury currently hosts the most active centralized access process – a collaboration between the local CMHA and addictions and mental health services at Health Sciences North. This was also a recommendation of the 2015 review of community mental health services in that area.

A provincial scan of centralized access models in Ontario as well as a comprehensive review of evidence concerning their key features and effectiveness is nearing completion by Brian Rush and Birpreet Saini for Addictions and Mental Health Ontario and the Centre for Addiction and Mental Health. Further efforts in the Sudbury area as other parts of the NE LHIN should await the completion of that report and the subsequent knowledge exchange process around its release.

### Principle 7: Mix of Evidence-Informed Psychosocial and Clinical Interventions

**Once an individual is placed in the initial level of care, the individualized treatment plan must include the right mix and duration of evidence-informed psychosocial and clinical interventions.**

This part of the environmental scan clearly presented issues with respect to scope and the project team drilled down specifically in four areas.

- Screening, brief intervention and referral to treatment (SBIRT)
- Addiction medicine, essentially medication-assisted treatment for opioid addiction
- Housing
- Internet and mobile services

The implications and recommendations are briefly summarized below:

Screening, brief Intervention and referral to treatment (SBIRT): This significant gap is noted elsewhere in this summary and we repeat here the recommendation for demonstration/pilot work initiated in the region. There is a large literature to draw upon as well as Canadian-based models and expertise to draw upon. The planning committee should also build upon past experience in the region with addiction liaison nurses placed in the regions emergency department in light of research

evidence and very positive experience elsewhere in Ontario and other parts of Canada and with appropriate, well-timed, evaluation criteria in place.

Addiction medicine: Aside from the strong recommendation noted earlier for engagement of addiction medicine experts from the region in the ensuing planning process as one step towards improved communication and collaboration there is need to the planning committee to examine areas of strong collaboration that currently exist on the ground in many communities and aim to build upon and potentially scale up these initiatives in other parts of the region. A case in point is the META-PHI project in Sudbury, the results of which should be monitored closely for regional implications. There is also a need for better education across the system as w hole on the pros and cons of methadone-assisted treatment versus Suboxone assisted treatment and overall more support lent to emergent efforts for using Suboxone through now well-establish community-level intervention.

Housing: The housing needs are so integral to the overall needs of the population needing help with substance use (and mental health) issues that they need to be considered as an integral rather than peripheral aspect of the planning process ahead. There is a need for continued investment in supported housing while recognizing the increasing complexity of cases who will need an increased level of daily or weekly support. This has resource implications that need to be acknowledged and fleshed out, again by building upon the many strengths in the region with respect to supportive housing.

Also with respect to housing the new effectiveness of the new harm reduction Home in Sudbury should be closely monitored for potential scale up in other parts of the region. Not only does it represent an excellent harm reduction approach it clearly illustrates the need to consider housing needs along a very wide spectrum. There are also needs in some communities for enhanced men's shelter and transition housing supports that will need to be prioritized by the local planning groups working from this main report and the sub0regional summaries in Appendix 1.

Internet and mobile treatment/supports – The research evidence is building rapidly with respect to "e-options" for addictions and mental health care and support. Looking into the future all experts in this area agree that these technologies hold the promise of significant increasing the reach and effectiveness of addiction and mental health service – not as a full-on replacement to the current service model but as a complement to it.

It is recommended that a sub-committee of the emerging planning structure take this on this topic bringing back to the larger committee ideas and identified innovations that should be pilot tested and evaluated and incorporated into planning in the next 3-5 years. This should build upon current examples developed or underway in the NE region as well as existing projects and expertise within northern regional research groups and CAMH, including a current DTFP project on youth and e-technology.

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# 6.0 Appendices

## Appendix 1: Hub/Sub-regional Summaries and Implications

## A1.1 Coast Sub-Region

### *Coast Sub-region Context*

#### *Population Trends*

James Bay is home to 6,213 people and its population represents only 1.12% of the NE LHIN's total population. This sub-region has the smallest proportion of the NE LHIN's Francophone population at 0.55%, and the largest population of First Nations people. Based on 2006 Census data (which should be interpreted with caution as it does not reach individuals on reserve), 96.2% of the population reported FNIM identity.

This census data also indicated that this sub-region had by far the highest percentage of families with children headed by a lone parent (35.7% - more than double the average of the NE LHIN and Ontario). The area also had the highest child dependency rate compared to the rest of the NE LHIN and Ontario (65.0%, 26.6%, 22.0%, respectively). The senior population only accounts for 3.3% of the population, which is much lower than the NE LHIN and Ontario average (3.3%, 16.5%, 13.6%).

#### *Substance Use Trends*

There are not large numbers recorded of new individuals who received substance use treatment in the NE LHIN who reside in the James Bay and Hudson Bay Coast area as shown in the data presented previously in Table 7. However, DATIS data were not being entered during the fiscal year in the mental health and addiction program administered by the Weeneebayko Health Authority.

Of what data are available (see Table 17), it can be seen that 63.3% of new admissions from the Coast area who received substance use services somewhere in the NE LHIN were men, compared to 36.7% women, and most of these new admissions were between the age of 25 and 44. The gender ratio is about the same as the NE LHIN as a whole. In spite of the relatively young population in the sub-region, the proportion of new admissions under the age of 24 (8.9%) is lower than that found in the NE LHIN as a whole (21.2). Over half of new admissions (58.9%) reported Ontario Works or ODSP as their source of income, a proportion approaching double the percentage for the LHIN as a whole.

In line with the regional trend, alcohol was reported as the main presenting problem substance for new admissions, with cannabis as the second most common. Cocaine, amphetamines, and prescription opioids were also reported in almost equal measure and reported almost as frequently as cannabis.

**Table 17.** Characteristics of New Admissions Who Received Substance Abuse Treatment in James Bay and Hudson Bay Coast (Fiscal Year 2014/2015)

| Characteristics | James Bay and Hudson Coast | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| **Gender** | | | | |
| Male | 57 | 63.3 | 5913 | 65.9 |
| Female | 33 | 36.7 | 3053 | 34.0 |
| Other | 0 | 0.0 | 0 | 0.0 |
| Total | 90 | 100.0 | *8967* | *100.0* |
| **Age Group** | | | | |
| Under 16 | 0 | 0.0 | 139 | 1.6 |
| 16-24 | 8 | 8.9 | 1760 | 19.6 |
| 25-34 | 45 | 50.0 | 2740 | 30.6 |
| 35-44 | 28 | 31.1 | 1824 | 20.3 |
| 45-54 | 9 | 10.0 | 1423 | 15.9 |
| 55-64 | ... | ... | 902 | 10.1 |
| 65 and over | 0 | 0.0 | 179 | 2.0 |
| Total | 90 | 100.0 | 8967 | *100.0* |
| **Source of Income** | | | | |
| Employment | 11 | 12.2 | 1506 | 16.8 |
| Employment Insurance | 7 | 7.8 | 432 | 4.8 |
| ODSP (Ontario Disability Support Program) | 11 | 12.2 | 2105 | 23.5 |
| Disability Insurance | ... | ... | 319 | 3.6 |
| Other Insurance (excluding Employment Insurance) | ... | ... | 54 | 0.6 |
| Ontario Works | 42 | 46.7 | 2293 | 25.6 |
| Retirement Income | 0 | 0.0 | 227 | 2.5 |
| Other | 0 | 0.0 | 293 | 3.3 |
| None | 13 | 14.4 | 933 | 10.4 |
| Family Support | ... | ... | 497 | 5.5 |
| Unknown | 0 | 0.0 | 221 | 2.5 |

| Characteristics | James Bay and Hudson Coast | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| Missing | 1 | 1.1 | 26 | 0.3 |
| Total | 90 | 100.0 | *8967* | *100.0* |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 90 | 100.0 | 2695 | 30.1 |
| Non-FNIM | … | … | 6272 | 69.9 |
| Total | 90 | 100.0 | *8967* | *100.0* |
| **Presenting Problem Substances** | | | | |
| None | 0 | 0.0 | 245 | 2.7 |
| Alcohol | 78 | 86.7 | 6101 | 68.0 |
| Cocaine | 36 | 40.0 | 1799 | 20.1 |
| Amphetamines. & other stimulants exc. methamphetamines | 22 | 24.4 | 734 | 8.2 |
| Cannabis | 43 | 47.8 | 3465 | 38.6 |
| Benzodiazepines | 1 | 1.1 | 441 | 4.9 |
| Barbiturates | 1 | 1.1 | 25 | 0.3 |
| Heroin/Opium | 2 | 2.2 | 197 | 2.2 |
| Prescription opioids | 26 | 28.9 | 2194 | 24.5 |
| Over-the-counter codeine preparations | 2 | 2.2 | 142 | 1.6 |
| Hallucinogens | 2 | 2.2 | 89 | 1.0 |
| Glue & other inhalants | 2 | 2.2 | 30 | 0.3 |
| Tobacco | 10 | 11.1 | 2753 | 30.7 |
| Other psychoactive drugs | 0 | 0.0 | 95 | 1.1 |
| Steroids | 0 | 0.0 | 9 | 0.1 |
| Crack | 8 | 8.9 | 788 | 8.8 |
| Ecstasy | 0 | 0.0 | 66 | 0.7 |
| Methamphetamines (crystal meth.) | 0 | 0.0 | 152 | 1.7 |
| Unknown | 0 | 0.0 | 71 | 0.8 |

*DATIS 2014/2015*

## Strengths and Challenges of the James Bay and Hudson Bay Coasts Treatment System

Several *common themes* in the feedback from participants were noted in the regional overview in Section 3.2. They are noted again here as they were common to the Coast sub-region as well.

***Variation across the region:*** The first "common theme" was the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions but also *within* these areas, including to some extent the Coast sub-region. We note this variability within the Coast area guardedly as resources did not allow for travel and on-site observation and interviews outside Moose Factory and Moosonee. Feedback was obtained, however, from workers responsible for providing services in the various Coast communities and others quite familiar with the diversity of the area.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the Coast sub-region for several reasons, including:

- The vast geography, including its remote communities.
- The population mix, largely First Nations, many with strong ties to land and the Cree language.
- Challenges with recruitment and retention of qualified staff in part due to the remote nature of much of the region.
- The weather conditions in the winter that impact travel and other transportation challenges associated with the fly-in only communities.
- Significant migration patterns within and out of the area, for example, for work, school, justice involvement and in response to flooding.
- A shortage of affordable housing/rental options and employment opportunities.

***Highly valued workforce:*** The staff providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants commonly highlighted that staff are working in challenging circumstances, at a comparatively low level of compensation and, in most cases, without a salary increase for several years.

***Changing nature of those seeking help*:** Among those interviewed who are providing direct service to clients, there was strong, almost unanimous, opinion that client complexity has increased dramatically in the last decade or so—the typical presentation now includes use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health.

***FNIM people and choice:*** FNIM non-FNIM participants alike reflected on the high needs within First Nations communities and among the individuals and families seeking help. Citing high rates of suicide, and epidemic levels of prescription opioid addiction, layered on top of high rates of alcohol and other drug abuse, the needs are clearly urgent. While there is significant support in the Coast sub-region and the NE LHIN generally for culture-based treatment, experiences of stigma and discrimination in the wider regions' mainstream health services were commonly reported and much more needs to be done within many programs to ensure cultural safety and choice for people seeking help. The need was also commonly voiced across the NE region as a whole for more support and engagement of FNIM leaders, organizations and traditional healers in planning regional and local treatment system enhancements. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement under challenging circumstances and effective transitions to continuing care within their family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual level (e.g., front-line workers facilitating transitions across services). This affirmation, notwithstanding, significant tensions exist in the sub-regions and many communities that significantly challenge collaboration and coordination, particularly at the organization-level. Across the NE LHIN region as a whole these challenges variously include tensions between "hospital and community"; "mental health and addiction"; "addiction medicine and mainstream addiction treatment"; and "FNIM and non-FNIM services", to name the more common versions of these tensions. While, to a certain extent, such tensions are to be expected in Ontario's complex health and social service delivery system, the tensions are running very deep in many communities and strong leadership is needed at the LHIN-level, and collaborative leadership at the community level, to work together in the interests of the community as a whole.

***Funding challenges**:* Participants across the region as a whole commented at length on the funding challenges that present barriers to the delivery of quality services. These challenges are further described below but primarily reflect the lack of basic increases to budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Participants also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to professional and other staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this report show the significant level of utilization of physicians and hospitals, including ED visits, for substance-related conditions. In the Coast sub-region this is clearly evident in the ED data. The costs of this service utilization are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example.

Given the complex nature of substance use, however, this work to reduce costly health care utilization (as well as other high social and justice-related costs) needs more focus and more collaborative efforts that engage both hospitals and community services. This includes more sharing of strategies across the NE region as a whole. The costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals and addiction nursing liaison; various models of collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

## Strengths in the James Bay and Hudson Bay Coasts Treatment System

- A major strength is the range of services that are available including:
    - The WAHA hospital and the physicians and others who travel into the outlying areas as well as other critical services and supports at the hospital such as the healing resource/room and truth and reconciliation resources (Stella Schimmens).
    - Traditional healers such as Jules Tapas.
    - The WAHA mental health and addiction program located in Moosonee and the distribution of its workers in the outlying communities.
    - The area's NNDAAP workers and the Health Canada funded healing lodge with its family program.
    - Moose Cree Health Services and many other organizations deeply involved with addiction and mental health-related treatment and support.

Overall, this represents a strong foundation upon which to build a more coordinated system and to support the additional resources recommended in the report.

- An existing complement of workers that overcome major hurdles on a daily basis to not only deal with crises and motivate people to seek treatment, but also to secure travel permissions, health-related clearances and to manage a host of technical issues and transportation challenges to get someone out of the community to treatment (or withdrawal management services)

- Growing cultural awareness but the need for education and trust building within communities is ongoing. There is a strong cultural base for treatment in the area, although the need for cultural safety awareness among local non-FNIM services will be an ongoing task.

- An existing "well-oiled" pathway to accessing withdrawal management services in Smooth Rock Falls, which offers considerable ongoing and historical support to this sub-region despite transportation and other challenges described below. This support needs to be acknowledged and continue in a seamless way as other options for withdrawal management and treatment are developed in the Coast sub-region itself. As new resources are developed many people FNIM and non-FNIM residents will want to consider service options away from community as well as options closer to home.

### Challenges in the James Bay and Hudson Bay Coasts Treatment System

- Most, if not all, the challenges experienced in the other sub-regions of the NE LHIN are extremely exacerbated in the Coast region- including housing and economic opportunity—in addition to such things as the annual flooding and evacuation of many communities and the concomitant closure of resources and the cost of food, gas and household necessities. The impact of the residential school/trauma is also particularly acute here due to the size of the FNIM population and more limited opportunities for healing.

- Generational and intergenerational trauma including, but not limited to, the residential school experience. This affects virtually *everything* in the area but particularly:
    - Low trust in the help-seeking process and level of engagement with services.
    - The need for trauma-informed treatment and treatment of longer duration and, ideally, the involvement of family members.

- The need for significant work related to relapse prevention, including prevention and health promotion for the whole community to which people will return after treatment.

In addition, the five-year window of compensation in the reconciliation process is not seen as sufficient in duration and many people are just coming out now. Thus, requests for service are likely to increase in the short term.

- Difficult conditions for workers in Coast communities, many of whom report needing their own support for self-care and healing

- Additional training and skill building regarding short-term response to crisis/intoxication, counseling and continuing care, including OTN set up and operation.

- While there is a strong foundation of services in the region, there is a need for better coordination/communication among them. This is especially true with respect to the need to build a strong network of support for people accessing treatment, in or out of the Coast area, and to support an effective transition back to the community.

- Prescription drug abuse is routinely reported at epidemic levels in many communities and alcohol remains an ongoing substance of major concern (other drugs as well, but the primary ones are reported locally to be prescription drugs and alcohol). Substance use and abuse is closely connected to mental health and other challenges, including high rates of suicide. The lack of capacity in the Coast sub-region for complex mental health problems is particularly challenging, including the lack of Schedule 1 mental health services (Timmins, North Bay). This presents challenges for managing severe concurrent disorders as well as psychotic disorders and other severe conditions.

- Cultural awareness and sensitivity can still be improved in some programs in the Coast area, as well as for those people who are accessing services outside the region. There is a need to find the right balance of accountability and program structure and flexibility and cultural safety concerns.

## Implications and Recommendations for the James Bay and Hudson Bay Coasts Treatment System

- A new withdrawal management service (WMS) is recommended, to be administered by the WAHA, and planned in concert with new construction of the hospital in Moosonee. While a small number of "medical crisis beds" will be needed in the new hospital for severe cases of intoxication needing medical supports, the main WMS should be funded through and sponsored by the hospital but sited in a community residential setting and with a very strong cultural healing component and on-site nursing capability. There should be a close affiliation to the WAHA Mental and Addictions Program as well as a strong collaboration with the local federally-funded Healing Lodge. In planning the new service, strong engagement of a range of local and other stakeholders is required, including, but not limited to, Moose Cree Health Services.

- In preparation for the new program, which may take some time to actualize, there is work to be done that could be called "Withdrawal Management Readiness". This should involve trust building and collaboration among services, in particular among LHIN-funded and non-LHIN-funded services. There is also a need for training and capacity building to link withdrawal management services (in Moosonee and elsewhere) to community services and supports throughout the Coast sub-region for short-term crisis management via OTN. Decision-making protocols need to be developed regarding travel for withdrawal management or treatment, and should include details regarding information transfer and post-treatment planning for continuity-of-care. In short, the immediate work is to identify "*what communities themselves can do"* to support local workers and the people who are choosing to go to withdrawal management and/or treatment and returning home.

- Another recommendation to help people transition back to community after short-term treatment is to develop a land–based, longer term recovery/transition program that includes a family component. An option to explore would be a collaboration with the Moose Cree Health Services, as the organization owns a property that may be re-purposed for this type of addiction recovery program.

- In addition, a Coast-level plan needs to be developed for Suboxone-assisted treatment, building on the emergent work of the WAHA physicians, and that is closely connected to the Coast sub-region support network noted above for withdrawal management. The area plan for Suboxone-assisted treatment should engage other addiction medicine experts familiar with the area (Dr. Jonathan Bertram from CAMH in particular) and perhaps others who have paved the way elsewhere for integrated models of addiction medicine and traditional healing (e.g., Dr. Ralph Dell'Aquila and the North Shore Tribal Council). FNIM health professionals bringing this form of medication-assisted treatment to First Nations communities in the Northwest LHIN, and recently in some parts of the Northeast (Mae Katt, in particular), should also be engaged in planning and perhaps service delivery.

## A1.2 Cochrane Sub-Region

### *Cochrane Sub-region Context*

#### Population Trends

The Cochrane sub-region covers a large area of the NE LHIN. The area is known for having long distances between health and social services. According to data from the 2006 Census (as summarized by the NE LHIN in the North East Local Health Integration Network Demographic and Health Profile), the total population of the Cochrane region was 76,856 or 13.9% of the NE LHIN's total population, making it the second least populated sub-region. Almost half of the population is Francophone (49%). The unemployment rate is comparable to the rest of the NE LHIN at 8.2%, with 9.0% of families living below the Low Income Cut-Off. In addition, the sub-region has a slightly higher infant mortality rate (7 per 1,000) than the NE LHIN (5.2 per 1,000).

#### Substance Use Trends

Approximately 13.4% of new admissions that received substance use treatment in the NE LHIN during the 2014/2015 fiscal year were residents of the Cochrane sub-region (see Table 18). This number is approximate as 30% of new admissions were classified as "no fixed address" or "other", therefore their sub-region of residence is unknown. Compared to the NE LHIN as a whole, this sub-region serves proportionally more women. Of the new admissions who reside in Cochrane, just over half were men (54.3%) compared to women (45.7%).

Over half of new admissions were between the ages of 25 and 44 (54.8%), with 19.0% under the age of 24 and 26.3% over the age of 45. These proportions generally reflect those found in the NE LHIN as a whole. With regard to source of income, 38.3% of new admissions were receiving ODSP or Ontario Works, with 25.1% remaining employed - the highest percentage of new admissions reporting employment across the sub-regions.

Much like the regional substance use trends, the most common presenting problem substance for new admissions of those residing in the Cochrane sub-region were, alcohol, cannabis, tobacco, amphetamines and other stimulants, prescription opioids, and cocaine.

**Table 18.** Characteristics of New Admissions Who Received Substance Abuse Treatment in the Cochrane Region (Fiscal Year 2014/15)

| Characteristic | Cochrane | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| **Gender** | | | | |
| Male | 652 | 54.3 | 5913 | 65.9 |
| Female | 549 | 45.7 | 3053 | 34.0 |
| Other | 0 | 0.0 | 0 | 0.0 |
| Total | 1201 | 100.0 | *8967* | *100.0* |
| **Age Group** | | | | |
| Under 16 | 25 | 2.1 | 139 | 1.6 |
| 16-24 | 203 | 16.9 | 1760 | 19.6 |
| 25-34 | 433 | 36.1 | 2740 | 30.6 |
| 35-44 | 224 | 18.7 | 1824 | 20.3 |
| 45-54 | 155 | 12.9 | 1423 | 15.9 |
| 55-64 | 131 | 10.9 | 902 | 10.1 |
| 65 and over | 30 | 2.5 | 179 | 2.0 |
| Total | 1201 | 100.0 | 8967 | *100.0* |
| **Source of Income** | | | | |
| Employment | 302 | 25.1 | 1506 | 16.8 |
| Employment Insurance | 88 | 7.3 | 432 | 4.8 |
| ODSP (Ontario Disability Support Program) | 214 | 17.8 | 2105 | 23.5 |
| Disability Insurance | 32 | 2.7 | 319 | 3.6 |
| Other Insurance (excluding Employment Insurance) | 11 | 0.9 | 54 | 0.6 |
| Ontario Works | 246 | 20.5 | 2293 | 25.6 |
| Retirement Income | 51 | 4.2 | 227 | 2.5 |
| Other | 24 | 2.0 | 293 | 3.3 |
| None | 125 | 10.4 | 933 | 10.4 |
| Family Support | 99 | 8.2 | 497 | 5.5 |
| Unknown | … | … | 221 | 2.5 |

| Characteristic | Cochrane | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| Missing | … | … | 26 | 0.3 |
| Total | 1201 | 100.0 | *8967* | *100.0* |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 451 | 37.6 | 2695 | 30.1 |
| Non-FNIM | 750 | 62.4 | 6272 | 69.9 |
| Total | 1201 | 100.0 | *8967* | *100.0* |
| **Presenting Problem Substances** | | | | |
| Alcohol | 766 | 63.8 | 6101 | 68.0 |
| Amphetamines & other stimulants exc. Methamphetamines | 262 | 21.8 | 734 | 8.2 |
| Barbiturates | 11 | 0.9 | 25 | 0.3 |
| Benzodiazepines | 34 | 2.8 | 441 | 4.9 |
| Cannabis | 494 | 41.1 | 3465 | 38.6 |
| Cocaine | 216 | 18.0 | 1799 | 20.1 |
| Crack | 49 | 4.1 | 788 | 8.8 |
| Ecstasy | 7 | 0.6 | 66 | 0.7 |
| Glue & other inhalants | 1 | 0.1 | 30 | 0.3 |
| Hallucinogens | 19 | 1.6 | 89 | 1.0 |
| Heroin/Opium | 24 | 2.0 | 197 | 2.2 |
| Methamphetamines (crystal meth.) | 9 | 0.7 | 152 | 1.7 |
| None | 31 | 2.6 | 245 | 2.7 |
| Other psychoactive drugs | 12 | 1.0 | 95 | 1.1 |
| Over-the-counter codeine preparations | 19 | 1.6 | 142 | 1.6 |
| Prescription opioids | 236 | 19.7 | 2194 | 24.5 |
| Steroids | 0 | 0.0 | 9 | 0.1 |
| Tobacco | 349 | 29.1 | 2753 | 30.7 |
| Unknown | 4 | 0.3 | 71 | 0.8 |

As shown earlier in Table 7, some clients from all the other sub-regions of the NE LHIN, excepting Algoma, seem to be accessing services in Cochrane, albeit in small numbers. Most new admissions who received treatment in the Cochrane sub-region during the 2014/2015 fiscal year are residents of the area (70.9%), with 20.1% reporting "no fixed address" or "outside region" when reporting their area of residence. The next highest percentage of cases accessing services in Cochrane is from James Bay and Hudson Bay Coast (4.2%), this proportion no doubt reflecting a significant number who access the withdrawal management program at Smooth Rock Falls.

Also as noted above, among Cochrane's residential services, a significant percentage of annual clients report their residence as outside the NE LHIN – Jubilee (22% of 209 new admissions), Maison Renaissance (27.5% of 90) and Maison Arc-en-Ciel (46.7% of 60).

Other DATIS data examined by the review team show a substantial percentage of residential clients who do not complete treatment for a variety of reasons, but these data need to be validated by local managers in the context of a more substantive review of the residential services across the NE LHIN as a whole.

### Strengths and Challenges of the Cochrane Treatment System

Several *common themes* in the feedback from participants were noted in the regional overview in Section 3.2. They are noted again here as they were common to the Cochrane sub-region as well.

***Variation across the region:*** The first "common theme" was the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions of the NE LHIN but also *within* these areas, including the Cochrane sub-region. Within the sub-region there are two major sub-areas – North and South Cochrane.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the Cochrane sub-region for several reasons, including:

- The vast geography, including its mix of urban/rural/remote communities.
- The population mix, including significant Francophone and FNIM populations.
- Challenges with recruitment and retention of qualified staff due in part to language requirements in hiring as well as the rural/remote nature of much of the area.
- The weather conditions in the winter that impact travel, and other transportation challenges such as the lack of a bus service.

- The significant migration patterns into and out of the area, for example, for work, school, justice involvement and in response to flooding in the Coast area that brings people to the Cochrane sub-region.
- A shortage of affordable housing/rental options and employment opportunities.

***Highly valued workforce:*** The staff providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants almost universally highlighted that staff are working in challenging circumstances, at a comparatively low level of compensation and, in most cases, without a salary increase for several years.

***Changing nature of those seeking help*:** Among those interviewed who are providing direct service to clients, there was strong, almost unanimous, opinion that client complexity has increased dramatically in the last decade or so—the typical presentation now including use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health.

***FNIM people and choice:*** FNIM and non-FNIM participants alike reflected on the high needs within FNIM communities and among the individuals and families seeking help. Citing high rates of suicide, and epidemic levels of prescription opioid addiction, layered on top of high rates of alcohol and other drug abuse, the needs are clearly urgent. While there is significant support in the Cochrane sub-region, and the NE LHIN generally, for culture-based treatment, experiences of stigma and discrimination in the Cochrane area's mainstream health services were commonly reported and much more needs to be done to ensure cultural safety and choice for people seeking help.

The need was also commonly voiced across the Cochrane area, and NE region as a whole, for more support and engagement of FNIM leaders, organizations and traditional healers in planning regional and local treatment system improvements. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement of FNIM people under challenging circumstances and to ensure effective transitions to continuing care within their family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances

the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual level (e.g., front-line workers facilitating transitions across services). This affirmation, notwithstanding, significant tensions exist in the sub-regions, including the Cochrane sub-region, and particularly at the organization level. Across the NE LHIN region as a whole, these challenges variously included tensions between "hospital" and "community"; "mental health and addiction"; "addiction medicine and mainstream addiction treatment"; FNIM and non-FNIM services, and LHIN-funded and non-LHIN-funded services, to name the more frequently mentioned versions of these tensions. While community tensions such as these might be expected in Ontario's complex health and social service delivery system, some tensions between providers are running very deep in the Cochrane district. Strong leadership from the NE LHIN and collaborative leadership at the community level is needed to ensure the Cochrane service providers continue to work together in the interests of the people needing assistance.

***Funding challenges****:* Participants across the region as a whole, and certainly within the Cochrane sub-region, commented at length on the funding challenges that are presenting barriers to the delivery of quality services. These challenges primarily reflect the lack of any increase to base budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Objectively measured reductions in service were noted by the review team. Participants in the Cochrane district and elsewhere also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to professionals and other staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this report show the significant level of utilization of physicians and hospitals across the NE LHIN, including ED visits, for substance-related conditions. In the Cochrane sub-region this is clearly evident in all the ICES utilization data that was presented. The costs of this service utilization are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example.

Given the complex nature of substance use and addiction, the work to reduce costly health care utilization (as well as other high social and justice-related costs) needs more focus and more collaborative efforts that engage both hospitals and

community services. This includes more sharing of strategies across the NE region as a whole.

The costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals, addiction nursing liaison, various models of collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

## Strengths in the Cochrane Treatment System

- Most parts of the continuum of care for addiction treatment are in place in the Cochrane sub-region (North and South Cochrane combined) – withdrawal management services, short-term residential, community treatment, including significant outreach services and supportive housing.

- Despite inter-organizational tensions related to past funding decisions and merger attempts, the services appear to be working reasonably well together at the client-level and there is a strong local planning table. In general, the main providers seem to look out for each other (i.e., "*got each other's back*"). An example is the local CMHA covering the annual budget shortfall for the Smooth Rock Falls withdrawal management service (WMS).

- The WMS at Smooth Rock Falls is highly regarded locally and regionally (concerns about its location notwithstanding). In particular, participants expressed their appreciation for the focus on flexible length of stay and commitment to engaging clients in subsequent treatment.

- Flexible use of safe beds in Jubilee Centre helps to meet some of the withdrawal management needs in Timmins, as do Jubilee's methadone nursing support and the strong cultural safety available for FNIM people.

- Francophone residential treatment (Maison Renaissance) and long term residential treatment for Francophone youth (Maison Arc-en-Ciel) are important elements of the local/provincial continuum of services for the Francophone population.

- The availability of important outreach capacity (Misiway, South Cochrane Addiction Services, and North Cochrane Addiction Services – the latter two including home, schools and methadone support. Both North and South Cochrane Addiction Services provide a strong backbone of community

treatment and case management for much of the district. Misiway provides significant outreach support to First Nations communities, many some distance from Timmins and challenging to access.

- Good working relationships between addiction providers and the local CMHA - a provider of some addictions services, including concurrent disorders workers and supportive housing. There is a strong collaboration with the South Cochrane Addiction Services for Addiction Supported Housing. CMHA has a nursing complement that can be leveraged in beneficial ways via collaboration with addictions providers.

- Overall good community relationships and attitudes toward methadone/ Suboxone assisted treatment for opioid addiction and harm reduction generally.

- Early signs of the community mobilization hub working well; presence of Health Links.

- Overall relationships and cultural sensitivity regarding working with FNIM people is strong in the sub-region. Only one anecdotal exception was noted in all the interviews and survey feedback gathered across the area.

- Strong FNIM leadership (e.g., Friendship Centre), including involvement in local planning and a strong network of experienced traditional healers.

## Challenges in the Cochrane Treatment System

- As noted in other areas of the NE LHIN, the impact of the longstanding provincial funding freeze for addiction services is being felt hard in all Cochrane services. In addition, there are long-standing funding shortfalls at Jubilee Centre and the Smooth Rock Falls WMS. Summer closure of Jubilee, reported to be a result of the significant funding shortfall, was a frequently cited concern in the area and well-known and discussed as a problem in many other of the NE LHIN sub-regions. The main challenge reported by participants was the virtually *complete closure,* including all administrative functions as well as other services provided, such as the safe beds and addiction nursing (both funded for year-round operation).

- The location of the WMS in Smooth Rock Falls was often cited as a challenge due to transportation and safety concerns, particularly for clients coming from the Coast area. That being said, participants acknowledged the reality of

that past decision and expressed no negative concerns about the services provided at the centre. Participants from the Coast sub-region expressed a desire for more follow up and transitional support for people coming from their area and returning home.

- There is no day treatment option in the sub-region although one was housed at Jubilee Centre at one point but closed amidst various funding attempts to cover the Centre' s budget shortfall.

- Other system gaps cited included mobile crisis services, a men's shelter, and an Ontario Works office, as well as the need for the return of the HIV/Hepatitis C program that was lost to the community.

- There are long standing and outdated negative views on home/community withdrawal management. Among key opinion leaders in the area. These negative views have impeded renewed exploration of this cost-effective option, despite many positive views regarding past experience with community withdrawal management noted by some community stakeholders and clear success in other parts of the region, provincially and nationally. These negative views are holding back important innovation with cost-effective withdrawal management that is needed in the Cochrane district.

- The remaining tensions in the community from merger attempts and/or continuing active discussion about mergers (e.g., CMHA/South Cochrane Addiction Services; Jubilee and South Cochrane Addiction Services). As well, past funding allocation decisions (e.g., length of time for CD positions to get filled, transition of funding to CMHA for the CD positions) need to be dealt with. While working relationships between providers, and certainly between workers at the client level, seem to "rise above" these tensions, any lingering considerations for amalgamations should be played out and resolved openly. Leadership from the LHIN and locally is likely needed to resolve these tensions.

- The sub-contractual arrangement between Maison Renaissance and Maison Arc-en-Ciel is a concern for this review team as it weakens direct accountability and performance measurement to and by the LHIN itself. The operation at Maison Arc-en-Ciel also needs a closer look than is possible in this review from the point of view of caseload and completion rates and whether the youth being serviced might be suitable for treatment at Maison Fraternité in Ottawa.

## Implications and Recommendations for the Cochrane Treatment System

- The top priority for system enhancement in the region should be to increase outreach staffing/capacity at South Cochrane Addiction Services and to Misiway, in support of their important outreach work. When the budget situation gets resolved at the WMS at Smooth Rock Falls (see below), then an increase in outreach capacity at North Cochrane Addiction Services would also be warranted.

- Sustained funding should be allocated to close the historical funding gap at the Smooth Rock Falls WMS. This review found no sign that the centre required programmatic changes. Further, the recommendation in the section above for the Coast sub-region to have a WMS in Moosonee is not intended to diminish the importance of the Smooth Rock Falls program to the Cochrane district and the NE LHIN region as a whole, including the Coast sub-region. There is a well-established pathway to service that will need to remain as an option for those seeking services outside the Coast area. Support from Smooth Rock Falls for capacity building in a new Coast WMS program will also be important and would build upon strong historical relationships.

  All this being said, the implications of a new WMS in the Coast sub-region, when it becomes operational, will need to be examined given the high number of WMS clients at Smooth Rock Falls from the Coast area. This may free up some resources that can be allocated to other functions.

- Filling the budget shortfall at Jubilee Centre, or making required programmatic/administrative changes to work within their budget, should also be a high priority but pending a review of the region's residential programs as a group. The summer closure is a major challenge that should be resolved as soon as possible but which needs more information from an accounting perspective than is available in this review. A decision regarding a permanent budget top-up for Jubilee could also benefit from more comparable provincial data of cost, occupancy rates, wait time, program completion rates, etc., data which could be collected in a more in-depth regional or provincial review of residential treatment services. As noted above, there are several strong features of program content at Jubilee and strong support from the community and region as a whole. Their expansion proposal also has strong features, including co-location with other community services. However, the proposal is large in scope and could benefit from more focus on the core business of the centre, including removal of the day treatment component (see below).

- Fund/develop a day treatment program at South Cochrane Addiction Services. Such a program is apparently in the plan for expansion at Jubilee. However, the recommendation here is to take it out of that proposal, thereby providing more focus to the Jubilee proposal which otherwise has many strong features, including multi-service co-location. The day program is better positioned at South Cochrane Addiction Services, given their strong outreach capacity and focus on community treatment and case management.

- Fund/develop a community WMS for Timmins and area with collaboration between South Cochrane Addiction Services and CMHA. This should build upon their current collaboration for Addiction Supported Housing as it will not be such a big jump to go to community WMS. Engaging Misiway in some capacity would also be ideal. The existing nursing complement in CMHA, and the strong outreach capacity with South Cochrane Addiction Services suggest a natural *functional* synergy that could be a model for the NE LHIN. It will need a solid evaluation plan, including engagement of those opinion leaders in the area who have resisted this type of service as their support will be needed to scale this up across the region if successful.

- Maison Renaissance should have its scope of practice expanded to cover services aimed at the mental health needs to the *local* Francophone community. This should be done with criteria and monitoring processes inn place to ensure the addictions mandate is not diminished. In short, the aim should be a program adaptation towards a sustainable addiction AND mental health mandate. Support should also be provided to Maison Renaissance for its proposal for crisis/safe beds as this would also be consistent with this adapted mandate.

- With respect to Maison Arc-en-Ciel, its funding and accountability agreement directly to the NE LHIN needs to be re-established (currently they are sub-contracted through Maison Renaissance and this is not ideal from an accountability and performance measurement perspective). More information is also needed regarding youth services provided through Maison Arc-en-Ciel, in particular its client profile in relation to needs that could perhaps be addressed by Maison Fraternité in Ottawa (which often reports space availability). This closer examination of Arc-en-Ciel should be done in the context of a regional review of operational details of all the NE LHIN residential services (noted elsewhere in this report).

## A1.3 Algoma Sub-Region

### *Algoma Sub-region Context*

#### Population Trends

Data from the 2006 Census (as summarized by NE LHIN in the North East Local Health Integration Network Demographic and Health Profile) show the total population of the Algoma sub-region at 21.3% of NE LHIN's population, with the largest proportion of people over the age of 65 years. The unemployment rate is comparable to the rest of the NE LHIN at 8.9%, with 10.3% of families living below the Low income Cut-Off. Data from the 2011 census shows that Francophones make up 6% of the population.

#### Substance Use Trends

The Algoma sub-region is home to approximately 17.3% of new admissions that received substance use treatment in the NE LHIN during the 2014/2015 fiscal year (see Table 19). This number is approximate, as 30% of new admissions were classified as "no fixed address" or "other", therefore their sub-region of residence is unknown. Of the new admissions who reside in Algoma, 63.6% were men compared to women (36.4%) which parallels the gender distribution for the NE LHIN as a whole. Just under half of new admissions were between the ages of 25 and 44 (44.3%), with 28.5% under the age of 24 and 27.2% over the age of 45. The higher percentage of youth compared to the rest of the region no doubt reflects the significant community treatment capacity for youth in Algoma (i.e. Alternatives for Youth). There is a smaller percentage of FNIM clients than for the region as a whole (17.7%) With regards to source of income, 43.3% of new admissions in the Algoma sub-region were receiving ODSP or Ontario Works, which approximates the percentage for the region as whole (49.1%).

Much like the regional trends in substances of concern among treatment admissions, the most common presenting problem substances among clients residing in the Algoma sub-region were, alcohol, cannabis, tobacco, cocaine, and prescription opioids, and benzodiazepines. Any differences to the regional data as a whole are small in nature.

**Table 19**. Characteristics of New Admissions Who Received Substance Abuse Treatment in Algoma (Fiscal Year 2014/15) - DATIS

| Characteristic | Algoma | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| **Gender** | | | | |
| Male | 985 | 63.6 | 5913 | 65.9 |
| Female | 564 | 36.4 | 3053 | 34.0 |
| Other | 0 | 0.0 | 0 | 0.0 |
| Total | 1549 | 100 | *8967* | *100.0* |
| **Age Group** | | | | |
| Under 16 | 68 | 4.4 | 139 | 1.6 |
| 16-24 | 374 | 24.1 | 1760 | 19.6 |
| 25-34 | 386 | 24.9 | 2740 | 30.6 |
| 35-44 | 300 | 19.4 | 1824 | 20.3 |
| 45-54 | 206 | 13.3 | 1423 | 15.9 |
| 55-64 | 176 | 11.4 | 902 | 10.1 |
| 65 and over | 39 | 2.5 | 179 | 2.0 |
| Total | 1549 | 100 | 8967 | *100.0* |
| **Source of Income** | | | | |
| Employment | 270 | 17.4 | 1506 | 16.8 |
| Employment Insurance | 64 | 4.1 | 432 | 4.8 |
| ODSP (Ontario Disability Support Program) | 318 | 20.5 | 2105 | 23.5 |
| Disability Insurance | 36 | 2.3 | 319 | 3.6 |
| Other Insurance (excluding Employment Insurance) | 11 | 0.7 | 54 | 0.6 |
| Ontario Works | 369 | 23.8 | 2293 | 25.6 |
| Retirement Income | 43 | 2.8 | 227 | 2.5 |
| Other | 58 | 3.7 | 293 | 3.3 |
| None | 90 | 5.8 | 933 | 10.4 |
| Family Support | 180 | 11.6 | 497 | 5.5 |

| Characteristic | Algoma | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| Unknown | 99 | 6.4 | 221 | 2.5 |
| Missing | 11 | 0.7 | 26 | 0.3 |
| Total | 1549 | 100 | *8967* | *100.0* |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 274 | 17.7 | 2695 | 30.1 |
| Non-FNIM | 1275 | 82.3 | 6272 | 69.9 |
| Total | 1549 | 100.0 | *8967* | *100.0* |
| **Presenting Problem Substances** | | | | |
| Alcohol | 1074 | 69.3 | 6101 | 68.0 |
| Amphetamines & other stimulants exc. methamphetamines | 42 | 2.7 | 734 | 8.2 |
| Barbiturates | … | … | 25 | 0.3 |
| Benzodiazepines | 76 | 4.9 | 441 | 4.9 |
| Cannabis | 569 | 36.7 | 3465 | 38.6 |
| Cocaine | 374 | 24.1 | 1799 | 20.1 |
| Crack | 90 | 5.8 | 788 | 8.8 |
| Ecstasy | 16 | 1.0 | 66 | 0.7 |
| Glue & other inhalants | … | … | 30 | 0.3 |
| Hallucinogens | 6 | 0.4 | 89 | 1.0 |
| Heroin/Opium | 48 | 3.1 | 197 | 2.2 |
| Methamphetamines (crystal meth.) | 29 | 1.9 | 152 | 1.7 |
| None | 35 | 2.3 | 245 | 2.7 |
| Other psychoactive drugs | 19 | 1.2 | 95 | 1.1 |
| Over-the-counter codeine preparations | 31 | 2.0 | 142 | 1.6 |
| Prescription opioids | 303 | 19.6 | 2194 | 24.5 |
| Steroids | … | … | 9 | 0.1 |
| Tobacco | 532 | 34.3 | 2753 | 30.7 |
| Unknown | 22 | 1.4 | 71 | 0.8 |

Table 7 in a previous section illustrated the sub-region or residence of new admissions who receive substance use treatment in the Algoma sub-region. Clients from all the other sub-regions seem to be accessing services in Algoma, albeit in relatively small numbers. Most new admissions who received treatment in the Algoma sub-region during the 2014/2015 fiscal year were residents of the area (63.8%), with 28.7% reporting "no fixed address" or "outside region". Services with the highest percentage of clients from outside the NE LHIN include St. Joseph's General Hospital (Camillus Centre and Oaks Centre; 48.8%); Ken Brown Recovery Home (34.4%); and Benbowopka Treatment Centre in Blind River (20.4%). Interestingly, 17.9% of new admissions to the Sault Area Hospital Community Addictions Services were recorded as out of the region, whereas the services provided are primarily community treatment and withdrawal management.

## Strengths and Challenges of Algoma Treatment System

Several *common themes* in the feedback from participants were noted in the regional overview in Section 3.2. They are noted again here as they were common to the Algoma sub-region as well.

***Variation across the region:*** The first common theme was the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions of the NE LHIN but also *within* these areas, including the Algoma sub-region. Within the district there are three major sub-areas – North, Central and East Algoma.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the Algoma sub-region for several reasons, including:

- The vast geography, including its mix of urban/rural/remote communities.
- The population mix, including the FNIM population (about 11%), and a smaller percentage of Francophones (6.8%) than most of the remainder of the region.
- Challenges with recruitment and retention of qualified staff due in part to the rural/remote nature of much of the area.
- The weather conditions in the winter that impact travel, and other transportation challenges such as lack of bus service.
- Significant migration patterns into and out of the area, for example, for work, school, and justice involvement.
- A shortage of affordable housing/rental options and employment opportunities.

***Highly valued workforce:*** The staff providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants almost universally highlighted that staff are working in challenging

circumstances, at a comparatively low level of compensation, and, in most cases, without a salary increase for several years.

***Changing nature of those seeking help*:** Among those interviewed who are providing direct service to clients, there was strong, almost unanimous, opinion that client complexity has increased dramatically in the last decade or so—the typical presentation now including use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health.

***FNIM people and choice:*** FNIM and non-FNIM participants alike reflected on the high needs within First Nations communities and among the individuals and families seeking help. Citing high rates of suicide and epidemic levels of prescription opioid addiction, layered on top of high rates of alcohol and other drug abuse, the needs are clearly urgent. While there is significant support for culture-based treatment in the Algoma sub-region, and in the NE LHIN generally, experiences of stigma and discrimination in Algoma area's mainstream health services were commonly reported and much more needs to be done to ensure cultural safety and choice for people seeking help.

The need was also commonly voiced within the Algoma area, and the NE region as a whole, for more support and engagement of FNIM leaders, organizations and traditional healers in planning regional and local treatment system improvements. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement of FNIM people under challenging circumstances, as well as how to ensure effective transitions to continuing care within their family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual level (e.g., front-line workers

facilitating transitions across services). This affirmation notwithstanding, significant tensions exist in the NE LHIN sub-regions, including the Algoma sub-region, and particularly at the organization level. Across the NE LHIN region as a whole these challenges variously included tensions between "hospital" and "community"; "mental health and addiction"; "addiction medicine and mainstream addiction treatment"; "FNIM" and "non-FNIM services"; and "LHIN-funded" and "non-LHIN-funded" services, to name the more frequently mentioned versions of these tensions. While community tensions such as these might be expected in Ontario's complex health and social service delivery system, some tensions between providers are running very deep in the Algoma sub-region. Strong leadership from the NE LHIN and collaborative leadership at the community level are needed to ensure that Algoma service providers continue to work together in the interests of the people needing assistance.

***Funding challenges**:* Participants across the region as whole, and certainly within the Algoma sub-region, commented at length on the funding challenges that are presenting barriers to the delivery of quality services. These challenges primarily reflect the lack of any increase to base budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Objectively measured reductions in service were noted by the review team. Participants in the Algoma sub-region and elsewhere also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to professionals and other staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this report show the significant level of utilization of physicians and hospitals across the NE LHIN, including ED visits, for substance-related conditions. In the Algoma sub-region this is clearly evident in all the ICES utilization data that was presented. The costs of this service utilization are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example.

Given the complex nature of substance use and addiction, the work to reduce costly health care utilization (as well as other high social and justice-related costs) needs more focus and more collaborative efforts that engage both hospitals and community services. This includes more sharing of strategies across the NE region as a whole.

The costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals, addiction nursing liaison, various models of collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

## Strengths in the Algoma Treatment System

- As in most parts of the NE LHIN, Algoma hosts a strong network of substance use services along the continuum of care – withdrawal management services, short and longer term residential treatment services, community assessment and treatment, supportive housing, hospital-based care for the more complex cases with psychiatric and medical co-morbidity, youth and women's services, and services tailored to FNIM people.

- There has been significant improvement in community collaboration following the challenges presented by the Anchor Agency[22] project and earlier attempts at structural integration. Indeed, this comprehensive attempt at organizational and structural integration appears to have stimulated more voluntary forms of collaboration among service providers in the area. Improvement is still needed in relationships among some key players in the local system (see below) but much progress has been made and the fruits of improved collaboration are starting to show, albeit slowly (e.g., the single session model to improve access to services noted below). Community planning tables are strong despite underlying tensions. A very strong planning table exists in East Algoma.

- A major strength in the district is the integration of prevention and health promotion and addiction services through Algoma Public Health, as well as the regional reach of these services, including Wawa and East Algoma. These integrated prevention, health promotion and treatment services are particularly important for engaging First Nations communities, and Algoma Public Health has demonstrated considerable success in this area (e.g., recently contracting to provide counselling services at Garden River Health Centre). Algoma Public Health offers a full basket of services (i.e., assessment, counselling, case management, harm reduction, methadone clinic, addiction supportive housing), having evolved considerably over the years from its narrower role as one of Ontario's first specialized assessment and referral services. This important trend has happened across the province resulting in a strong provincial cohort of community treatment programs built upon key principles of comprehensive assessment and treatment matching.

- The Addiction Treatment Clinic (ATC) at the Sault Area Hospital brings several strengths to the system including strong concurrent disorder capacity in its inpatient and community treatment program, including critical engagement of

[22] The term Anchor Agency was given to the proposed integrated mental health and addiction service for the Algoma District

psychiatry for an addiction clinic .5 days per week and case consultation. The ATC also provides important capacity for gambling treatment.

- The Alternative for Youth Program offered through Algoma Family Services offers very strong addiction services for youth, in the context of a completely integrated mental health and addiction service delivery model. One can safely say it is the strongest designated youth treatment service in the NE LHIN, offering outreach counselling to all the high schools in the region as well as a day program (Genesis).

- The District is very strong on supportive residential recovery services, hosting both a women's and men program, Breton House and Ken Brown Recovery Home, respectively. Breton House offers a range of important services for women, including its Early Childhood Development Program and opiate case management.

- A new collaborative initiative aimed at improving access, referred to as "Single Session Service, is operational in Sault Ste. Marie after considerable planning and collaboration among many community partners. Aimed at reducing wait time, the community partners provide staff one day a week and offer a same-day 60-90 minute session based on a narrative, problem solving approach. In addition to near immediate access to service,e there is a high level of staff supervision and, therefore, opportunity for cross-training and skill building among the community partners.

- North Algoma (Chapleau) and East Algoma (Elliot Lake) host well-integrated mental health and addiction services that offer a range of counselling and case management services.

- Throughout the sub-region, linkages and relationships with addiction medicine providers is good and stands out among the best in the NE LHIN. Examples include the methadone clinic run by physicians contracted by Algoma Public Health, the involvement of the Chief of Psychiatry and an emergency physician in the OATC, the long-standing relationship between Camillus Centre/Oak Centre and Dr. Shapiro as well as the work of Dr. Dell'Aquila with the North Shore Tribal Council.

- A 1-800 information line for Algoma mental health and addiction services is operating through the Sault CMHA but with few calls reported in the early stages of operations from people seeking addiction services - only 10 in the first year. In an attempt to better serve clients and the public, a small number of local addiction programs and CMHA will begin to provide group schedules to the

central access line so the information can be relayed directly to callers seeking information. Central access workers will also complete the initial intake form with basic demographic information if they are referring to the Sault Area Hospital Addiction Treatment Clinic or the addiction services at Algoma Public Health. The central access line is also being used for by Algoma Public Health for callers in need of referral during the single session service that has been started about collaborating providers.

- There are some innovative *local* solutions such as the Web-based platform developed in East Algoma for facilitating access to treatment and other support services. It is noted here as an example of the continued need for adaptation and some flexibility in wider sub-regional or regional-level initiatives. Adaptations are important when justified by local community context.

- In Elliot Lake, Camillus Centre and Oaks Centre function as one department of the local hospital, offering residential treatment and withdrawal management, respectively, with good medical management. Medical supports include tapering down from opioids. The co-location of these services with several other community services is also a strength in the local area.

- The residential treatment service at Blind River offers a strong culture-based approach to treatment, a harm reduction philosophy, an in-kind collaborative care model with the local hospital that brings a nurse practitioner to the program once a week for medical services—including medication management—and an integrated partnership with the local North Shore Tribal Council. It also has significant training capacity that can be accessed by other programs and professionals wishing to build FNIM, culture-based treatment capacity. The Dan Pine Healing Lodge at Garden River is also an important component of the sub-region's treatment and wellness capacity.

- The partnership model developed by the North Shore Tribal Council is noteworthy as it incorporates addiction services within a broad spectrum of other health and social services that are needed, including highly integrated addiction and mental health services. In some respects the North Shore Tribal Council operates like a "Health Links" model for FNIM services. The community development model that led to the establishment of this partnership is also exemplary.

- Strong capacity for addictions services also exists within the North Shore Tribal Council's Addiction Services Initiative (ASI) provided as part of the Council's Ontario Works program. This includes strong capacity for ADAT assessments

and provision of significant case management and wrap-around services for their clients (e.g., education, employment and employment readiness supports).

- Also, with respect to the North Shore Tribal Council, an exemplary model of integration of mainstream addiction service, addiction medicine (led by Dr. Dell'Aquila), and traditional FNIM healing has emerged. The community WMS that is affiliated with the Tribal Council's addiction program and primary care service is also noteworthy.

## Challenges in the Algoma Treatment System

- As noted in other areas of the NE LHIN, the impact of the longstanding provincial funding freeze for addiction services is being felt hard in all Algoma services and particularly in those organizations providing smaller-scale but critical community addiction (and mental health) services in the region.

- All participants from the Algoma treatment system agreed on the need for a new withdrawal management facility and the need for enhanced medical supports in the new services. It is understood that discussions continue in the area on the optimal location. New managers at the hospital perceive the current situation as one of very high risk management. They are not alone in this regard provincially and in other parts of the NE LHIN. As in North Bay, for example, there is a "pull" to bring the WMS much more closely into a hospital-based medical model.

- Also with respect to withdrawal management the need was noted for a small number of "safe beds" to be added to Oaks Centre in Elliot Lake in order to increase capacity for medical crisis management and add flexibility for engaging people in treatment. The need for a men's shelter in Elliot Lake was strongly expressed by local participants.

- The high needs of the sub-region's FNIM community in relation to available addiction (and mental health) services was noted by several participants, FNIM and non-FNIM alike. Enhancing services at the community level to support treatment engagement/preparation and post-treatment transitions was seen as particularly important and in the context of the existing partnership model within the North Shore Tribal Council. Challenges among the region's FNIM people accessing hospital-based services in both Sudbury and Sault Ste. Marie were emphasized.

- Community awareness of, and access to, addiction services through the sub-region's central 1-800 information line has been a challenge that needs to be monitored going forward.

- Day treatment for adults is a remaining gap in the Algoma treatment continuum and addressing this gap would complement the strong community treatment services in the region as a whole.

- The need was also highlighted for bedded-services for youth, including "youth housing", withdrawal management and youth residential treatment. Perhaps these were highlighted in the Algoma area more than other parts of the NE LHIN because the sub-region is so strong on youth community and day treatment.

- Both Breton House and the Ken Brown Recovery Home reported the need for additional bed capacity and, in the case of Breton House, a new facility, given the age and poor condition of its facility.

- Despite considerable progress in re-building inter-organizational relationships among addiction service providers that were negatively impacted by the failed Anchor Agency, work is still needed in this area. The tensions run deep between some service providers as the Anchor Agency project exacerbated a long history of challenging inter-provider relationships. Much of the current tension is due to funding decisions from the past but which now appear to some as "duplication" and "opportunity for synergy." The remaining and most significant example is between the community treatment programs offered by the Sault Area Hospital and Algoma Public Health. From the perspective of the present review team, both offer unique and important services and any decisions regarding future amalgamation must carefully weigh the potential benefits (e.g., more structurally integrated psychosocial and medical management and support) against the potential risks (e.g., lost service capacity for the region as a whole due to differing scope of service and also wage differentials; loss of integration with prevention and health promotion). Also, as noted, several participants in the area expressed a strong preference for non-hospital based services.

## Implications and Recommendations

- Leadership is needed from the LHIN and collaborative leadership among senior managers in the Algoma sub-region to resolve remaining community tensions, in particular between the area hospital and community partners. The overt tension regarding potential amalgamation of the community treatment services at the Sault Area Hospital and Algoma Public Health needs

to be resolved as quickly as possible. There is also a risk that the decision regarding physical location and the programmatic model of the new withdrawal management centre will also exacerbate existing tensions.

The process of resolving the location and model of care for the new WMS is operationally distinct from, but philosophically related to, the unresolved question about amalgamating the Sault Area Hospital program and the Algoma Public Health addiction services. It will be important to take the time required to weigh all the pros and cons in terms of potential benefit and potential risk (see above). Leadership and perhaps outside facilitation may be required. In the main section of this report that outlines regional recommendations (Section 4), the need to balance an increase in medical supports medical supports within the region's addiction treatment services and the need to retain accessible and equitable services in community-based settings. In brief, there are a number of ways to enhance medical capacity through collaborative care and nursing supports, without putting significant investment in hospital-based care and overly medicalizing the addiction treatment system as a whole.

- Continue enhancing the capacity of the local 1-800 information line for mental health and addiction services, and ensure that improving access to addiction services remains a priority. If challenges continue, a more formal developmental evaluation may be required to help assess these challenges and build that capacity.

- Gaps in the continuum regarding intensive day treatment and youth-related services are important, as well as the over-riding funding situation hampering all the providers in the region. That being said the primary issue at the moment seems to be the location of the new WMS and the lingering question of amalgamation.

- Funding for the three-quarter way transition beds offered through Ken Brown Recovery Home and the new site for Breton House should be a medium-term priority in large part because of the significant role they play in transition support and the scarcity of such residential recovery services in the region as a whole.

- There should also be enhanced support in the more immediate term for addictions and mental health services offered through the North Shore Tribal Council in light of the scope of community need, and the strong collaborative base on which to build, including the treatment centres at Blind River and Garden River.

- The important work being done by the Addiction Services Initiative (ASI) of the Tribal Council's Ontario Works program must also be acknowledged and supported as part of the local treatment continuum. For example, as they are currently ADAT trained and up and running on Catalyst there will be value in including the program in the local implementation plan for the new staged screening and assessment protocol.

## A1.4 Nipissing-Temiskaming Sub-Region

### *Nipissing-Temiskaming Sub-Region Context*

#### Population Trends

The Nipissing-Temiskaming sub-region has a population of 140,456, making it the second most populated of the NE LHIN sub-regions. The sub-region is bounded by Burks Falls to the south to Kirkland Lake in the North, and Mattawa and area to the East and West Nipissing to the West. Of the total population, 19% are over the age of 65. Data from the 2006 Census (as summarized by NE LHIN in the North East Local Health Integration Network Demographic and Health Profile) shows the majority of the population has English as their mother tongue (69.6%) and just under a quarter of the population has French as their mother tongue (24.9%). With respect to the FNIM population the percentages are: 8.7% Nipissing and 5.0% Temiskaming. The unemployment rate is comparable to the rest of the NE LHIN at 8.3% versus 8.4%. This area has slightly more families living below the Low income Cut-Off than the average across the LHIN (11.6% versus 9.6%).

#### Substance Use Trends

The Nipissing-Temiskaming sub-region is home to approximately 14.6% of new admissions that received substance use treatment in the NE LHIN during the 2014/2015 fiscal year (Table 20). This number is approximate as 30% of new admissions were classified as "no fixed address" or "other", therefore their sub-region of residence is unknown. Of the new admissions that reside in Nipissing-Temiskaming, well over half were men (62.9%) compared to women (37.1%), similar to the LHIN as whole. The age distribution was also similar to the regional caseload; for example, about half of new admissions were between the ages of 25 and 44 (50.2%), with 24.1% under the age of 24, and 24.7% over the age of 45. With regard to source of income, the percentage of clients employed was marginally higher than the regional rate (22.1% compared to 16.8%) and with over half (55%) of new admissions receiving ODSP, other disability-related assistance or assistance from Ontario Works.

Much like the regional trends in presenting problem substances among clients accessing treatment, the most common presenting problem substance for new admissions in the Nipissing-Temiskaming sub-region was alcohol, followed by cannabis, tobacco, prescription opioids, cocaine, and amphetamines and other stimulants.

**Table 20.** Characteristics of New Admissions Who Received Substance Abuse Treatment in Nipissing-Temiskaming Sub-region (Fiscal Year 2014/15)

| Characteristic | Nipissing Temiskaming | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| **Gender** | | | | |
| Male | 824 | 62.9 | 5913 | 65.9 |
| Female | 486 | 37.1 | 3053 | 34.0 |
| Other | 0 | 0.0 | 0 | 0.0 |
| Total | 1310 | 100.0 | *8967* | *100.0* |
| **Age Group** | | | | |
| Under 16 | 21 | 1.6 | 139 | 1.6 |
| 16-24 | 295 | 22.5 | 1760 | 19.6 |
| 25-34 | 379 | 28.9 | 2740 | 30.6 |
| 35-44 | 292 | 22.3 | 1824 | 20.3 |
| 45-54 | 175 | 13.4 | 1423 | 15.9 |
| 55-64 | 136 | 10.4 | 902 | 10.1 |
| 65 and over | 12 | 0.9 | 179 | 2.0 |
| Total | 1310 | 100.0 | 8967 | *100.0* |
| **Source of Income** | | | | |
| Employment | 289 | 22.1 | 1506 | 16.8 |
| Employment Insurance | 47 | 3.6 | 432 | 4.8 |
| ODSP (Ontario Disability Support Program) | 267 | 20.4 | 2105 | 23.5 |
| Disability Insurance | 27 | 2.1 | 319 | 3.6 |
| Other Insurance (excluding Employment Insurance) | 13 | 1.0 | 54 | 0.6 |
| Ontario Works | 364 | 27.8 | 2293 | 25.6 |
| Retirement Income | 32 | 2.4 | 227 | 2.5 |
| Other | 27 | 2.1 | 293 | 3.3 |
| None | 89 | 6.8 | 933 | 10.4 |
| Family Support | 117 | 8.9 | 497 | 5.5 |
| Unknown | 34 | 2.6 | 221 | 2.5 |
| Missing | 4 | 0.3 | 26 | 0.3 |

| Characteristic | Nipissing Temiskaming | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| Total | 1310 | | *8967* | *100.0* |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 180 | 13.7 | 2695 | 30.1 |
| Non-FNIM | 1130 | 86.3 | 6272 | 69.9 |
| Total | 1310 | 100.0 | *8967* | *100.0* |
| **Presenting Problem Substances** | | | | |
| Alcohol | 751 | 57.3 | 6101 | 68.0 |
| Amphetamines & other stimulants exc. methamphetamines | 107 | 8.2 | 734 | 8.2 |
| Barbiturates | … | … | 25 | 0.3 |
| Benzodiazepines | 52 | 4.0 | 441 | 4.9 |
| Cannabis | 537 | 41.0 | 3465 | 38.6 |
| Cocaine | 178 | 13.6 | 1799 | 20.1 |
| Crack | 76 | 5.8 | 788 | 8.8 |
| Ecstasy | 10 | 0.8 | 66 | 0.7 |
| Glue & other inhalants | … | … | 30 | 0.3 |
| Hallucinogens | 19 | 1.5 | 89 | 1.0 |
| Heroin/Opium | 35 | 2.7 | 197 | 2.2 |
| Methamphetamines (crystal meth.) | 34 | 2.6 | 152 | 1.7 |
| None | 92 | 7.0 | 245 | 2.7 |
| Other psychoactive drugs | 10 | 0.8 | 95 | 1.1 |
| Over-the-counter codeine preparations | 15 | 1.1 | 142 | 1.6 |
| Prescription opioids | 254 | 19.4 | 2194 | 24.5 |
| Steroids | … | … | 9 | 0.1 |
| Tobacco | 451 | 34.4 | 2753 | 30.7 |
| Unknown | 20 | 1.5 | 71 | 0.8 |

Table 7 shown previously illustrates movement of new admissions who receive substance use treatment in the Nipissing-Temiskaming sub-region. Of those receiving services in this sub-region, 60.4% were from the Nipissing-Temiskaming

sub-region, and 20.3% resided outside of the region. Those from outside the region were primarily admitted to the residential services at North Bay Recovery Home (42.2% from outside the LHIN) and North Bay Regional Health Centre (29.4% from outside).

### Strengths and Challenges of the Nipissing-Temiskaming Treatment System

Several common themes in the feedback from participants were noted in the regional overview in Section 3.2. They are noted again here as they were common to the Nipissing-Temiskaming sub-region as well.

***Variation across the region:*** The first "common theme" was the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions of the NE LHIN but also *within* these areas, including the Nipissing-Temiskaming sub-region. In Nipissing, there are three further sub-areas: North Bay/East Parry Sound; Mattawa and area; West Nipissing. Temiskaming can be divided as North (Kirkland Lake), Central (Englehart) and South (Temiskaming Shores).

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the Nipissing-Temiskaming sub-region for several reasons, including:

- The vast geography, including its mix of urban/rural/remote communities.
- The population mix including the FNIM population (8.7% Nipissing and 5.0% Temiskaming) and a significant Francophone population (about 25% in both areas).
- Challenges with recruitment and retention of qualified staff, due in part to the rural/remote nature of much of the area, as well as French-language requirements.
- The weather conditions in the winter that impact travel and other transportation challenges such as lack of bus service.
- The significant migration patterns into and out of the area, for example, for work, school and justice involvement, and as a result of flooding in the Coast sub-region and movement to Nipissing-Temiskaming and elsewhere.
- A shortage of affordable housing/rental options and employment opportunities.

***Highly valued workforce:*** The staff providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants almost universally highlighted that staff are working in challenging circumstances, at a comparatively low level of compensation and, in most cases, without a salary increase for several years.

***Changing nature of those seeking help*:** Among those interviewed who are providing direct service to clients, there was strong, almost unanimous, opinion that client complexity has increased dramatically in the last decade or so; the typical presentation now including use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health.

***FNIM people and choice:*** FNIM and non-FNIM participants alike reflected on the high needs within FNIM communities and among the individuals and families seeking help. Citing high rates of suicide and epidemic levels of prescription opioid addiction, layered on top of high rates of alcohol and other drug abuse, the needs are clearly urgent in FNIM communities. While there is significant support for culture-based treatment in the Nipissing-Temiskaming sub-region, and in the NE LHIN generally, experiences of stigma and discrimination in the area's mainstream health services were commonly reported. Much more needs to be done to ensure cultural safety and choice for people seeking help.

The need was also commonly voiced within the Nipissing-Temiskaming area, and the NE region as a whole, for more support and engagement of FNIM leaders, organizations and traditional healers in planning improvements to regional and local treatment systems. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement of FNIM people under challenging circumstances, and to ensure effective transitions to continuing care within their family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual-level (e.g., front-line workers facilitating transitions across services). This affirmation notwithstanding, significant tensions exist in the NE LHIN sub-regions, including the Nipissing-Temiskaming districts, and particularly at the organization-level. Across the NE

LHIN region as a whole these challenges variously included tensions between "hospital" and "community"; "mental health and addiction"; "addiction medicine and mainstream addiction treatment"; "FNIM" and "non-FNIM services"; and "LHIN-funded" and "non-LHIN-funded" services, to name the more frequently mentioned versions of these tensions. While community tensions such as these might be expected in Ontario's complex health and social service delivery system, some tensions between providers are running very deep in the Nipissing-Temiskaming sub-region. Strong leadership from the NE LHIN, and collaborative leadership at the community level, is needed to ensure the area's service providers continue to work together in the interests of the people needing assistance.

***Funding challenges**:* Participants across the region as whole, and certainly within the Nipissing-Temiskaming sub-region, commented at length on the funding challenges that are presenting barriers to the delivery of quality services. These challenges primarily reflect the lack of increase to base budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Objectively measured reductions in service were noted by the review team. Participants in the Nipissing-Temiskaming sub-region and elsewhere also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to professionals and other staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this report show the significant level of utilization of physicians and hospitals across the NE LHIN, including ED visits, for substance-related conditions. In the Nipissing-Temiskaming sub-region this is clearly evident in all the ICES utilization data that was presented. The costs of this service utilization are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example.

Given the complex nature of substance use and addiction, the work to reduce costly health care utilization (as well as other high social and justice-related costs) needs more focus and more collaborative efforts that engage both hospitals and community services. This includes more sharing of strategies across the NE region as a whole.

The costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals, addiction nursing liaison; various models of collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and this is consistent with the well-established business case for addictions treatment in the research literature.

## Strengths in the Nipissing-Temiskaming Treatment System

- As in most parts of the NE LHIN, Nipissing-Temiskaming hosts a strong network of substance use services along the continuum of care – withdrawal management services, short- term residential treatment and longer term-supportive recovery services, community assessment and treatment, including youth services, supportive housing, hospital-based care for the more complex cases with psychiatric and medical co-morbidity (regional concurrent disorders program), addiction medicine services, and services tailored to FNIM people through the local Friendship Centre.

- Several examples of good provider collaboration are evident in the sub-region, including, but by no means limited to, the local planning table which seems to be working well and with FNIM programs represented; the local Drug Strategy Committee (although not all partners are represented, including FNIM); collaborative work on a Common Referral Form; and the Gateway Hub – a collaborative effort involving 29 service providers that supports people in crisis.

- There are many strengths to the services provided by the Community Counseling Centre, and in particular their walk-in services offered on Tuesdays which increases accessibility, as well as their youth and family program. They also offer an FNIM community treatment program and an opioid community treatment program. In brief, their scope of service is large and important.

- The North Bay Recovery Home is an important regional and provincial resource that offers continuing residential recovery support to clients who have completed a short-term residential treatment program in any part of the province. This transition and recovery support plays an important role in the treatment continuum.

- The Regional Mental Health Program is of considerable importance in North Bay, the wider sub-region of Nipissing-Temiskaming, and the NE LHIN as whole. Their strong medical and psychiatric capacity and the mix of mental health and concurrent disorder services are of critical importance. The centre also administers the withdrawal management service and the 21-day residential treatment program, both critically important elements of the continuum of care.

- The Sturgeon Falls program (Alliance) is one of several examples across the NE LHIN region (e.g., Chapleau, Parry Sound, Kapuskasing, Elliot Lake) where "small is working well", perhaps by necessity, but also in congruence with less complicated local treatment systems and through close integration of the mental health and addictions work. The scope of practice for this small service provider is impressive. Also noteworthy are the well-communicated priority levels for accessing their services:

    - *Priority Level I* – pregnant, risk of harm, on methadone but still using, referral for ADAT to access residential treatment so the window of opportunity is not lost;
    - *Priority Level II* - a transfer between their own programs, for example, mental health and addiction; and
    - *Priority Level III* - all other requests for service.

- The addictions worker at the North Bay Friendship Centre (Ms. Amanda Dokis) is an important and under-utilized local and regional resource for direct addictions service as well as system planning. Ms. Dokis is a significant resource in North Bay for client assessments (currently the ADAT tools). For example, she has been called upon for assessments by the withdrawal management centre and conducts assessments on an outreach basis (e.g., jail). She knows the local network as well as regional residential services and has intimate knowledge of FNIM needs and challenges, including issues related to cultural safety and migration (most of North Bay FNIM clients are Cree from the Coast sub-region). In North Bay, however, she reports not getting many referrals for help with FNIM clients and she is not engaged in local planning processes.

- There is significant strength in North Bay and the surrounding area with respect to addiction medicine and provision of ancillary support services, including counselling. This includes the methadone nurse at the WMS/residential treatment centre, an important and exemplary model for other WMS services regionally, if not provincially.

  For the most part, the methadone physicians/clinics in the area were said to be supportive of connecting clients to counselling. The least connected was said to be the OATC program, although their social worker was noted to have reached out to local services. The clinic run by Dr. Ralph Dell'Aquila provides psychosocial wrap-around services. Dr. Dell'Aquila is also a wider regional resource, including his work bridging the worlds of mainstream treatment, medication-assisted treatment and FNIM traditional healing with the North Shores Tribal Council.

## Challenges in the Nipissing-Temiskaming Treatment System

- Based on participant feedback, most of the challenging contextual factors in the NE LHIN region appear to be exacerbated here in the Nipissing-Temiskaming sub-region. This includes:

    - Significant trust issues between community and hospital;
    - Major stigma issues in the community at large and in local health services, including the ED;
    - A high percentage of mandated clients in the system;
    - Challenges regarding housing needs/options and transportation;
    - The Children's Aid Society (CAS) being cited as too quick to remove children from the home of FNIM women and lacking sensitivity to issues of cultural safety.
    - North Bay physicians reported as too quick to prescribe opiate medication and, in general, having a lack of knowledge/expertise in addiction, except among a few key individuals, some noted above.

- It was commonly reported by participants that the collaborations and partnerships noted above as strengths do not in fact translate into well-defined community care pathways across providers. Essentially, the core parts of the Nipissing-Temiskaming system were reported as very much a "*non–system*". Based on the feedback received, and observations of the review team, this area appears to the most challenged of the five sub-regions in the NE LHIN as far as working together seamlessly for clients.

- There is an evident paradox with respect to this sub-region hosting the NE LHIN's largest and most specialized mental health program(s), including significant investment of addictions/concurrent disorder resources, while at the same time having participants throughout the Nipissing-Temiskaming sub-region and beyond noting that: "*there is not enough here for the really complex*".

  There seem to be several underlying factors behind this reported disconnect. Firstly, the Regional Mental Health Centre was reported as "*not addiction-friendly*", with participants access to the service typically described as a process of "*screening out rather than in*". Secondly, concerns were cited by participants about the way the CD resources appear to have been diverted to support internal hospital functions and to the detriment of overall community capacity. This was reported as an example of the hospital working from the perspective of more internal accountabilities than

externally accountability to the community as whole. Thirdly, concerns were expressed about the lack of access to the Centre's psychiatrists for consultation and lack of access to regional services more broadly speaking from outside the immediate North Bay area. Lastly, the Centre was reported as needing considerable improvement with respect to ensuring cultural safety for FNIM people.

- With respect to the North Bay residential treatment program and WMS administered by the Regional Mental Health Centre, and notwithstanding the existence of the methadone nurse (very much a positive), participants noted the need for enhanced medical supports/collaborative care for the increasingly complex cases routinely presenting in this combined facility. Such concerns were not unique to North Bay, nor are they unique to the NE LHIN as a whole for that matter. They were, however, quite strongly expressed in this sub-region, particularly by the responsible managers within the Regional Mental Health Centre.

  The WMS was also noted by participants as needing to be more flexible in length of stay and thereby offering more support to transition to treatment. This was puzzling feedback in the context of the overall bed-mix of the centre as whole as it houses the WMS beds as well as 10 "flex beds" and 29 residential beds. It was not possible to examine this issue deeper within this review. The feedback received about the need for more flexibility may reflect criteria the staff are using to determine which clients can and cannot access those flex beds. It may also be a reflection of program capacity.

  Other important feedback about the residential program and the WMS concerned issues related to cultural safety for FNIM clients and capacity for supporting people with concurrent disorders. As is widely known these two issues are closely connected for many clients accessing these services.

- While the challenges with funding were noted by all community-based resources, it is evident that the challenges associated with the flat-lined budgets and ongoing incremental costs are exacerbated for smaller service providers such as Alliance in Sturgeon Falls (e.g., if you lose a .5 or a full FTE). Being "*small and rural*" was also reported as being more or less "*out of sight - out of mind*" with a strong feeling expressed that the focus of attention for planning and resourcing was primarily on the "*bigger players*".

- Challenges were noted serving outlying communities with several participants citing the need for more outreach, including transportation and more community/home withdrawal management services.

- Challenges meeting the needs of seniors with alcohol and/or gambling related problems were also noted, including the need for debt counselling. Outreach services were seen as being needed to reach this important and growing population.

- In addition to concerns cited by participants with respect to cultural safety in programs administered by the Regional Mental Health Centre, this same issue came up with respect to other services in the area, including specialized substance use services as well as health services and emergency departments. These concerns reinforce the need for ongoing staff training on cultural safety.

- Many of the more vocal concerns summarized in the main body of the report relating to performance measurement and system metrics arose in this sub-region. Concerns were expressed regarding the lack of program monitoring and accountability and limited use of the available information for planning (e.g. OCAN); and lack of comparability in how even the most basic of information is being recorded, reported and interpreted.

## Implications and Recommendations for the Nipissing-Temiskaming Treatment System

- Aside from addressing the overall funding challenge due to the lack of an increase in base budgets across the board, the immediate priority for funding in this sub-region is increased resources to both the Community Counseling Service and Alliance in Sturgeon Falls, so as to increase outreach, case management and system navigation supports. The Community Counselling Service might also be considered a good candidate organization to sponsor a community WMS outside of North Bay but pending success with a pilot project and a community-based partnership model in Timmins.

- A more medium-term priority would be to enhance the bed capacity at the North Bay Recovery Home, based on its wait time and its important role in transitioning people to community recovery following more intensive short-term treatment. Prior to any funding enhancement, however, this program should also be part of a wider review of the residential services in the NE LHIN using provincial and regional comparators in terms of operating costs, occupancy and retention rates.

- Specific recommendations with respect to the Regional Mental Health Centre and the addictions programs under its administration are challenging at present given the other review of the regional mental health and addiction services that has been commissioned and recently completed. Some of the implications of the feedback received about the Centre's addiction-related work suggest the following be considered:

    - The WMS and residential programs need to be more closely examined with better regional and provincial comparators for cost, occupancy rates, retention, and criteria for admission and discharge. This should also include a concurrent disorder capacity assessment of these two programs and an assessment of ways to immediately increase the in-house nursing capacity.

    - Pressures to pull the WMS service directly into the hospital should be resisted and collaborative care solutions sought for addressing medical and other complex needs. Pending the results of the META-PHI project in Sudbury this may be a useful model to look to, as well as designating a small number of beds in the Centre for complex co-morbidity while enhancing nursing capacity in the community services.

- The area requires investment in community-wide, cultural safety training for FNIM people seeking mental health and addiction services, including addiction programs, selected departments of the hospital, including the ER, and the Children's Aid Society (CAS).

## A1.5 Sudbury-Manitoulin-Parry Sound Sub-Region

### *Sudbury-Manitoulin-Parry Sound Sub-region Context*

#### Population Trends

The Sudbury-Manitoulin-Parry Sound sub-region has a population of 140,456, making it the second most populated of the NE LHIN sub-regions. Of that population, 19% are over the age of 65. Data from the 2006 Census (as summarized by the NE LHIN in the North East Local Health Integration Network Demographic and Health Profile) shows the majority of the population has English as their mother tongue (69.6%). For Sudbury-Manitoulin, just under a quarter of the population has French as their mother tongue (24.9%) and for Parry Sound – only 3%. The percentage of the population that is FNIM in Sudbury-Manitoulin is 9.2% and 5.4%, respectively. The unemployment rate is about comparable to the rest of the NE LHIN at 8.3% for Sudbury-Manitoulin and a bit lower at 6.7% for Parry Sound. The percentage of families living below the Low Income Cut-Off is about the same as the average across the LHIN (11.6% versus 9.6%).

#### Substance Use Trends

The Sudbury-Manitoulin-Parry Sound sub-region is home to approximately 26.0% of new admissions to substance use treatment across the NE LHIN during the 2014/2015 fiscal year (Table 21). This number is approximate as 30% of new admissions were classified as "no fixed address" or "other", therefore their sub-region of residence is unknown. Client characteristics are generally similar to those found among clients served in the NE LHIN overall. Of the new admissions that reside in Sudbury-Manitoulin-Parry Sound, about two-thirds were men (65.8%) compared to just over one-third for women (34.2%). Just over half of new admissions were between the ages of 25 and 44 (52.7%), with 19.3% under the age of 24 and 28.0% over the age of 45. Age and gender distributions parallel those for the NE LHIN as a whole. The percentage of clients who are FNIM is somewhat higher than the regional rate (35.9% vs 30.1%). With regard to source of income, over half (54%) of new admissions were receiving ODSP, other disability-related assistance or Ontario Works, with 15.9% remaining employed.

Much like the regional trends for presenting problem substance among clients across the region, the most common presenting problem substance for new admissions in the Sudbury-Manitoulin-Parry Sound sub-region was alcohol, followed by cannabis, prescription opioids, tobacco, and cocaine. However, the percentage presenting for prescription opioids is quite a bit higher than the region as whole at 33.9% compared to 24.5%.

**Table 21.** Characteristics of New Admissions Who Received Substance Abuse Treatment in Sudbury-Manitoulin-Parry Sound Sub-region, Fiscal Year 2014/15.

| Characteristic | Sudbury-Manitoulin-Parry Sound | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| **Gender** | | | | |
| Male | 1522 | 65.8 | 5913 | 65.9 |
| Female | 791 | 34.2 | 3053 | 34.0 |
| Other | ... | ... | 0 | 0.0 |
| Total | 2314 | 100.0 | *8967* | *100.0* |
| **Age Group** | | | | |
| Under 16 | 18 | 0.8 | 139 | 1.6 |
| 16-24 | 428 | 18.5 | 1760 | 19.6 |
| 25-34 | 743 | 32.1 | 2740 | 30.6 |
| 35-44 | 477 | 20.6 | 1824 | 20.3 |
| 45-54 | 398 | 17.2 | 1423 | 15.9 |
| 55-64 | 209 | 9.0 | 902 | 10.1 |
| 65 and over | 41 | 1.8 | 179 | 2.0 |
| Total | 2314 | 100.0 | 8967 | *100.0* |
| **Source of Income** | | | | |
| Employment | 368 | 15.9 | 1506 | 16.8 |
| Employment Insurance | 91 | 3.9 | 432 | 4.8 |
| ODSP (Ontario Disability Support Program) | 656 | 28.3 | 2105 | 23.5 |
| Disability Insurance | 54 | 2.3 | 319 | 3.6 |
| Other Insurance (excluding Employment Insurance) | 12 | 0.5 | 54 | 0.6 |
| Ontario Works | 594 | 25.7 | 2293 | 25.6 |
| Retirement Income | 50 | 2.2 | 227 | 2.5 |
| Other | 93 | 4.0 | 293 | 3.3 |
| None | 297 | 12.8 | 933 | 10.4 |
| Family Support | 42 | 1.8 | 497 | 5.5 |
| Unknown | 54 | 2.3 | 221 | 2.5 |

| Characteristic | Sudbury-Manitoulin-Parry Sound | | NE LHIN | |
|---|---|---|---|---|
| | N | % | N | % |
| Missing | … | … | 26 | 0.3 |
| Total | 2314 | 100.0 | *8967* | *100.0* |
| **Ethnicity** | | | | |
| First Nations, Inuit & Metis (FNIM) | 830 | 35.9 | 2695 | 30.1 |
| Non-FNIM | 1484 | 64.1 | 6272 | 69.9 |
| Total | 2314 | 100.0 | *8967* | *100.0* |
| **Presenting Problem Substances** | | | | |
| Alcohol | 1611 | 69.6 | 6101 | 68.0 |
| Amphetamines & other stimulants exc. methamphetamines | 85 | 3.7 | 734 | 8.2 |
| Barbiturates | 6 | 0.3 | 25 | 0.3 |
| Benzodiazepines | 142 | 6.1 | 441 | 4.9 |
| Cannabis | 880 | 38.0 | 3465 | 38.6 |
| Cocaine | 431 | 18.6 | 1799 | 20.1 |
| Crack | 258 | 11.1 | 788 | 8.8 |
| Ecstasy | 19 | 0.8 | 66 | 0.7 |
| Glue & other inhalants | … | … | 30 | 0.3 |
| Hallucinogens | 16 | 0.7 | 89 | 1.0 |
| Heroin/Opium | 22 | 1.0 | 197 | 2.2 |
| Methamphetamines (crystal meth.) | 16 | 0.7 | 152 | 1.7 |
| None | 32 | 1.4 | 245 | 2.7 |
| Other psychoactive drugs | 21 | 0.9 | 95 | 1.1 |
| Over-the-counter codeine preparations | 39 | 1.7 | 142 | 1.6 |
| Prescription opioids | 784 | 33.9 | 2194 | 24.5 |
| Steroids | 9 | 0.4 | 9 | 0.1 |
| Tobacco | 512 | 22.1 | 2753 | 30.7 |
| Unknown | … | … | 71 | 0.8 |

Data shown earlier in Table 7 illustrate the movement of people admitted to substance use treatment in the Sudbury-Manitoulin-Parry Sound sub-region based on the treatment agency they accessed. Of those receiving services in the Sudbury-Manitoulin-Parry Sound sub-region, 63.5% were residents of this sub-region, with a small percentage residing in the other sub-regions, excepting the James Bay and Hudson Bay Coast. In contrast to the other sub-regions, there was a much smaller percentage (6.7%) of new admissions who resided outside the region, the largest percentage accessing Monarch Recovery Services (14%).

## Strengths and Challenges of Sudbury-Manitoulin-Parry Sound Treatment System

Several *common themes* in the feedback from participants were noted in the regional overview in Section 3.2. They are noted again here as they were also common to the Sudbury-Manitoulin-Parry Sound sub-region.

***Variation across the region:*** The first common theme was the variability across the region with respect to several key strengths and challenges. This variability on key themes occurred *across* the five sub-regions but also *within* these areas, including the Sudbury-Manitoulin-Parry Sound sub-region.

***Common contextual challenges for service delivery:*** Variability aside, the provision of addiction and other health and social services is very challenging in the Sudbury-Manitoulin-Parry Sound sub-region for several reasons, including:

- The vast geography, including its mix of urban/rural/remote communities.
- The population mix, including significant Francophone and FNIM populations.
- Challenges with recruitment and retention of qualified staff, in part due to language requirements as well as the rural/remote nature of much of the area.
- The weather conditions in the winter that impact travel, and other transportation challenges, such as lack of bus service.
- The significant migration patterns into and out of the area, for example, for work, school, and justice involvement.
- A shortage of affordable housing/rental options and employment opportunities.

***Highly valued workforce:*** The staff providing addictions treatment and support services were universally seen as one of the greatest strengths in the system. Participants commonly highlighted that staff are working in challenging circumstances, at a comparatively low level of compensation and, in most cases, without a salary increase for several years.

***Changing nature of those seeking help*:** Among those interviewed who are providing direct service to clients, there was strong, almost unanimous, opinion that client complexity has increased dramatically in the last decade or so; the typical presentation now includes use/abuse of multiple drugs, multiple physical and mental co-comorbidities, employment and housing needs, trauma histories, and other factors related to the social determinants of health.

***FNIM people and choice:*** FNIM and non-FNIM participants alike reflected on the high needs within FNIM communities and among the individuals and families seeking help. Citing high rates of suicide, particularly among youth on Manitoulin Island, and epidemic levels of prescription opioid addiction layered on top of high rates of alcohol and other drug abuse, the needs are clearly urgent. While there is significant support in the Sudbury-Manitoulin-Parry Sound sub-region, and the NE LHIN generally, for culture-based treatment, experiences of stigma and discrimination in the area's mainstream health services were commonly reported. Much more needs to be done to ensure cultural safety and choice for people seeking help.

The need was also commonly voiced across the Sudbury-Manitoulin-Parry Sound sub-region and the NE region as a whole for more support and engagement of FNIM leaders, organizations and traditional healers in planning enhancements to regional and local treatment systems. Their advice is needed on how best to invest in a community-based system of support to facilitate treatment engagement under challenging circumstances and effective transitions to continuing care within their family and community context.

***Importance of self-help organizations:*** Self-help groups are available in most communities in the NE LHIN, as elsewhere in Ontario and have been around for many years. They are excellent examples of peer support, now a widely recognized element of the continuum of care within the addiction (and mental health) system. A number of residential treatment centres still embrace the abstinence-oriented philosophy of AA and NA. Group meetings from these and other self-help organizations such as Women for Sobriety are hosted at many of the region's treatment programs, including community treatment programs. In many instances the groups are also open to the public. Volunteers from these self-help organizations may also provide in-program supports, for example, a Big Book Study or as part of AA's Bridging the Gap program. It is widely recognized, and supported by research, that such involvements with clients are valuable and effective for a large number of clients and that it supports their exploration of self-help as a recovery tool at no cost to the health care system.

***Managing tensions:*** Participants affirmed the value of collaborating and coordinating services at the organization-level (e.g., program managers seeking to avoid duplication of services) and the individual-level (e.g., front-line workers facilitating transitions across services). This affirmation, notwithstanding, significant tensions exist in the NE LHIN sub-regions, including the Sudbury-

Manitoulin-Parry Sound district, and particularly at the organization-level. Across the NE LHIN region as a whole these challenges variously included tensions between "hospital" and "community"; "mental health and addiction"; "addiction medicine and mainstream addiction treatment"; "FNIM" and "non-FNIM services"; and "LHIN-funded" and "non-LHIN-funded" services, to name the more frequently mentioned versions of these tensions. While community tensions such as these might be expected in Ontario's complex health and social service delivery system, some tensions between providers run deep in the Sudbury-Manitoulin-Parry Sound district, particularly in Sudbury. While leadership from the NE LHIN, and collaborative leadership at the community level, may be needed from time to time to ensure the area's service providers continue to work together in the interests of the people needing assistance, it is also noteworthy that relationships across the addiction services providers in this sub-region appear stronger and more functional than the other sub-regions of the NE LHIN.

***Funding challenges**:* Participants across the region as whole, and certainly within the Sudbury-Manitoulin-Parry Sound sub-region, commented at length on the funding challenges that are presenting barriers to the delivery of quality services. These challenges primarily reflect the lack of increase to base budgets for several years despite rising costs, and the concomitant reductions in service required to manage the increasing shortfall. Objectively measured reductions in service were noted by the review team. Participants in the Sudbury-Manitoulin-Parry Sound sub-region and elsewhere also noted challenges related to the disparity between funding levels/wages in the addictions sector compared to professionals and other staff working within many community partner organizations, particularly community and hospital-based mental health services.

***High cost of current health service utilization related to alcohol and drug use/addiction:*** ICES data synthesized earlier in this report show the significant level of utilization of physicians and hospitals across the NE LHIN, including ED visits, for substance-related conditions. In the Sudbury-Manitoulin-Parry Sound sub-region this is clearly evident in all the ICES utilization data that was presented. The costs of this service utilization are significant, yet still exclude significant costs in the justice, social welfare, children and family services, for example.

Given the complex nature of substance use and addiction, the work to reduce costly health care utilization (as well as other high social and justice-related costs) needs more focus and more collaborative efforts that engage both hospitals and community services. This includes more sharing of strategies across the NE region as a whole.

The costs of investment in addiction services, including enhancing the medical supports within community-based addiction services (e.g., more nursing professionals, addiction nursing liaison; various models of collaborative care) will be partially or fully recovered by decreases in the extremely high level and cost of health care utilization. In short, it will "take money to eventually save money" and

this is consistent with the well-established business case for addictions treatment in the research literature.

## Strengths in the Sudbury-Manitoulin-Parry Sound Treatment System

- As in most parts of the NE LHIN, Sudbury-Manitoulin-Parry Sound hosts a strong network of substance use services along the continuum of care – withdrawal management services (residential and community withdrawal management), short- term residential treatment and longer term- supportive recovery services for men and women, community/outpatient assessment and treatment, including youth services, supportive housing, hospital-based care for the more complex cases with psychiatric and medical co-morbidity, addiction medicine services, and services tailored to FNIM people through a residential treatment centre on Manitoulin Island, various health services and the Friendship Centre in Sudbury.
- Relationships among providers are reasonably strong, albeit with occasional tension identified between community and hospital-sponsored services in Sudbury. Examples of strong collaborative support include:

    - The local, multi-partner planning tables on Manitoulin Island and in Parry Sound, each with a solid slate of projects and activities behind them.
    - The community mobilization table that facilitates access to treatment and support for high need, complex cases.
    - The collaborative arrangement for supportive housing between Monarch Recovery Services and CMHA, including the collaborative scoring and decision-making process to determine priorities for access.
    - The coordinated intake process between Health Sciences North community treatment services and CMHA.
    - The WMS using it's flex beds to facilitate treatment entry for women accessing Monarch Recovery Services.
    - The plan and considerable support for a major co-location of services (a project known as Shared Space) is also a sign of good community collaboration, although it is not known why the community services through Health Sciences North do not intend to re-locate if the proposal is supported and a site mutually agreed upon.

- In Sudbury, the full continuum of addiction services within Health Sciences North is a major strength of the system, including the shared electronic record, little or no wait time, its outreach to Manitoulin Island and multiple entry points to its service continuum.

- The longstanding Community Withdrawal Management program on Manitoulin Island is a model for other parts of the region. Also with respect to withdrawal management, the safe beds within the Sudbury WMS allow for some flexibility to length of stay that supports treatment transitions. The medical supports, including support for tapering off prescription opioids is also a strength.

- The housing continuum offered through CMHA is a strong feature of the treatment system, including the new Harm Reduction Home and its co-location with the shelter and primary care clinic.

- An exemplary range of services at Monarch Recovery Services, including its women's services and a successful integration of men's residential and recovery services. Within Monarch, the Connections program is particularly noteworthy given its focus on facilitating treatment entry as well as post-treatment recovery monitoring as is their FNIM aftercare program.

- The scope of service provided through Parry Sound CMHA is a system strength for a program serving a small but high need population. Its scope of service includes addiction supportive housing, an addiction opioid worker, integrated mental health and addictions, youth and concurrent disorder services, and community treatment and outreach.

- There are significant strengths with respect to the FNIM work in mental health and addictions in the area, including a long-standing and highly regarded treatment centre on Manitoulin island (Ngwaagan Gamig Recovery Centre); the pain management, opiate treatment and other services offered through the N'Mninoeyaa Community Health Access Centre also on Manitoulin Island; community-based addictions and mental health work in services such as Parry Sound CMHA's B'saanibamaadsiwin Aboriginal Mental Health Program;; the engagement of formal psychological services at Noojmowin Teg Health Centre; the FNIM aftercare program for women at Monarch Recovery Services coordinated by Charlain Skinner-Stahan and the traditional teachings she also incorporates into the Monarch women's treatment program; the Youth Cultural Camp run by Brian Nootchtai at Shkagamik-Kwe Health Centre in Sudbury, and the work of David Restoule at the Sudbury Friendship Centre.

- the META-PHI project in Sudbury is a system strength from the point of view of research and development and its potential scale-up since it is an

integrated model involving the local emergency department, community withdrawal management and rapid access to addiction medicine, including medication-assisted treatment.

- The protocol developed between the emergency medical services (EMS) in Sudbury, the emergency department at Health Sciences North and the WMS serves as a model for potential scale up in the NE region given its potential to divert medically non-urgent cases involving intoxication away from the emergency department and directly to the WMS;

- Unlike other parts of the NE LHIN, the situation with respect to CAS and child custody issues involving addiction issues was reported to be improving significantly, at least in the Sudbury area. In this regard, the monthly case conferencing between members of a Professional Resource Committee, in which both CAS and Monarch Recovery Services participate, appears to be important from the point of view of relationship and capacity building in the CAS. While the relationship with CAS was still reported to be somewhat dependent on individual case workers, this kind of case conferencing, as well as the local community mobilization hub, was said to be improving the overall relationship with CAS. Importantly, 90% of referrals for women to Monarch Recovery Services were now reported to be coming from CAS.

- The collaboration between the NE LHIN and various community health services regarding the provision of French language services was noted by participants as particularly strong in this sub-region.

- The research capacity of the sub-region is also very important including, for example, Laurentian University (e.g., the Centre for Rural and Northern Health Research), Health Sciences North and ICES North.

- The Sudbury-Manitoulin-Parry Sound sub-region hosts some the NE LHIN's strongest leaders with respect to addiction medicine, including but not limited to, Dr. David Marsh and Dr. Mike Franklin. Both physicians are closely involved in key initiatives with significant potential for regional demonstration and scale up, for example, the META PHI project and the Harm Reduction Home.

## Challenges in the Sudbury-Manitoulin-Parry Sound Treatment System

In addition to the many common regional themes that challenges the delivery of addiction services, for example, financial shortfalls, housing and transportation needs and stigma and discrimination, there were several aspects of the Sudbury-Manitoulin-Parry Sound treatment system that were presented as particular challenges by participants.

- Despite strong evidence of collaboration between the three main addiction service providers in Sudbury (Monarch, HSN and CMHA), participants continued to highlight challenges with seamless continuity of care for clients and that the public remained uncertain about how to access services. This perception is reinforced somewhat by results of the CAMH RHOC study presented earlier (Section 2.3.4 and which apply specifically to downtown Sudbury and Chelmsford. A previous review focused largely on community mental health services—but which also included Monarch Recovery Services as an important stakeholder—recommended a centralized intake system, which is in its nascent form between CMHA and HSN mental health and addiction services.
- It is noteworthy that Sudbury does not currently have a local planning table, it having been disbanded as participants reported concerns that it had become largely an information sharing, as opposed to collaborative planning agent of change. Some participants also report that it was "*a bit too dominated by HSN*".
- The most evident funding shortfall in the sub-region is that within Monarch Recovery Services – funding required to operate the men's treatment program that was transitioned by the LHIN from the Salvation Army. Despite the successful transition, there are said to be insufficient funds to operate the program and it remains dormant at present.
- Notwithstanding the many strengths at the Wikwemigong Aboriginal treatment centre, it was apparent to the review team that additional beds were needed, as reflected in the extremely long wait list, its commitment to providing a broader range of community support services, such as community and day treatment, and its outstanding reputation. More support is also needed for enhancing the capacity for treatment of clients with co-occurring mental health challenges, a large percentage of clients due to trauma histories. The centre currently has no relationship with the NE LHIN.
- Several people noted that the facilities for the men's residential services provided by Monarch Recovery Services needed to be "*brought up to par*" in terms of physical infrastructure.
- The co-ed nature of the WMS based on current infrastructure was also identified as a concern by some participants.

- In contrast to most other sub-regions in the NE LHIN, participants cited the need for better screening for substance use within primary care settings and more on-site support and case managers in the hospital setting, including the emergency department. There was a program delivered through Monarch Recovery Services that located addiction liaison nurses in the ED department at Health Sciences North. The objective, and performance metric, was to reduce ER use by people with addiction challenges. Despite success in integrating into the ER routine and other parts of the hospital, and identifying cases needing specific addiction treatment, the program was cancelled by the NE LHIN as it wasn't reaching the desired metrics related to reductions in ER use.
- Some participants noted that FNIM clients are not particularly comfortable accessing services offered through Health Science North for reasons related to cultural safety. While this was not expressed as strongly as in other parts of the NE LHIN, and in relation to the comfort level of FNIM people with accessing hospital versus community services, it came up frequently enough that it should be noted here. It also ties into a broader and important theme across the NE region as whole.
- Given the highly integrated nature of mental health and addiction services in Health Sciences North, the concern was expressed about perceived overlap with current requirements for completion of the OCAN assessment tool for mental health and the new screening and assessment tools for addiction that are being rolled out to replace the ADAT tools. This has been identified as a provincial issue.
- As in other sub-regions of the NE LHIN, the poor relationships between the local providers of addiction medicine, methadone in particular, was noted, especially in the Sudbury area. Negative feedback in this regard was expressed explicitly in relation to OATC as it was noted that the counselling services provided previously in conjunction with opioid substitution services at Pinegate "*all but disappeared with the arrival of the OATC*". This was noted as a major step backwards in the provision of evidence-based care for opioid maintenance treatment in the Sudbury area.
- Participants working in Parry Sound noted that since their services are not funded through the NE LHIN, but are at least partially aligned with the service delivery network in Sudbury-Manitoulin, they continuously remain "*off the radar*" for gap analysis, planning and resource allocation. The most obvious gap in services cited in the Parry Sound area was the lack of local withdrawal management services given distance and other challenges accessing services to the south and in Sudbury or North Bay.
- Given the depth and severity of addiction and related issues on Manitoulin Island, including high suicide rates and significant levels of addiction to prescription opioid medication, there is a need to better understand the

scope of the problems and how best the system of services might be improved. Certainly ensuring reliable access to opioid substitution treatment for Island residents needs to be an ongoing focus of concern given repeated challenges in that area on the Island.

## Implications and Recommendations for the Sudbury-Manitoulin-Parry Sound Treatment System

- In addition to resolving the overall funding situation in the sub-region resulting from the long-standing budget freeze, the most immediate priority for funding would be to address the funding shortfall at Monarch Recovery Services for the men's treatment program transitioned from the Salvation Army. As with other situations in the NE region facing funding deficits for residential treatment (e.g., Jubilee Centre in Timmins), enhancements to these residential services should follow a more thorough assessment of the region's residential treatment capacity, with more comparable data on costs, occupancy and completion rates etc. than was possible in this review.
- Another significant funding priority should be a WMS in Parry Sound, with the first option for consideration being a community/mobile WMS and with close collaboration and back up support from HSN in Sudbury. The Parry Sound CMHA would be the logical host for this new service given its strong community base, its current focus on supportive housing and its strong FNIM mental health and addiction services.
- Considerations of potential support from the NE LHIN to the Wikwemigong treatment centre on Manitoulin Island should start with relationship building and a more consistent LHIN-level plan and policy for the support it provides to the region's FNIM addiction treatment and other related community services.
- As noted above, despite strong evidence of collaboration between the three main addiction service providers in Sudbury (Monarch, HSN and CMHA), participants in this review continued to highlight challenges with seamless continuity of care for clients and that the public remained uncertain about how to access services. A previous systems review in 2015 that focused largely on community mental health services, but which also included Monarch Recovery Services as an important stakeholder, recommended a centralized intake system in the area. This centralized intake is in operation between the local CMHA and HSN's mental health and addiction services.

  Further enhancement of this common intake process to more formally include Monarch Addiction Services should proceed very cautiously, if at all, given Monarch's unique services, including its provincial role, its well-organized continuum of care and its well-known service base in the

community. With only three major providers of addiction services in the Sudbury area, all with important strengths as well as effective past collaborations, the pros and cons of adding another layer of information gathering and triage ostensibly to facilitate access to treatment and support should be carefully weighed against other collaborative care and community education options. The results of a provincial environmental scan of centralized/coordinated access models will also be important to inform any future enhancements.

- The current process underway for a major co-location of several service providers, the Shared Space project, should continue to be supported by the NE LHIN as it offers significant potential for collaborative care. It is understood that challenges have been encountered in finding a site suitable for all partners involved. The collaborative process should continue, however, as there would no doubt be several advantages to local consumers and family members as well as the providers themselves. There would be significant advantage to also having the addiction and mental health services offered through Health Sciences North also co-located in the same site or at least a full assessment undertaken of pros and cons of that option.
- In agreement with a recommendation from the community mental health review the local planning table in Sudbury should be re-constituted. Its initial efforts could well be focused on this report and its implications and recommendations for local system planning.
- The outcomes of the Harm Reduction Home and META-PHI should be carefully assessed for their implications for scale up in other parts of the NE LHIN.

## Appendix 2: NE LHIN Addiction Services Review Steering Committee – Membership List and Terms of Reference

| Sub-region | Name | Alternate |
|---|---|---|
| Algoma | Jane Sippell<br>Director, Clinical Programs<br>Sault Area Hospital<br>750 Great Northern Road, Sault Ste. Marie, ON P6B 0A8<br>Phone: 705-759-3434 ext. 4117 | Barbara Ridley<br>Patient Care Manager,<br>Sault Area Hospital<br>750 Great Northern Road, Sault Ste. Marie, ON P6B 0A8<br>Phone: 705-941-1540 |
| Algoma (East) | Ralph Regis<br>Director<br>Oaks Centre Director<br>9 Oakland Boulevard, Suite 2, Elliot Lake, ON P5A 2T1<br>Phone: 705-461-4508 ext. 300 | Jane Sippell (Above) |
| Cochrane | Harry Jones<br>Executive Director<br>Jubilee Centre<br>140 ouest, avenue Jubilee Avenue West<br>Timmins, Ontario, P4N4M9<br>Phone: 705-268-2666 | Marielle Cousineau<br>Executive Director<br>29 Byng Ave, Ste 2, Kapuskasing, ON P5N 1W6<br>Phone: 705-338-2761 |
| Nipissing | Laurie Wardell<br>Director, Addictions & MH<br>NBRHC<br>50 College Drive, P.O. Box 2500, North Bay, ON P1B 5A4<br>Phone: (705) 474-8600 ext. 2538 | Lise LeBlanc<br>Program Manager<br>Alliance Centre<br>West Nipissing Hospital<br>725 Coursol Rd<br>Sturgeon Falls, ON P2B 2Y6<br>Phone: 705-753-3110 |
| Sudbury | Kathryn Irwin-Seguin<br>CEO<br>Monarch Recovery Services<br>405 Ramsey Rd.<br>Sudbury,ON P3E 2Z3<br>Phone: 705-674-4193 ext. 223 | N/A |
| James Bay | Deborah Hill<br>Vice President of Patient Care & Chief Nursing Executive<br>WAHA<br>19 Hospital Drive<br>Moose Factory, ON POL 1W0<br>Phone: 705-658-4544 ext. 2294 | Andrew Uschenko<br>Director, Community MH&A Program,WAHA<br>19 Hospital Drive<br>Moose Factory, ON POL 1W0<br>Phone: 705-336-2164 ext. 422 |
| FNIM | Dorothy Kioke<br>Executive Director<br>Sagashtawao Healing Lodge<br>Box 99, 100 Quarry Road<br>Moosonee, ON P0L 1Y0<br>Phone: 705-336-3450 | N/A |
| Manitoulin | Barb A. Deschamps<br>Manager<br>Manitoulin Health Centre<br>11 Meredith St. | Pat Morka<br>CNO & VP Clinical Services<br>Manitoulin Health Centre<br>11 Meredith St. |

| Sub-region | Name | Alternate |
|---|---|---|
| | Little Current, ON P0P 1K0<br>Phone: 705-368-2300 | Little Current, ON P0P 1K0<br>Phone: 705-368-2300 |
| MPS | Shane Tabobondung<br>Addiction Team Leader<br>CMHA Muskoka-Parry Sound<br>87 Main Street East<br>P.O. Box 40<br>Sundridge, ON P0A 1Z0<br>Phone : 705-746-4264 ext. 292 | N/A |
| Language | Sylvie Sylvestre<br>Community Engagement and Planning Officer<br>Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) | N/A |

**NE LHIN Addiction Review Steering Committee**
**Terms of Reference**

Members of the NE Addiction Review Steering Committee will provide advice, feedback and support on data collection, design and recommended models of care for addiction services throughout the northeast.

The addiction system as a whole has not been reviewed in some time. There are pressures being faced by organizations, particularly those with bedded services, and there are requests for new services. The review includes the examination of the current state and of best practice literature. It is the intent of the project to provide the addiction system throughout the Northeast with a broad current state snapshot of where it is, and to position it toward a desired state. Ultimately, the ideal is a system that is comprehensive, responsive and leading the way in the provision of addiction services.

**Objectives of the steering committee** are to support the consultation team:

- through the provision of available documents and other resources necessary to complete the review and plan;
- with advice and direction where appropriate concerning system priorities;
- by facilitating communications between stakeholders, and through the development of a communication strategy
- by providing feedback on recommended models based on the potential impact on program operations and client services

**Commitment of steering committee members** and/or alternate:

- act as a representative of the addiction system in the northeast, and/or as a member of the population group for which I serve.
- respect my fellow committee members, bring an open mind, ask questions openly, listen, and offer insights
- attend scheduled meetings, or arrange for an alternate member to attend.

**Goals and deliverables** of the project:

The goals and deliverables of the addiction services review throughout the North East LHIN area include the following:

1. Environmental Scan: of all the addiction services that includes the information necessary to develop a long term plan to address the continuum of needs for people experiencing addiction issues, while ensuring financial sustainability of the system. This environmental scan will look at the range of services (community, residential treatment, detoxification…) in the five sub-regions: Cochrane, James Bay, Algoma, Sudbury-Manitoulin-Parry Sound, and Nipissing-Temiskaming.

   The scope of the environmental scan of current programs being offered:

   a. Outline the service, staffing and cost comparisons by functional centre;

b. Review organizational capacity and priorities in order to meet future demand
c. Identify client service gaps in programs and services;
d. Identify opportunities for improvement of client care and organizational efficiencies within the funding allocation current in place;
e. Describe immediate threats/risks to the delivery of quality services both internal and external.

2. Literature review of evidence based and promising practice: to conduct a lit review and summary of evidence based and promising practice in the field of addictions to inform the long term plan. The literature will include the full scope and range of addiction services and practices within those areas of care.

3. To provide a more in-depth review of addiction services for each sub-region with the inclusion a number of suggested models for the continuum of care.

**Meeting frequency**: The steering committee will meet according to the schedule below.

Committee members will assign an alternate if a meeting cannot be attended to ensure representation at each meeting. The chair, a member of the consultation team, will send the meeting details (connection information, agenda, materials to review that reflect the project deliverables, including draft reports) one week prior to each meeting.

Each meeting will be two hours, from 9:00am until 11:00am. The following dates are to be attended by the steering committee representative or an alternate as named by the representative. One of the September dates may be cancelled depending on need and timing.

- June 25, 2015
- July 16, 2015
- Aug 13, 2015
- Sept 3, 2015
- Sept 10, 2015
- Nov. 13, 2015
- Feb 1, 2016

## Appendix 3: Key Informant and Agency List – NELHIN Addictions Services Review

| Agencies | Contact Name | Sub-region | Interview Complete | Steering Committee Member |
|---|---|---|---|---|
| Algoma Family Services | Deborah Irwin | ALGOMA | ✓ | |
| Breton House - Algoma Substance Abuse Rehabilitation Centre | Mickey Naccarato | ALGOMA | ✓ | |
| Counselling Centre of East Algoma | Shelley Watt Proulx - Executive Director | ALGOMA | ? | |
| Region of Algoma Healh Unit | Sandy Byrne | ALGOMA | ✓ | |
| Sault Area Hospital | Jane Sippell, Director, Clinical Programs | ALGOMA | ✓ | ✓ |
| Sault Ste Marie Alcohol Recovery Home - Ken Brown | Wince Lyons - ED | ALGOMA | ✓ | |
| Services de Sante de Chapleau Health Services | Gail Bignucolo, CEO | ALGOMA | ? | |
| Moose Cree First Nation | Allen Sailors - Director of Health | COAST | ✓ | |
| Moose Cree First Nation | Victor Weapenicappo - Health Wellness Coordinator | COAST | ✓ | |
| Mushkegowuk Tribal Council | Donna Seary - ED | COAST | ✓ | |
| Mushkegowuk Tribal Council | Grand Chief Lawrence Martin | COAST | ✓ | |
| Sagashtawao Healing Lodge | Dorothy Kioke - ED | COAST | ? | ✓ |
| Weenebayko General Hospital | Dr. Dahl, Chief of Staff | COAST | ✓ | |
| Weeneebayko Area Health Authority | Deb Hill, Vice President of Patient Care & Chief | COAST | ✓ | ✓ |
| Weeneebayko Area Health Authority | Andrew Uschenko, Program Manager | COAST | ✓ | ✓ |
| Weeneebayko Area Health Authority | Stella Schimmens*, Traditional Healing Program Manager | COAST | ✓ | |
| Weeneebayko Area Health Authority | Dr. Arnold Hill (Director of Medical Staff) | COAST | ✓ | |
| Weeneebayko Area Health Authority | Dr. Gordon Green | COAST | ✓ | |
| Weeneebayko Area Health Authority | Rebecca Friday (Case Manager, Kashechewan) - no longer at WAHA | COAST | ✓ | |

| Agencies | Contact Name | Sub-region | Interview Complete | Steering Committee Member |
|---|---|---|---|---|
| Weeneebayko Area Health Authority | Mary Jane Wabano (Case Manager, Peawanuck) | COAST | ✓ | |
| Weeneebayko Area Health Authority | Gertie Linklater (Case Manager, Moosonee) | COAST | ✓ | |
| Canadian Mental Health Association - Cochrane/Temiskaming | Clark MacFarlane, Executive Director | COCHRANE | ✓ | |
| Cochrane Region Detox Centre - Smooth Rock Falls Hospital | Marielle Cousineau - ED | COCHRANE | ✓ | ✓ |
| Jubilee Centre - Centre de Reeducation Cor Jesu de Timmins Inc | Harry Jones - ED | COCHRANE | ✓ | ✓ |
| La Maison Renaissance Inc | Rita Robin, ED. | COCHRANE | ✓ | |
| Maison Arc-en-Ciel | Chantal Laurin, ED | COCHRANE | ✓ | |
| Misiway Milopemahtesewin Community Health Centre | Doug Davey - Child and Youth Coordinator | COCHRANE | ✓ | |
| Misiway Milopemahtesewin Community Health Centre | Rachel Cull - Interim Executive Director | COCHRANE | ✓ | |
| North Cochrane Addiction Services | Marielle Cousineau - ED | COCHRANE | ✓ | ✓ |
| Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO) | Sylvie Sylvestre - Community Engagement and Planning Officer | COCHRANE | ✓ | √ |
| South Cochrane Addiction Services | Angele Desormeau, ED. | COCHRANE | ✓ | |
| Timmins Native Friendship Centre | Veronica Nicholson, ED. | COCHRANE | ✓ | |
| Canadian Mental Health Association - Muskoka/Parry Sound | Shane Tabobondung, Parry Sound and Sundridge Crisis and Addiction Team Leader | NIP-TEM | ✓ | ✓ |
| Community Counseling Centre of Nipissing | Allan McQuarry, ED | NIP-TEM | ✓ | |
| Enaaghtig Healing Lodge & learning Centre | Germaine Elliott , Mental Health Program Coordinator | NIP-TEM | ? | |
| Enaaghtig Healing Lodge & learning Centre | Steve Beaupre, Concurrent Disorders Case Manager | NIP-TEM | ? | |
| North Bay  Indian Friendship Centre | Amanda Dokis - Addictions Worker | NIP-TEM | ✓ | |

| Agencies | Contact Name | Sub-region | Interview Complete | Steering Committee Member |
|---|---|---|---|---|
| North Bay Recovery Home | Wendy Prieur - Executive Director | NIP-TEM | ✓ | |
| North Bay Regional Health Centre | Laurie Wardell - Director, Addictions and Mental Health | NIP-TEM | ✓ | |
| North Bay Regional Health Centre | Sandy Deschenes - Manager of Crisis Intervention | NIP-TEM | ✓ | |
| North Bay Regional Health Centre | Tanya Nixon - VP Mental Health | NIP-TEM | ✓ | |
| North Bay Regional Health Centre | Dana Godin - Coordinator CAMHU | NIP-TEM | ✓ | |
| West Nipissing General Hospital - Alliance Centre | Lise Leblanc - Program Director | NIP-TEM | ✓ | |
| Noojmowin Teg Health Centre | Brad Hempel - Psychologist | SUD-MAN | ✓ | |
| Anishnabie Naadmaagi Gamig Substance Abuse Treatment(Benbowopka Treatment Centre) | Jim Baraniuk - Acting Executive Director | SUD-MAN | ✓ | |
| Canadian Mental Health Association - Sudbury/Manitoulin | Patty MacDonald - Director of Operations | SUD-MAN | ✓ | |
| Health Sciences North | Catherine Watson, Clinical Manager, WMS & Safe Bed Program | SUD-MAN | ✓ | |
| Ontario Addiction Treatment Centre (Sudbury) | Dr. Mike Franklyn and Wendy Maura-Allard - Area Manager | SUD-MAN | ✓ | |
| Manitoulin Health Centre | Barb Deschamps - Manager | SUD-MAN | ✓ | ✓ |
| Monarch Recovery Services | Kathryn Irwin-Seguin, CEO | SUD-MAN | ✓ | ✓ |
| N'Swakamok Native Friendship Centre | Marie Meawasige, Executive Director (Met with Lisa Osawamick and David Restoule ) | SUD-MAN | ✓ | |
| N'Mninoeyaa Community Health Access Centre | Chantal Gaudreau - Clinical Team Lead, Pain Management/Opiate Treatment Program | SUD-MAN | ✓ | |
| NgWaagan Gamig Recovery Centre Inc | Rolanda Manitowabi - ED | SUD-MAN | ✓ | |
| Shkagamik-Kwe Health Centre | Brian Nootchtai | SUD-MAN | ✓ | |
| Sudbury Counselling Centre | Lynne Lamontagne | SUD-MAN | ✓ | |
| The Oaks Centre -St Josephs General Hospital (Camillus Centre) | Ralph Regis - Director | SUD-MAN | ✓ | ✓ |

| Agencies | Contact Name | Sub-region | Interview Complete | Steering Committee Member |
|---|---|---|---|---|
| NE LHIN | Christine Leclair | COCHRANE | ✓ | |
| NE LHIN | Sherry Frizzell | SUD-MAN | ✓ | |
| NE LHIN | Nancy Lacasse | SUD-MAN | ✓ | |
| NE LHIN | Nicole Vezina | SUD-MAN | ✓ | |
| NE LHIN | Carol Philbin Jolette | NIP-TEM/COAST | ✓ | |
| NE LHIN | Lise Anne Boissonneault | NIP-TEM/COAST | ✓ | |
| NE LHIN | Wallenius, Jennifer | ALGOMA | ✓ | |
| NE LHIN | Atkinson, Natalie | ALGOMA | ✓ | |
| NE LHIN | Marie Paluzzi | ALGOMA | ✓ | |
| NE LHIN | Sylvie Guenther | REGIONAL | ✓ | |
| NE LHIN | Mike OShea | REGIONAL | ✓ | |

## Appendix 4: Focus group/Interview guide for the NE LHIN Addiction System Review

1. When you think of the "substance use treatment system" in your "hub" or sub-region of the NELHIN, from your perspective (e.g., front-line, management, senior administrators) what do you include within that?

*Follow-up:* Do you consider other sectors included in that "treatment system", for example, primary care, emergency, justice, and public health?

*Follow-up:* Is the nature and scope of this "system" different for particular sub-groups of the population in need of support, e.g. adolescents, Francophone, FNIM people, people concurrent disorders, other…

*Follow-up:* What would you include in the "treatment system" if one also consider services in other parts of the overall LHIN region and beyond?

2. What would you identify as the major strengths of the current system of services (a) inside the "hub" (b) Including services in other parts of the NE-LHIN and beyond?

3. What would you consider the major challenges or areas of improvement of the current system? (a) inside the local "hub" (b) Including services in other parts of the NE-LHIN and beyond.

4. The following table helps break down the "treatment system" to a set of core **functions and** provides the opportunity to give some additional detail on strengths and challenges.

Referring to these core **functions**, please identify the strengths, areas for improvement and any specific suggestions and/or challenges in delivering those functions.

| **Functions** | **Identified Strengths** | **Identified Areas for Improvement/ Challenges** | **Additional Comments/ Suggestions** |
|---|---|---|---|
| Early Identification and Intervention | | | |
| Provision of Information, Engagement and Linkage Supports, Outreach | | | |
| Problem Identification, Assessment of Strengths and Needs, and Individualized Treatment and Support Planning | | | |
| Delivery of Substance Use Specific and Biopsychosocial Interventions and Supports | | | |
| Continuing Care/Recovery Monitoring | | | |
| Delivery of Substance Use, Specific and Highly Integrated Psychosocial, Medical and Psychiatric Interventions and Supports | | | |
| *Prevention and Health Promotion* (including addressing stigma and discrimination) | | | |
| *Harm Reduction* | | | |

Referring to the different **service categories** of a comprehensive substance use system, we are going to ask you to identify, from your perspective, the strengths, areas for improvement and any specific suggestions and/or challenges in delivering those categories of services. You may also choose to comment on these service categories from the perspective of a particular sub-population.

| **Service Category** | **Identified Strengths** | **Identified Areas for Improvement/Challenges** | **Additional Comments/ Suggestions** |
|---|---|---|---|
| 1. Screening, Brief Intervention, Referral to Treatment (SBIRT) | | | |
| 2. Withdrawal Management Services | | | |
| a. Home-based/mobile: | | | |
| b. Social/community/ residential: | | | |
| c. Complexity enhanced/ hospital-based: | | | |
| 3. Community Services and Supports | | | |
| a. Community Services minimal | | | |
| b. Community Services moderate | | | |
| c. Community Services intensive | | | |
| 4. Residential Services and Supports | | | |
| a. Supportive recovery | | | |
| b. Residential treatment | | | |
| c. Complexity enhanced (medical/psychiatric) | | | |
| 5. Internet and Mobile Services and Supports | | | |
| 6. Mutual Aid/Self-Help | | | |
| Substitution Services | | | |
| Housing | | | |

6. There are a number of important system features that have been identified as important in supporting a comprehensive, evidence-based substance use system. Please reflect on each of these from an overall LHIN/***regional or provincial*** perspective, to identify strengths, areas for improvement/challenges and any additional context that may be helpful to consider.

| **System Supports** | **Identified Strengths** | **Identified Areas for Improvement/ Challenges** | **Additional Comments/ Suggestions** |
|---|---|---|---|
| 1. Policy | | | |
| 2. Leadership | | | |
| 3. Funding | | | |
| 4. Performance measurement and accountability | | | |
| 5. Information management | | | |
| 6. Research and knowledge exchange | | | |

7. If you could wave a magic wand and adapt, add, or remove something for your local hub/system, what would that be? [Written feedback will be also encouraged with a template for responses (or web survey questions if we can't fully explore this in group discussion)].

# NH LHIN'S ADDICTION SERVICE REVIEW STAKEHOLDER SURVEY

**The questions that follow ask for your perspectives about the system of services and supports for people with substance use problems, funded either directly by the NE LHIN, or through other funding sources.**

**1. In your own words, how would you describe the overall system of services for people with substance use problems, including those people who may also have mental health challenges? In other words, what services and supports do you see as part of this system? Please indicate if you are responding from your local, or a more regional, perspective.**

**2. What would you identify as the major strengths of the system for people needing substance use services and supports? You may respond from your local, or more regional, perspective.**

**3. What would you identify as the major challenges of the system for people needing substance use services and supports? You may respond from your local, or more regional, perspective.**

**4. If you could wave a magic wand and adapt, add, or remove something for this system, what would that be?**

**To help us organize the feedback collected in this survey please answer the following questions:**

## 5. In which geographical area of the NE LHIN are you primarily located?

- ◯ Algoma
- ◯ Cochrane
- ◯ James Bay/Coast
- ◯ Nippising
- ◯ Sudbury/Manitoulin
- ◯ Not sure (provide name of community): _____

## 6. How would you describe your involvement with people with substance use problems?

- ◯ I/my agency provide services primarily to people with substance use problems
- ◯ I/my agency provide other types of services but have people with substance use problems on my/our caseload
- ◯ Other – Please describe: _____

## 7. Please describe the primary mandate of your services:

- ◯ Substance use
- ◯ Mental health
- ◯ Concurrent disorders
- ◯ FNIM services
- ◯ Justice
- ◯ Social services
- ◯ Health
- ◯ Other - please describe: _____
- ◯ Not applicable

## 8. Do you provide services primarily to:

- ◯ Youth
- ◯ Adult
- ◯ Older adults
- ◯ Mixed age
- ◯ Not applicable

## 9. Do you provide services primarily to:

- ◯ Men
- ◯ Women
- ◯ All genders
- ◯ Not applicable

## 10. Is your work closely associated with FNIM people?

- ◯ Yes, very associated - please describe: _____
- ◯ Somewhat associated - please describe: _____
- ◯ Not at the present time
- ◯ Not applicable

## 11. Is your work closely associated with Francophone people?

- ◯ Yes, very associated - please describe: _____
- ◯ Somewhat associated - please describe: _____
- ◯ Not at the present time
- ◯ Not applicable

## 12. Please indicate your role:

- ◯ Front-line service provider
- ◯ Coordinator/Clinical Supervisor
- ◯ Manager
- ◯ Executive leader
- ◯ Other – Please describe: _____

## 13. Please indicate the number of years you have been working in your current field:

[ ]

**Thank you for participating in this survey.**

## Appendix 6: ICES-based Addiction-related Health Services Utilization Definitions

| Addiction-Related Health Services Definitions | |
|---|---|
| **Database** | **Codes** |
| DAD (ICD-10-CA)<br>dx10code1-dx10code25<br>dxtype1-dxtype25<br>(M,W,X,Y,1,2,3)<br>INCLSUSPECT = F<br><br>NACRS (ICD-10-CA)<br>dx10code1-dx10code10<br>INCLSUSPECT = F | F10: Mental and behavioural disorders due to use of alcohol<br>F11: Mental and behavioural disorders due to use of opioids<br>F12: Mental and behavioural disorders due to use of cannabinoids<br>F13: Mental and behavioural disorders due to use of sedatives or hypnotics<br>F14: Mental and behavioural disorders due to use of cocaine<br>F15: Mental and behavioural disorders due to use of other stimulants, including caffeine<br>F16: Mental and behavioural disorders due to use of hallucinogens<br>F17: Mental and behavioural disorders due to use of tobacco<br>F18: Mental and behavioural disorders due to use of volatile solvents<br>F19: Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances<br>F55: Abuse of non-dependence-producing substances |
| OMHRS (DSM-IV)<br>Any code in Axis 1 or Axis 2 variables | 291.0: Alcohol – Intoxication or withdrawal delirium<br>291.1: Alcohol – Induced persisting amnestic disorder<br>292.2: Alcohol – Induced persisting dementia<br>291.3: Alcohol – Induced psychotic disorder, with hallucinations<br>291.5: Alcohol – Induced psychotic disorder, with delusions<br>291.81: Alcohol – Withdrawal<br>291.89: Alcohol – Induced anxiety/mood disorder or sexual dysfunction<br>291.9: Alcohol – Related disorder not otherwise specified (NOS)<br>292.0: Substance – Withdrawal<br>292.11: Substance – Induced psychotic disorder, with delusions<br>292.12: Substance – Induced psychotic disorder, with hallucinations<br>292.81: Substance – Intoxication or withdrawal delirium<br>292.82: Substance – Induced persisting dementia<br>292.83: Substance – Induced persisting amnestic disorder<br>292.84: Substance – Induced mood disorder<br>292.89: Substance – Intoxication or induced anxiety disorder/sexual dysfunction<br>292.9: Substance – Related NOS<br>303.00: Alcohol intoxication<br>303.90: Alcohol dependence<br>304.00: Opioid dependence<br>304.10: Sedative, hypnotic or anxiolytic dependence<br>304.20: Cocaine dependence<br>304.30: Cannabis dependence<br>304.40: Amphetamine dependence<br>304.50: Hallucinogen dependence<br>304.60: Inhalant or phencyclidine dependence<br>304.80: Polysubstance dependence<br>304.90: Other (or unknown) substance dependence<br>305.00: Alcohol abuse<br>305.10: Nicotine dependence<br>305.20: Cannabis abuse<br>305.30: Hallucinogen abuse<br>305.40: Sedative, hypnotic or anxiolytic abuse<br>305.50: Opioid abuse<br>305.60: Cocaine abuse<br>305.70: Amphetamine abuse<br>305.90: Other (or unknown) substance abuse |
| OMHRS (Provisional Diagnosis – use only if no DSM-IV diagnosis) | PROVDX1 = 4 |
| OHIP (DXCODE) | 291 Alcoholic psychosis, delirium tremens, Korsakov's psychosis<br>292 Drug psychosis<br>303 Alcoholism<br>304 Drug dependence, drug addiction<br>305 Tobacco abuse |

| Addiction-Related Health Services Definitions | |
|---|---|
| **Database** | **Codes** |
| OHIP (FEECODE) | K682 Opioid Agonist Maintenance Program monthly management fee - intensive<br>K683 Opioid Agonist Maintenance Program monthly management fee - maintenance<br>K684 Opioid Agonist Maintenance Program monthly management fee - team maintenance<br>K680 Substance Abuse – Extended Assessment |
| ODB (DIN)<br>Note that methadone DINs are liquid only | Suboxone, 2/0.5 mg 02295695<br>Suboxone, 8/2mg 02295709<br>Methadose, 10 mg/ ml 02394596<br>Methadose, 10 mg/ml 02394618<br>Methadone 09850619 |

## Appendix 7: Pan-Canadian Categories of Substance Use Services for Placement

The pan-Canadian service categories that have emerged out of the National Needs-based Planning project are identified below.

| Service Category/ Types of Services | Definition/Examples |
|---|---|
| **Generic Services** | The services in this category are frequently points of first (and often only) contact with health and other public service systems, including but not limited to, primary care clinics, emergency rooms, social welfare agencies, correctional services, and educational settings. While the mandates of points of first contact are typically to provide a broad range of services and supports, they are also well-positioned to deliver general prevention and health promotion functions as well as opportunistic early identification (screening), brief intervention and referral to treatment. |
| **Withdrawal Management Services** | |
| Home-based/mobile | This involves voluntary withdrawal management with support provided in a client's home or other safe accommodation. It may also involve visits to a central location (e.g., substance use program) during the day, while returning home at night. This service may involve a medical assessment by a physician and regular monitoring by a nurse and health care worker during the withdrawal process to provide medical management and support. |
| Community/medical residential | This involves voluntary withdrawal management in a non-hospital residential setting. While the environment and supportive services are largely non-medical, this service may involve a medical assessment by a physician and regular monitoring by a nurse and health care worker during the withdrawal process to provide basic medical management and support. Treatment can be provided with or without drug therapy. |
| Hospital/complexity enhanced | This involves assistance with voluntary withdrawal management where care is provided within the structure of a health care setting with a high level of medical and psychiatric capability. Treatment can be provided with or without drug therapy, but typically involves medication management, for example, for physical stabilization, withdrawal and for co-occurring mental disorders. |
| **Substance Use Community Services** | |
| Minimal | This involves a very limited number of sessions of substance use-specific counselling activities in individual or group formats. These sessions may be quite brief and sometimes offered on an outreach basis. This category also includes brief education for people convicted of driving while impaired. |
| Moderate | This involves a scheduled course of 1-2 hour sessions of substance use-specific counselling in group sessions or individual format. This category also includes opioid replacement services with or without a counselling component. |
| Intensive | This involves a structured schedule of substance use-specific counselling activities taking place over some days/evenings, or partial days/evenings, of the week. This category may include the initial intensive phase of opioid substitution therapy. Programs are generally offered for a defined number of weeks while the client resides elsewhere. |

| Service Category/ Types of Services | Definition/Examples |
|---|---|
| **Substance Use Residential Services** | |
| Supportive recovery | This involves accommodation, and a range of lifestyle and psychosocial supports in an alcohol and drug-free setting but not including a highly structured schedule of treatment. |
| Residential treatment | These services provide accommodations but also engage clients in structured, scheduled interventions and activities specifically designed to ameliorate substance use problems and/or moderate severity of co-occurring disorders |
| Complexity-enhanced treatment | These services provide accommodations but also involve structured, scheduled programs of substance use treatment activities for clients with significant substance use problems, co-occurring medical/ psychiatric disorders, or other complex needs. |
| **Other services and supports** | |
| Internet-based (virtual) and mobile-based technologies | These innovations are emerging as critically important in the delivery of substance use services and supports. Such technologies have been increasingly harnessed to distribute educational and health literacy materials as well as to deliver a range of self-administered and therapist-assisted interventions. |
| Mutual aid groups | Supports available through groups such as Alcoholics Anonymous (AAA) and Narcotics Anonymous (NA) are widely recognized as a key component of substance use systems, even though these are not formally included in planning and funding processes. |
| Housing | This involves accommodation that addresses the housing needs of people with substance use problems, and/or co-occurring disorders. There is a continuum of housing supports that range from short-term low threshold shelter, to supervised supportive housing including support and counselling, to longer-term third-stage housing with access to more limited supports. |
| Harm reduction services and supports | Services and supports such as needle exchange services and injection sites are important elements of a comprehensive treatment system. Also included are a wide range of other prevention and treatment (e.g., opioid substitution; interventions to reduce violence in bars; alcohol control policies. |

## Appendix 8: Summary of Sub-Region Agency Profiles

### Summary of ALGOMA Agency Profiles

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Algoma Family Services | √ | Alternatives for Youth – Community Treatment Program | Community Treatment | All | Ages 14-25 | | English | | | | | √ | √ |
| | | Genesis Day Treatment Program | Community Day/Evening Treatment | All | Ages 12-18 | | English French | | | | | | |
| | | Rebound Choices*RCY | Community Treatment | All | Ages 12-18 | | English French | | | | | | |
| Breton House (Substance Abuse Rehabilitation Centre) | √ | Community Treatment | Community Treatment | Female | 19+ | | English | | | | | √ | |
| | | Residential Treatment Program | Residential Supportive Treatment Level 1 | Female | 19+ | | English French Italian | | | | | | |
| | | Community Treatment*ECD | Community Treatment | Female | 12+ | | English | | | | | | |
| | | Change: Attitude, Thinking, Behaviour, Education Group | Community Treatment | Fmale | 16+ | | English | | | | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Counselling Centre of East Algoma | √ | Adult Community Treatment (Oaks Centre and Blind River) | Community Treatment | All | Age 25-54 | | English French | | | | | √ | |
| | | Senior Community Treatment (Oaks Centre and Blind River) | Community Treatment | All | Age 55 and up | | English French | | | | | | |
| | | Youth Community Treatment (Oaks Centre and Blind River) | Community Treatment | All | Age 12-24 | | English French | | | | | | |
| Region of Algoma Health Unit | √ | Outpatient Counselling (Elliot Lake, Wawa, Blind River, Sault Ste. Marie) | Community Treatment | All | Age 18+ | 515 | English | | | | | √ | √ |
| | | Structured Relapse (Elliot Lake, Wawa, Sault Ste. Marie) | Community Treatment | All | Age 18+ | 41 | English | | | | | | |
| | | Pathways Program (Elliot | Community Treatment | All | Age 16+ | 0 | English | | | | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Lake, Blind River) | | | | | | | | | | | |
| | | Methadone Maintenance*MMT (Sault Ste. Marie) | Community Treatment | All | Age 16+ | 48 | English | | | | | | |
| | | Case Management*MMT (Sault Ste. Marie) | Community Treatment | All | Age 16+ | 47 | English | | | | | | |
| | | Anger Solutions (Sault Ste Marie) | Community Treatment | All | Age 16+ | 39 | English | | | | | | |
| | | ASH - Supportive Housing (Sault Ste Marie) | Support within Housing | All | Age 16+ | 78 | English | | | | | | |
| Sault Ste Marie Alcohol Recovery Home Inc – Ken Brown | √ | Residential Support Program | Residential Supportive Treatment Level 1 | Male | Age 16+ | | English | | | | | √ | √ |
| St. Joseph's General Hospital Elliot Lake – Oaks Centre | √ | Adult Residential Treatment Program | Residential Treatment | All | 17+ | | All programming in English. Written assignments accepted in French | | | | | √ | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | as per staff availability. | | | | | | |
| | | Family Residential Program | Residential Treatment | All | 17+ | | As above | | | | | | |
| | | Youth Adult Residential Treatment (17-24 years) | Residential Treatment | Male | Ages 17-24 | | As above | | | | | | |
| Services de Sante de Chapleau Health Services | | | | | | | | | | | | | |
| Sault Area Hospital | √ | Addictions Treatment Clinic | Outpatient/Community Treatment | All | 18+ | 726 (average for last 3 years) | English French | | | | | √ | √ |
| | | Problem Gambling | Outpatient/Community Treatment | All | 18+ | 37 | English French | | | | | | |
| | | Withdrawal Management Services | Residential Withdrawal Management | All | 16+ | 462 (average of current | English | 2012-13 54.2% | 12-13 2.6 days | 15 (4 observation beds - | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | and past four years; current year projected) | | 2013-14 49.8%<br><br>2014-15 52%<br><br>2015-April 1-Sept.16 54.4% | 13-14 3.8 days<br><br>14-15 3.5 days<br><br>15-16 2.74 days | male and female; 4 female beds; 7 male beds) | | | |

## Summary of COAST Agency Profiles

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rates | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sagashtawao Healing Lodge | √ | Residential Program - Individual<br>Residential Program - Family Healing Program | Residential Treatment | All | 18+<br>Age 0+ | | Cree English | 70% | 6 weeks | 12 | √ | √ | √ |
| Moose Cree First Nation | | | | | | | | | | | | | |
| Mushkegowuk Tribal Council | | | | | | | | | | | | | |
| Weenebayko General Hospital | | | | | | | | | | | | | |
| Weeneebayko Area Health Authority | √ | Court Diversion Program | Community Treatment | All | 18+ | Males 15 Females 6 | English | | | N/A | √ | √ | |
| | | Intensive Case Management | Community Treatment | All | 18+ | | English | | | | | | |
| | | Early Psychosis Intervention | Community Treatment | | Ages 16-34 | | English | | | | | | |
| | | Addiction and Problem Gambling Service | Community Treatment | All | Adults | | English Cree | | | | | | |
| | | Regional Concurrent Disorders Program | Community Treatment | All | Adults | | English | | | | | | |
| | | Central Intake and Referral Coordination | Community Treatment | | | | English Cree | | | | | | |
| | | Psychiatric Nurse Clinician | Inpatient/ Emergency | All | Adults | | English | | | | | | |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Regional Mental Health Worker | Community Treatment (Coastal) | All | Adults | | English | | | | | | |
| | | Coastal Mental Health Worker | Community Treatment | All | Adults | | English | | | | | | |
| | | Team Leader | Clinical | N/A | N/A | | English | | | | | | |
| | | Clinical and Administrative Manager | Clinical and Administrative | N/A | N/A | | English | | | | | | |

## Summary of COCHRANE Agency Profiles

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Brunswick House First Nation | | | | | | | | | | | | | |
| Jubilee Centre - Centre de Reeducation Cor Jesu de Timmins Inc | √ | Residential Treatment Program | Residential Treatment | All | 16+ | | English French | 100% based on Q14 2015/16 | 10 funded co-ed.<br><br>2 non-funded co-ed<br><br>Total 12 | 12 | | √ | √ |
| | | Short-term Residential Crisis Support Program (aka Safe-Bed Program) | Short-term residential Crisis Support Services | All | 16+ | | English French | Over 100% based on Q1 2015/16 | 3 Funded<br><br>**1 Non-funded**<br><br>**Total 4** | 4 | | | |
| | | Community Day Treatment Program (temporarily suspended) | Community Day Treatment | All | 16+ | | English French | | | | | | |
| | | Evening Treatment (not funded - is absorbed into residential) | Community Evening Treatment | All | 16+ | | English French | | | | | | |
| | | Ontario Telemedicine Network (OTN) | Nurse Supported | All | 16+ | | English French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Telemedicine Program | | | | | | | | | | |
| | | Supportive Housing (in final stages of development) | | | 16+ | | English French (anticipated) | | | | | | |
| La Maison Renaissance Inc./Maison Arc-en-Ciel | √ | Residential Treatment Program (Maison Renaissance) | Residential Treatment | All | 16+ | | French | N/A | Co-ed program: 19.8 days<br>Women's program: 23.91 days | 14 | | √ | |
| | | Residential Treatment (Maison Arc-En-Ciel) | Residential Treatment | Male | Ages 12-24 | | | 55% | 33 days | 6 | | | |
| Misiway Milopemahtesewin Community Health Centre | √ | Child and Youth Program | | All | Chldren, youth and their families | 330 | English French | | | | √ | √ | √ |
| | | Traditional Healing Program | | All | All ages | 528 | English Cree Ojibway | | | | | | |
| | | Health Promotion | | All | | | | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Medical clinic | | All | All ages | 1650 | French<br>English<br>Cree | | | | | | |
| North Cochrane Addiction Services Inc/Services de Toxicomanie Cochrane-Nord Inc. | √ | Adult Treatment Program (Kapuskasing, Cochrane, Hearst College Universitaire de Hearst, Smooth Rock Falls) | Community Treatment | All | 18+ | | English<br>French | | | | √ | √ | |
| | | Youth Treatment Program (Kapuskasing, Cochrane, Hearst College Universitaire de Hearst, Smooth Rock Falls) | Community Treatment | All | Ages 0-18 | | English<br>French | | | | | | |
| | | Family Treatment (Kapuskasing, Cochrane, Hearst College Universitaire de Hearst, Smooth Rock Falls) | Community Treatment | All | 0+ | | English<br>French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Case Management (Hearst College Universitaire de Hearst) | Case Management | All | 0+ | | English | | | | | | |
| South Cochrane Addictions Services (Timmins, Iroquois Falls, Matheson Bingham Memorial Hospital) | √ | Brief Problem Solving Counselling (all three sites) | Community Treatment | All | 12+ | | English French Access interpreters for FNIM languages | | | | √ | √ | |
| | | The Info Program (all three sites) | Community Treatment | All | 12+ | | | | | | | | |
| | | Family Program (all three sites) | Community Treatment | All | All ages | | | | | | | | |
| | | Structured Relapse Prevention Program (all three sites) | Community Treatment | All | 12+ | | | | | | | | |
| | | Youth Program (all three sites) | Community Treatment | All | Ages 12-18 | | | | | | | | |
| | | Concurrent Disorders Program (all three sites) | Community Treatment | All | 12+ | | | | | | | | |
| | | Children's Program (all three sites) | Community Treatment | All | Ages 5-12 | | | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Men's Program (all three sites) | Community Treatment | Male | 18+ | | | | | | | | |
| | | The Chosen Path Program (Timmins) | Community Treatment | All | 18+ | | | | | | | | |
| | | The Optimum Program (all three sites) | Community Treatment | All | 55+ | | | | | | | | |
| | | Parents of Teens Program (all three sites) | Community Treatment | All | 18+ | | | | | | | | |
| | | Women's Program (all three sites) | Community Treatment | Female | 18+ | | | | | | | | |
| | | Case Management* MMT (Timmins) | Case Management | All | 16+ | | | | | | | | |
| | | Harm Reduction Program (all three sites) | Community Treatment | All | 12+ | | | | | | | | |
| | | Substance Abuse Support within Housing*SH (Timmins) | Support within Housing | All | 16+ | | | | | | | | |
| | | Opiate Case Management for Women*ECD (Timmins) | Case Management | Female | 0+ | | | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Assessment for Substance Abuse and Problem Gambling (all three sites) | Community Treatment | All | 12+ | | | | | | | | |
| | | Assessment for Family (all three sites) | Community Treatment | All | 0+ | | | | | | | | |
| | | Guide Self-Change Program (all three sites) | Community Treatment | All | 18+ | | | | | | | | |
| Timmins Native Friendship Centre | | | | | | | | | | | | | |
| Canadian Mental Health Association (CMHA) Cochrane Temiskaming Branch | √ | Crisis Response | Crisis Intervention | All | | Total- 530 Male-230 Female- 273 Other- 27 | English French | | | | | √ | |
| | | Dual Diagnosis | Case Management | All | | Total- 80 Male- 44 Female- 28 Other- 8 | English French | | | | | | |
| | | Intrepid Place | Social Rehabilitation/ Recreation | All | | Total- 196 Male- 95 Female- 101 | English French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Other- 0 | | | | | | | |
| | | Assertive Community Treatment Teams | Assertive Community Treatment Team | All | | Total- 118<br>Male- 76<br>Female- 42<br>Other- 0 | English<br>French | | | | | | |
| | | Case Management/ Community Support Program | Case Management | All | | Total- 641<br>Male- 255<br>Female- 396<br>Other- 0 | English<br>French | | | | | | |
| | | Justice Support Services | Diversion and Court Support | All | | Total- 324<br>Male- 243<br>Female- 80<br>Other- 1 | English<br>French | | | | | | |
| | | Regional Early Intervention Program | Early Psychosis Intervention | All | | Total- 22<br>Male- 18<br>Female- 4<br>Other- 0 | English<br>French | | | | | | |
| | | Community Treatment Order (CTO) Program | Case Management | All | | Total- 18<br>Male- 10<br>Female- 8<br>Other-0 | English<br>French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Senior's Mental Health | Psychogeriatric | All | | Total- 223<br>Male- 81<br>Female- 142<br>Other- 0 | English<br>French | | | | | | |
| | | Primary Care Program | Community Mental Health Clinic | All | | Total- 373<br>Male- 171<br>Female- 201<br>Other- 1 | English<br>French | | | | | | |
| | | Housing Support | Support Within Housing | All | | Total- 25<br>Male- 12<br>Female- 13<br>Other -0 | English<br>French | | | | | | |
| | | Concurrent Disorders | Case Management | All | | New Program- Not sufficient data to report. | English<br>French | | | | | | |
| | | Behavioural Supports Ontario | Psychogeriatric | All | | Total- 73<br>Male- 25<br>Female- 48<br>Other- 0 | | | | | | | |
| | | Temiskaming Crisis | Crisis Intervention | All | | Total- 445 | English<br>French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Response System | | | | Male- 181 Female- 254 Other- 10 | | | | | | | |
| | | Northern Star | Peer/Self-help Initiative | All | | Total- 186 Male- 91 Female- 94 Other- 0 | English French | | | | | | |
| | | Temiskaming Assertive Community Treatment Team | Assertive Community Treatment Team | All | | Total- 50 Male- 37 Female- 13 Other- 0 | English French | | | | | | |
| | | Temiskaming Adult Mental Health Program | Counselling and Treatment | All | | Total- 663 Male- 266 Female- 377 Other- 26 | English French | | | | | | |
| | | Temiskaming Adult Mental Health Program | Early Psychosis Intervention | All | | Total- 13 Male- 9 Female- 2 Other- 2 | English French | | | | | | |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Temiskaming Addictions Program | Substance Abuse | All | | Total- 144<br>Male- 104<br>Female- 35<br>Other- 5 | English<br>French | | | | | | |
| | | Temiskaming Addictions Program | Concurrent Disorders | All | | Total- 254<br>Male- 131<br>Female- 117<br>Other- 6 | English<br>French | | | | | | |
| | | Rendezvous Place | Social Rehabilitation/ Recreation | All | | Total- 30<br>Male- 15<br>Female- 12<br>Other- 3 | English<br>French | | | | | | |
| Cochrane Region Detoxification Centre de désintoxication du region de Cochrane | √ | Residential Supportive Services Level 1 | Residential Supportive Treatment Level 1 | All | 16+ | ~875 per year | English<br>French | 75% | 1 days in Phase 1<br><br>5 – 6 days in Phase 11 WMS<br>10.5 days in RSS | 4 acute Phase 1 beds (2 males, 2 females<br>10 WMS beds (6 males, 4 females)<br>6 RSS beds (males | | √ | √ |

| Agency | Profile Completed | Program(s) | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Phase 1 Crisis/ Withdrawal | Residential Withdrawal Management | All | 16+ | | English and French | | | | | | |
| | | Safe bed initiative | Case Management for persons with judicial and/or mental health issues | | | 80 | English and French | | | | | | |

## Summary of NIPISSING/TEMISKAMING Agency Profiles

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Canadian Mental Health Association - Muskoka/Parry Sound | | | | | | | | | | | | | |
| Community Counselling Centre of Nipissing | √ | Adult Substance Abuse Community Treatment | Community Treatment | All | 25+ | | English French | | | | √ | | |
| | | Youth Community Treatment Program | Community Treatment | All | Ages 0-17 | | English French | | | | | | |
| | | Family Community Treatment | Community Treatment | All | 12+ | | English French | | | | | | |
| | | Native Community Treatment Program | Community Treatment | | 16+ | | English French | | | | | | |
| | | Opioid Community Treatment Program-MOH*ECD | Community Treatment | | 0+ | | English French | | | | | | |
| Enaaghtig Healing Lodge & Learning Centre | | | | | | | | | | | | | |
| North Bay Friendship Centre | √ | The Aboriginal Drug and Alcohol Program | | | | | | | | | √ | | |
| North Bay Recovery Centre | √ | Residential Program | Residential Supportive Treatment Level 1 | All | 16+ | | English French | | | | | √ | √ |
| | | Addiction Supportive Housing (ASH) Program*SH | Support within Housing | All | 18+ | | English | | | | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| North Bay Regional Health Centre | √ | Day/Evening Client | Community Day/Evening Treatment | All | 16+ | | English French translation arranged as needed | | | | | √ | |
| | | Residential Treatment Program | Residential Treatment | All | 16+ | | English French translation arranged as needed | | | | | | |
| | | Crisis/ Withdrawal*WMS1 | Residential Withdrawal Management | All | 16+ | | English French | 45.1% | 1.8 days | 4 male 2 female | | | |
| Alliance Centre (West Nipissing General Hospital) | √ | Substance Abuse Community Treatment Program AA/YA | Community Treatment | All | 16+ | | English French | | | | | √ | |
| | | Mental Health Counselling and Treatment | Counselling and Treatment | All | 16+ | | English French | | | | | | |
| | | West Nipissing Crisis Intervention Services | Crisis Intervention | All | 16+ | | English French | | | | | | |
| | | Case Management | Case Management | All | 16+ | | English French | | | | | | |

## Summary of Sudbury-Manitoulin-Parry Sound Agency Profiles

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Noojmowin Teg Health Centre | | | | | | | | | | | | | |
| Canadian Mental Health Association - Sudbury/Manitoulin | √ | Harm Reduction Home - Managed Alcohol Program | Addictions Treatment - Substance Abuse | All | | 15 | English French | | | | | | |
| Benbowopka Treatment Centre | √ | Residential Treatment Program Federal | Residential Treatment | All | 18+ | | English Ojibway | | | | √ | √ | |
| | | Residential Treatment Program Provincial | Residential Treatment | All | 18+ | | English Ojibway | | | | | | |
| Health Sciences North | | | | | | | | | | | | | |
| Manitoulin Health Centre | √ | Acute Withdrawal Phase 1 | Community Withdrawal Management | All | 16+ | 300 | English | | | | | √ | |
| | | Monitoring Withdrawal/ Stabilization - Phase 2 | | | | | | | | | | | |
| Monarch Recovery Services | √ | Women's Residential Treatment Program | Residential Treatment | Female | 16+ | | English French | 78% | 18 days | 12 | √ | √ | |
| | | HER Program (Relapse Prevention Program) | Residential Treatment | Female | 16+ | | English | 90% | 5 days | 8 | | | |
| | | KWE Program | Residential Treatment | Female | 16+ | | English | 80% | 5 days | 8 | | | |
| | | Women's Community Treatment Program | Community Treatment | Female | 16+ | | English French | | | | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Women's Residential Support Program | Residential Supportive Treatment Level 2 | Female | 18+ | | English French | 70% | 3.5 months | 8 | | | |
| | | Addiction Supportive Housing (ASH) Program*SH | Support within Housing | All | 18+ | | English French | 100% | 11+ months | 16 | | | |
| | | Men's Residential Recovery Program Level 1 | Residential Supportive Treatment Level 1 | Male | 16+ | | English | 82% | 7.5 weeks | 18 | | | |
| | | Men's Community Program | Community Treatment | Male | 16+ | | English | | | | | | |
| | | Men's Residential Support Program Level 2 | Residential Supportive Treatment Level 2 | Male | 16+ | | English | 65% | 4 months | 5 | | | |
| | | Pregnancy/Parenting Outreach Program | | All | 16+ | | | | | | | | |

| Agency | Profile Completed | Program(s)* | Program Type | Gender | Age | Clients Served | Languages | Average Occupancy Rate | Average Length of Stay | # beds (Residential and WMS only) | FNIM | NE LHIN Funded | Other Funding |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| N'Swakamok Native Friendship Centre | √ | Community Treatment Services | Community Treatment | All | 14+ | | Cree English Ojibway Interpretation available for other languages | | | | √ | | |
| Maamwesying, North Shore Community Health Services Inc. | √ | N'Mninoeyaa Aboriginal Mental Health Services (8 sites) | Counselling and Treatment | All | 18+ | | English | | | | √ | √ | |
| Ngwaagan Gamig Recovery Centre (Rainbow Lodge) | √ | Community Treatment - Outpatient Program | Community Treatment | All | 18+ | | English | | | | √ | √ | √ |
| | | Community Day/Evening Treatment Program | Community Day/Evening Treatment | | | | English Ojibway | | | | | | |
| | | Four-Week Residential Program | Residential Treatment | | | | English Ojibway | 92% estimated | 26 days | | | | |
| | | Aftercare Program | Community Treatment | | | | English | | | | | | |
| Ontario Addiction Treatment Centre - Sudbury | | | | | | | | | | | | | |
| Shkagamik-Kwe Health Centre | | | | | | | | | | | | | |
| Sudbury Counselling Centre | | | | | | | | | | | | | |

## Appendix 9: Agency Case Examples

**AGENCY CASE EXAMPLE**

**Manitoulin Withdrawal Management Services**

| | |
|---|---|
| **Client** | 35 year old male |
| **Presenting Problems** | • History of seizures secondary to withdrawal from alcohol<br>• Needs help with money management and physical health<br>• Spends all his pay on alcohol |
| **Medications** | Celexa at bedtime |
| **Treatment History** | Manitoulin Withdrawal Management Services:<br>• First admission: 16/06/2008; discharged: 24/06/08<br>• Second Admission: 04/04/2009; discharged: 16/03/2009 (following admission to hospital)<br>• contact with community health nurse/mental health worker<br>• appointment with psychiatrist March 2009 and transported to residential WMS in Sudbury<br>• stayed in halfway house in March 2009;<br>• went to residential WMS in April 2009; left May 2009<br>• Third Admission: 20/05/2009 Discharged: 19/06/2009 (referral from hospital, client admitted for alcohol withdrawal symptoms)<br>• Fourth Admission; 24/06/2010 Discharge: 09/08/2010<br>• Accepted referral to long-term recovery home and stayed for 12 days<br>• Client moved and agency lost contact |
| **Substance Use Profile** | • Frequent alcohol use with brief periods of sobriety |
| **Admission** | |
| **Length of Service** | See Treatment History |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**North Cochrane Addiction Services**

| | |
|---|---|
| **Client** | 32 year old Native women |
| **Presenting Problems** | Physical problems:<br>• client fell down the stairs in 2001 while intoxicated with alcohol and was hospitalized for 5 days; client lost her sense of smell and taste for 2 months; has a history of falls and bruises<br>• pain in liver<br>• suffered injury from violent incident while intoxicated<br>• eczema and skin discoloration<br>• malnourishment<br><br>Cognitive problems: blackouts at least 2 to 3 times a week.<br><br>Emotional problems: history of sexual abuse resulting in moodiness, anxiety and flashbacks, history of suicidality<br><br>Relationship problems: on-off relationship<br><br>Aggressive behavior problems: charged with assault on her boyfriend in July 2014; involved with the Restorative Justice program; involvement in violent altercations and aggressive behaviours<br><br>Legal problems: client breached her probation conditions in late August 2008; assault charge in 2014; diverted to Restorative Justice Program and involvement in substance use treatment as condition of program<br><br>Financial problems: client unable to manager her finances independently; client's mother manages finances |
| **Medications** | |
| **Treatment History** | • Participated in Jubilee residential program in 2008<br>• She was referred for mental health counselling to deal with the sexual abuse and trauma but she is not consistent and does not attend services |
| **Substance Use Profile** | • **Alcohol:** first drink at 17 years of age; drinking progressed from age 18 from drinking cooler every weekend to age 21 drinking hard liquor and beer almost daily; in recent years drinking fluctuated in response to life stressors; out of the last 90 days she drank 90 times; last use was in current week<br>• **Amphetamines:** infrequent use in 2007/2008; out of the last 90 days she used once.<br>• **Benzodiazepines:** used Clonazepam twice last year; last use was January, 2015 (4 pills); out of the last 90 days she used once.<br>• **Cannabis:** used infrequently in 2008; in late 2014, she began using 3 to 4 times a weeks the amount of one gram every 2 days. Out of the last 90 days has smoked 70 times. |

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| | • **Cocaine/crack:** first use in 2007; snorted half a gram of cocaine once a week; started smoking crack in 2008; consumed cocaine every month for the past several years; period periods of non-use; in 2014, was smoking crack 3 times a week; her last use was December 2014. Out of the last 90 days she used 45 times.<br>• Client has difficulties remaining sober and following through with treatment |
| **Admission** | Client feels pressure from courts and mother to participate in services. Client wants to get healthier but appears unable to reach for it. Client has had extreme difficulty managing her day to day life, adjusting to major life stresses, being realistic about herself and others, and expressing her emotions appropriately. She has been having extreme difficulty with having direction in her life, feeling depressed and hopeless, becoming suicidal when thinking of the sexual abuse. She has been having extreme difficulty with drinking alcoholic beverages and taking drugs. Client copes by numbing herself from feeling any pain. The sexual abuse has left her feeling ashamed and worthless. She is at high risk.<br><br>Service needs identified following assessment:<br>• May require withdrawal management services<br>• Community treatment pre- and post-residential treatment<br>• Trauma services<br>• Residential treatment and long-term care |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**Cochrane Region Detox Centre**

| | |
|---|---|
| **Client** | Adult male |
| **Presenting Problems** | As a result of his substance use, client experienced problems with:<br>• Health – overdose<br>• Cognitive- blackouts<br>• Behavioral- flashback from war<br>• Relationships- not seeing his children<br>• Work – lost many jobs due to his alcohol and drug use<br>• School- informal education and needs some assistance when reading<br>• Legal- charged with DUI in 2010 and Assault in 2012<br>• Financial – spends everything he has on his substance use |
| **Medications** | • Cipralex 20 mg 1 tab per day for depression and PTSD<br>• Omeprazole 20 mg for his stomach<br>• Acetaminophen 500 mg when required |
| **Treatment History** | • Hospitalized twice in past year due to alcohol use<br>• Previous residential treatment at North Bay Regional Health Centre and North Bay Recovery Home<br>• Third admission to Cochrane Region Detox Centre |
| **Substance Use Profile** | • Alcohol: first drink at 9 years of age and consumed alcohol almo9st daily thereafter; he was sober for 5 months after completing treatment at the North Bay General Health Centre and North Bay Recovery Home in January 2015; client admits to drinking until he blackouts averaging 17 drinks per day. He last consumed alcohol on August 6, 2015.<br>• Cannabis: started smoking occasionally at 14 years of age; daily since 17 years of age, averaging a gram per day; client last smoked cannabis on August 6, 2015.<br>• Amphetamines: client experimented with speed at 32 years of age; at age 36, he consumed speed on 2 week binges, averaging 10 pills per day, and would stop for a month. He has not consumed speed since May 2015.<br>• Cocaine: client was introduced to cocaine at 9 years of age; in 1993, he stopped consuming cocaine until 2010 and then consumed daily for 3 years, averaging 2 grams per day; he has not consumed cocaine in the past 4 months. |
| **Admission** | Client wants to make changes in his life and recognizes that his problem will get worst if he does not make changes. He wishes to abstain from all substance recognizing that one substance will lead him to use another one.<br><br>Client seems to present moderate difficulties in most life areas. He has extreme difficulty managing day-to-day life, taking care of household responsibilities, finding work, feeling of loneliness, being impulsive in regards to his substance use and not being satisfied with his life. He has moderate difficulty adjusting to life stresses. |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**FH**

| | |
|---|---|
| **Client** | 61 year old male widower |
| **Presenting Problems** | • Mental health: observed behaviour resembling paranoid schizophrenia (undiagnosed), anxiety and depression, past suicide thoughts, hoarding and competency questions about cognitive decline. (Brain injury 25 years ago)<br>• Legal: outstanding warrant for not attending court theft under $5000. (Stealing a mickey of vodka) |
| **Medications** | |
| **Treatment History** | • 1 level supportive housing and treatment services<br>• Overnight Hospitalizations in last 12 months: Over 32 admissions to WMS services and over 15 visits to emergency services (crisis) at HSN |
| **Substance Use Profile** | Substances of Choice – alcohol, benzodiazepines |
| **Admission** | |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | • Staff Discharges – 1 for behavioural issues: hoarding, trying to selling prescription medication, anti-social negative behaviour<br>• Not suitable for residential addictions services, unable to meet basic needs, unable to maintain housing, unable to access services, because of cognitive decline. |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**AL**

| | |
|---|---|
| **Client** | 61 year old male widower |
| **Presenting Problems** | • Mental health: observed behaviour resembling paranoid schizophrenia (undiagnosed), anxiety and depression, past suicide thoughts, hoarding and competency questions about cognitive decline. (Brain injury 25 years ago)<br>• Legal: outstanding warrant for not attending court theft under $5000. (Stealing a mickey of vodka) |
| **Medications** | |
| **Treatment History** | • 1 level supportive housing and treatment services<br>• Overnight Hospitalizations in last 12 months: Over 32 admissions to WMS services and over 15 visits to emergency services (crisis) at HSN |
| **Substance Use Profile** | Substances of Choice – alcohol, benzodiazepines |
| **Admission** | |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | • Staff Discharges – 1 for behavioural issues: hoarding, trying to selling prescription medication, anti-social negative behaviour<br>• Not suitable for residential addictions services, unable to meet basic needs, unable to maintain housing, unable to access services, because of cognitive decline. |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**Jubilee Centre**

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|---|---|
| **Client** | 28 year old male from Sudbury-Manitoulin Region |
| **Presenting Problems** | • A&MH: substance abuse, anxiety, depression, panic attacks, sleep disorder, P.T.S.D., history. of sexual abuse<br>• Physical: herniated disc lower back, hx. of physical abuse, life skills deficit<br>• Neurological: substance induced seizures<br>• Other: difficulties with social/interpersonal relationships, broken family ties, unemployed, financial issues/impulsive spending, life skills deficits, problematic intimacy & sexual promiscuity |
| **Medications** | Gabapentin |
| **Treatment History** | 1. Health Science North – Residential WMS<br>2. Nipissing Detoxification & Substance Abuse Program – Residential Treatment Services (client remained alcohol free a few days post treatment, then relapsed.) |
| **Substance Use Profile** | Preferred substances:<br>• Opiates: fentanyl patches (4 years), methadone & oxy prior,<br>• Cannabis<br>• Benzodiazepines |
| **Admission** | Initial observations:<br>• Psychological/Emotional: disorganized thought process, apprehensive yet, optimistic & motivated for change.<br>• Physical: physically suitability predetermined prior to admission.<br>• Unmet Needs: In need of considerable emotional support, guidance and assistance with the written component during intake process and assignments.<br>• Shared Care: Not actively engaged with any other health/social service provider at time of admission.<br>• Intensity of Care Required: Does not require addiction &/or mental health residential crisis services and sufficiently stabilized from an addiction/MH standpoint to fully participate in residential treatment service. |
| **Length of Service** | 21 days (current LOS is 28 days) |
| **Scheduled Counselling Sessions** | weekly |
| **Treatment Summary** | Week 1<br>Intake process completed, client needing much guidance and reassurance. Written component difficulties were supported by staff. During orientation client was struggling with attention and racing thoughts. He was scared but motivated to learn new ways of coping and demonstrated motivation for change. Staff supported him by giving him reassurance especially in the evening when he had difficulties with sleeping. Client struggled significantly with general (non-facilitated) interpersonal interactions with others due to anxiety. He readily |

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| | accepted guidance and began working on social skills through the guidance and support of his clinician during the day and program workers during the evening and weekend. He also participated fully in educational sessions based on the Universal 12 Step Program (U-12)<br><br>The client participated in the OCAN assessment and the ensuing action plan. A family history of mental illness was self-reported; a referral to mental health was discussed and followed through.<br><br>Goal setting assignments were completed daily. The client struggled in some areas of active lifestyle change, but nonetheless began learning life skills, mainly improving his abilities to complete chores on time and sharing a living environment with others.<br><br>Week 2<br>In individual counseling, the client identified attachment issues. In conjunction with reflective journaling, he began Rational Emotive Behavioural Therapy (REBT) educational sessions; this increased his ability to change his thought patterns and decrease anxiety levels; client resisted change and struggled with the underlying theories and rationale; he persisted and continued to engage and made considerable progress through the second week.<br><br>Week 3<br>Client continued participating in interactive workshops; was able to understand the process of modifying his thought process around specific 'trigger thoughts' resulting in more rational management of unpleasant emotions. Behavioural deficits were identified and the client successfully employed tools gained in treatment. Client accepted recommendation for longer term treatment and completed residential treatment program at Jubilee and was discharged to Crossroads Treatment Centre where he entered long term residential treatment. Since resources and time did not allow for a mental health consult while at Jubilee the client put in place a plan to follow through with mental health assessment as part of his long term treatment at Crossroads in Thunder Bay. |
| **Additional Information** | Client statement: A personal conversation confirmed that client is celebrating a year of recovery. When asked: "What did the program mean for you?" He explains that at the time he entered treatment he didn't feel he was ready. He felt he didn't know how to live without drugs and alcohol. "The Jubilee Centre taught me there is a life without drugs and alcohol. To live life on life's term, to not have to escape reality and to know that if I can change my thoughts, I can change my life. I wanted a new life I didn't think it was possible. The 2 weeks before were the worse weeks of my life absolutely miserable. Your program with REBT I use that every day.<br><br>The program absolutely helped with anxiety. I no longer have that panic feeling, I felt it was overwhelming. My mind was constantly over-thinking those thoughts that made me anxious. I now understand and that's why and it's the REBT that helped. I used to think it was the situation that caused the anxiety but it was my thoughts. I no longer take any medication. I noticed that my back pain has subsided and I understand now that my drug use was making the pain worse. I |

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| | still have back pain but I seek help from my chiropractor and from natural solutions. The treatment program at the Jubilee really helped. As far as maintenance self-help groups are helping me maintain my sobriety but treatment at the Jubilee found the root of the issues and that's where I found solutions. Jubilee Centre taught me a life outside of drugs and alcohol."<br>Jubilee Alumni - Anonymous |

**AGENCY CASE EXAMPLE**

**Monarch Recovery Services – Women's Aftercare**

| | |
|---|---|
| **Client** | 30 year old female originally from Cobalt; currently living in the Sudbury Area |
| **Presenting Problems** | • Substance abuse<br>• history of child sexual abuse by father, uncle and friend<br>• history of suicide attempts and self mutilation<br>• child died of SIDS<br>• Mental Health Diagnoses **(**Dr. B, 09/02/12):<br>o Adult ADHD<br>o Bipolar disorder with depressed features<br>o prolonged bereavement reaction<br>o PTSD<br>o Borderline personality traits and anti-social personality traits<br>• Legal issues: 18 months probation and restitution for Theft under $5000, Fraud under $5000, Utter Forged Document and Breach Probation (September 2011)<br>• Physical health:<br>o tumor on her uterus; doctors to confirm need for complete hysterectomy<br>o chronic pain |
| **Medications** | No mental health medications;<br>Pain medications for chronic nerve pain in legs (which has not been fully diagnosed as to the cause of such pain) |
| **Treatment History** | • 2009 CAMH (did not complete and had one day of abstinence)<br>• 2011 Camillus (2 months abstinence)<br>• 2012 (March) Iris (Monarch) (over 2 months abstinence)<br>• 2012 (Sept) Iris ( Monarch ) (8 months abstinence)<br>• 2012 Iris Women's Aftercare(October - March)<br>• 2013 House of Sophrosyne (did not complete)<br>• 2013 ASH program (Monarch) |
| **Substance Use Profile** | • First drink at age 11; client reports that she has drank twice since January 2014<br>• Smoked pot at 12.<br>• Started using amphetamines in 2012 3-4 times a week, 2-3 pills.<br>• First used Cocaine in 2001, used a gram twice a year. In 2013 started using crack daily. Client reports using crack twice since March 2013. |
| **Admission** | |
| **Length of Service** | See 'Treatment History' above |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | Client is currently active in the Addiction Supportive Housing Program with Monarch Recovery Services. There have been many ups and downs with this client throughout the years that she has been involved with Monarch. Her daughter of two months died in 2010 from SIDS, and she sought out treatment from us two years after and has been diagnosed with Prolonged Bereavement Reaction. Her |

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| | struggles with her grief increased this past year after she gave birth to another baby girl. Referrals to HSN, Mood and Anxiety program has been made with the hopes that she will be seen for her PTSD as well. She is also involved with Healthy Babies, (Health Unit) and CAS.<br><br>This client often has severe flashbacks of her trauma and feelings of guilt related to death of her daughter; despite her grief, she has been an excellent mother and has had a lot of success in her recovery. She stated that she has had a few slips but has not used in excess since 2013. She does pose a challenge to staff as she often talks about suicide however, there has been no attempts since late 2012. She does on occasion still self-mutilate by cutting. In the past it was much more severe requiring medical attention; this behaviour seemed to subside after she has stable housing with ASH.<br><br>She does check in with staff on a daily basis to assess her day as per CAS. They are concerned that her depression/grief will be too much for her and they are concern for the safety of her daughter. She has complied with this request but does feel like she is being punished because she is sad that her first daughter died. |
| **Additional Information** | The plan for this client is to start DBT with her case manager from ASH. She is also currently attending the Beyond Trauma workshop at Monarch Women's Aftercare and tries to come to aftercare groups on Monday nights when she has a sitter. Will continue to work closely with client until she starts with counselling at 127 Cedar in the Mood and Anxiety program and starts individual counselling for her PTSD; suspect involvement with client for many years to come. |

## AGENCY CASE EXAMPLE

## Manitoulin – Example 1

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|---|---|
| **Client** | 17 year old First Nations male attending high school, living with friend's family off-reserve |
| **Presenting Problems** | • Trauma: Severe physical and emotional abuse episodes almost every week by step family member for a few years during (school-age) childhood; serious physical assault by family member three years ago<br>• Mental Health: Post-Traumatic Stress Disorder<br>• Substance use: Cannabis Dependency; binge drinking<br>• School: poor school attendance and failing marks<br>• Family: all teens and adults in current "family" situation use cannabis openly and frequently |
| **Medications** | None—refused to see psychiatrist |
| **Treatment History** | • Individual cognitive therapy delivered at school Total= 34 sessions from Feb/14 to Jun/15<br>• Refusal to invite current care givers to therapy<br>• Referral to Addictions Counsellor in Jan/15—attended several sessions<br>• Hospitalizations: Overnight at local hospital in 2014 for suicidal ideation during binge alcohol episode<br>• School: Placement in special resource class with individualized help in managing course work in Sept/2014 |
| **Substance Use Profile** | • Daily cannabis use, including at school (started at 13-14 year old)<br>• Weekend binge drinking episodes a couple of times per month<br>• Daily cigarette smoking |
| **Admission** | |
| **Length of Service** | Since February 2014 |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | (for this treatment provider only-- Attended most sessions at school):<br>• Cognitive Behaviour Therapy approach used to identify negative thought patterns and generate alternative thoughts.<br>• Psychoeducation about trauma effects and "grounding" techniques for flashback and memory episodes. Cognitive Processing Therapy for working through and coping with key trauma-related flashback/memory "triggers" (e.g., chance encounters with childhood abuser in community life). |
| **Additional Information** | PROGRESS:<br>• School attendance improved dramatically from 40% to close to 80%<br>• Cannabis use reduced to once every 2-3 days and not used at school<br>• (Tobacco) smoking cessation<br>• Binge drinking episodes reduced to monthly with lower consumption of standard size drinks<br>• No further suicidal ideation<br><br>Unforeseen circumstances: Rainbow Region School Board teacher walkout for one month duration disrupted healthy routines. Return to school routines was problematic and attendance dropped again with increase in cannabis use.<br><br>PLAN: Will be seen again for booster sessions starting Sept/15. |

## AGENCY CASE EXAMPLE

## Manitoulin – Example 2

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| **Client** | 42 year old First Nations female living on social assistance, off-reserve |
| **Presenting Problems** | • Trauma: childhood history of multiple episodes of sexual molestation by family member for a few years; one incident of violent sexual assault by adult male acquaintance five years past<br>• Mental health: Post-Traumatic Stress Disorder; Major Depressive Episode<br>• Substance use: Cannabis Dependency; binge drinking<br>• Social: Difficulties managing intimate relationship; social isolation<br>• Financial: unemployed with accompanying financial stress |
| **Medications** | SSRI Antidepressants as prescribed by family physician |
| **Treatment History** | • No hospitalizations during treatment period |
| **Substance Use Profile** | • Daily cannabis use<br>• Occasional weekend binge drinking episodes<br>• Daily cigarette smoking |
| **Admission** | |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | |
| **Treatment Summary** | • Individualized delivery of "Seeking Safety" skill development for managing PTSD and Addictions related issues + Motivational Interviewing for substance abuse issues --40 sessions from 2006 to 2007<br>• Several months "break" from treatment<br>• Re-entered therapy in Oct/2008 and attended 8 sessions of Prolonged Exposure (cognitive therapy for adult trauma episode) until Apr/2009 |
| **Additional Information** | Progress:<br>• Cannabis use eliminated<br>• Tobacco smoking reduced slightly<br>• Binge drinking episodes eliminated<br>• Sought and found employment within one month of leaving therapy in 2009<br>• Discontinued antidepressants successfully |

## AGENCY CASE EXAMPLE

## Canadian Mental Health Agency – Sudbury/Manitoulin

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| **Client** | 55 year old male; Sudbury |
| **Presenting Problems** | • Mental health: mood disorder, concurrent disorder<br>• Activities of Daily Living: in wheelchair<br>• Financial: unemployed, receiving ODSP<br>• Housing: rooming house and at risk of eviction<br>• Legal<br>• Substance Use/Addictions<br>• Threat to others/Threat to self<br>• Legal: on probation |
| **Medications** | |
| **Treatment History** | • Referred to Justice program through the courts.<br>• Supported individual through diversion court program.<br>• Withdrew from the diversion program and pled guilty; placed on probation.<br>• Secured housing with CMHA housing program (Fairview).<br>• Referred to CMHA Transitional Community Support program.<br>• In and out of detox. Unable to access local homeless shelter due to accessibility issues.<br>• Explored treatment programs, accepted to Camillus Treatment Centre, did not attend for admission date in June 2015.<br>• Secured new housing (Rooming House)<br>• Now facing further eviction<br>• Referred to the Rapid Mobilization Table on a number of occasions. |
| **Substance Use Profile** | |
| **Admission** | |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | Continues to work with transitional case manager on presenting issues. |
| **Treatment Summary** | |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**South Cochrane Addictions Services**

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| **Client** | 44 year old male |
| **Presenting Problems** | • Substance Abuse<br>• Schizophrenia<br>• Anger<br>• Anxiety<br>• Physical Abuse Survivor<br>• Physical health – severe pain in hands and knees from frostbite (fell asleep outside in winter two years ago) |
| **Medications** | • Anti-depressants - Effexor<br>• Anti-psychotics - Zyprexa Zydis<br>• Diabetes - metformin<br>• Gastro - Pentaloc |
| **Treatment History** | • 5 - residential treatments (could not complete due to his behaviours, his mental health concerns and low level reading & writing skills).<br>• No other resources for residential treatment available for this client<br>• In and out of the mental health unit for psychosis and psychotic breakdowns.<br>• Group home/Residence through CMHA (kicked out for not complying to rules)<br><br>Needs: Suitable treatment for concurrent disorders (Addiction and SMI), suitable housing, continuing care for CD. |
| **Substance Use Profile** | Over the years client's use has progressed from drinking and pot use, to Opiate abuse, speed, cocaine and method of use now includes needles. |
| **Admission** | Mental Health and addiction: His mental health stability can go from being somewhat stable to extreme anger, irritability and lack of patience. He can be compliant with his meds, however when using or living on the streets he becomes very ill due to non-compliance with meds. He has had involvement with the law for several years and has been put on the diversion program a few times in the past years. His offences usually involve destruction of property. Presently in jail. |
| **Length of Service** | Involved on and off with our agency since 2008 |
| **Scheduled Counselling Sessions** | Cannot commit to weekly sessions, most often forgets, doesn't show, or comes whenever he feels like it and becomes upset and frustrated because his counsellor cannot see him. |
| **Treatment Summary** | • Substance use has progressed over the past 2 years<br>• Client engages in high risk behaviours<br>• Client cannot complete residential treatment<br>• Client cannot follow community treatment<br>• Client has difficult time with medication (con-compliant)<br>• Barriers to finding him appropriate treatment<br>• Resulting in repeated MHU admittance<br>• Resulting in repeated incarceration<br>• Has been banned from Cochrane Region Detox and Jubilee Centre Safe Beds |
| **Additional Information** | |

**AGENCY CASE EXAMPLE**

**South Cochrane Addictions Services – Addiction Supportive Housing (ASH)**

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| **Client** | Female 34, French Canadian |
| **Presenting Problems** | • Mental health: Bi-Polar Disorder; intense anxiety - client is on wait list for mental health services. Due to the bi-polar and ECT, client experienced a lot of short term memory loss at the beginning of service entry and required supports from CM; client would refuse to attend appointments alone due to overwhelming anxiety. Client continues to struggle with depression and negative thoughts as well as some comprehension.<br>• Physical Pain - Client continued to experience back and neck pain, taking Percocet's as prescribed to deal with the pain from a 7 year old injury; during a doctor's visit with the prescribing doctor in June 2015, doctor stopped prescription abruptly due to concerns regarding dependence and advised her to attend a chiropractor; doctor dismissed CM suggestion to provide a weaning off period as client newly sober; client continues to struggle with pain; there is no funding available to clients over the age of 18 and under the age of 55 to help with these types of specialists.<br>• Percocet Dependency – see above<br>• Legal Issues - Client granted the court diversion program through Canadian Mental Health Association; awaiting intake into program; court diversion CM also put in a referral to access services through CMHA for counselling specific to bi-polar. Client's court diversion will ensure her record is cleared in September 2015 should she continue to follow through with services and follow her care plan.<br>• Financial Issues - Client was connected to Ontario Works and began receiving benefits half way through March; CM assisted with obtaining ODSP (August 2015); client has significant debt; CM connected her with non-profit credit counsellor; client had to file for bankruptcy in June 2015.<br>• Housing Issues (at the time of intake)<br>• Child Welfare Involvement - During early involvement (March 2015) when visits were supervised client was responsible to attend her visits using her resources; client has been given increased access to daughter, now receiving over nights unsupervised. During the early stages, client and CM requested drug testing to begin as per her care plan. Her family support worker agreed to begin testing (April 2015); however no requisitions were placed until mid-August 2015; client continues to have her mental health used against her during inappropriate times. |
| **Medications** | Percocet for pain management (see also above)<br>Client was given medication that caused weight gain. Client has a history of extreme dieting and fitness. The weight gain has caused severe anxiety for client. Client continues to see her psychiatrist once a month for medication adjustments. |
| **Treatment History** | Client hospitalized at the local Mental Health Unit from September 2014-Mid October 2014, receiving a diagnosis of Bi-Polar disorder. |

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| **Substance Use Profile** | Client has been sober since August 2014. She continues to work with a case manager; client is beginning a pattern of abusing Tylenol 1 for pain. Client also smokes 1 package of cigarettes daily. |
| **Admission** | None previous |
| **Length of Service** | |
| **Scheduled Counselling Sessions** | Case Manager continues to see client 2-3 times per week. |
| **Treatment Summary** | Client was referred in February 2015 to the ASH program by the social worker in the MHU.<br>Client had been hospitalized for the second time in December 2014 after breaking into a police officer's home and stealing their vehicle.<br><br>Client had little to no memory of what occurred from August 2014 to the time of hospitalization. When Case Manager met with her in February, she had received 6 treatments of ECT and was very confused.<br><br>Client had an inability to comprehend her circumstances and large difficulty remembering support persons in her life.<br><br>Client was discharged from the hospital in March 2015. She moved in with her ex-mother in law who is a good support person. The home she now resides in is located on a rural road with no access to public transportation and a flat rate for taxi at 25$ one way. |
| **Additional Information** | **Client History:**<br>• Client's father diagnosed with Bi-Polar disorder. Parents remained married until mother died when client was 9 years old from cancer. Client's maternal aunt would not allow client to live with father, and allowed little access to him after the mother's death. Client identifies feelings of loneliness, not belonging and disconnect from aunt and uncle.<br>• Client left home at 15 years old to move in with boyfriend, had her first child at the age of 16, and the second child at the age of 17. Client raised the two children as a single parent after the relationship with the father diminished.<br>• Client finished high school, attended college on two separate occasions being very successful on both occasions.<br>• Client later remarried and had another child 8 years later. When her third child was 11 months old, client was in a serious car accident and prescribed Percocet's for pain in her shoulder and neck.<br>• Client opened her own business and was very successful for a period of time. In February 2013 she became feeling disconnected from husband and began an affair with another man and closed the business. Eventually she left the marriage and moved into an apartment; custody of the youngest child was split 50/50.<br>• Client identifies racing thoughts, less need for sleep, erratic behavior and impulsivity beginning in spring 2014. Eventually she began using speed daily and consuming large amounts of alcohol, along with continued Percocet use (still coming from the same prescribing doctor). She was fired from her job as a pharmaceutical assistant and her using escalated along with her erratic behavior. |

**AGENCY CASE EXAMPLE**

**Ken Brown Recovery Home**

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| **Client** | 40 year old male from Hamilton area |
| **Presenting Problems** | Substance Abuse<br>Head Injury<br>Anxiety<br>Depression<br>Post Traumatic Stress Syndrome<br>Hyperactivity<br>Attention Deficit<br>Neck pain<br>Sporadic sleep patterns |
| **Medications** | Antidepressants - 2<br>Anti-psychotic - 2<br>Methadone 70mg<br>Neuropathic pain reliever<br>Non-steroidal anti-inflammatory - 1 |
| **Treatment History** | 6 - residential CD treatments in other centers<br>2 – In patient Traumatic brain injury Tx Centers<br>2- On going counseling with Head Injury Society |
| **Substance Use Profile** | Brief periods of abstinence following each of 6 residential CD Stays<br>Return to cocaine and alcohol abuse<br>Sporodic attendence 12 Step programs; sponsorship for 7 years |
| **Admission** | Substance Abuse: 5 days withdrawal management<br>Mental health: very anxious -required 2 counselling sessions with counsellor; needs constant reassurance<br>Physical health: evaluate physical health for activities<br>Needs: clothing, toiletries |
| **Length of Service** | 90 days |
| **Scheduled Counselling Sessions** | average 2/week – numerous unscheduled sessions<br>(12 step meetings 5/week) |
| **Treatment Summary** | • Client is met to fill in consent forms and other related forms; revision of referral documents and request for admission. Taken on general orientation tour, assigned room, filled out and signed various consents, policies, and house rules. Taken through bed bug protocol.<br>• Introduced to the 12 Step community, received a sponsor. Began working the 12 steps.<br>• Introduced to in house meetings; group therapy, anger management, relapse prevention and life skills.<br>• Assigned a pass for the YMCA.<br>• Client was assigned a chore and was shown what to do.<br><br>Initial Assessment: |

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| | • Over the next several weeks the client's behavior was assessed to understand how much Traumatic Brain Injury influenced his behavior. It became apparent that this client would need a slightly altered treatment plan to compensate for deficits created by TBI.<br>• Contacted the TBI Association. Case conference. Received work book for client to complete.<br>• Worked out some modified scheduling to assist client to stay on task.<br><br>Ongoing Treatment:<br>• The client was monitored and given reminders around scheduling appointments, meetings, and commitments around the home.<br>• Shorter and more frequent one on one counselling sessions were added to the schedule.<br>• A more tactile method of participating in group settings was adopted.<br><br>Discharge Planning:<br>• The aftercare plan was broken down into discrete pieces. The pieces were methodical and detailed.<br>• Checks, balances and reporting were built into the plan and follow up was stressed. |
| **Additional Information** | To date the client remains abstinent. |

## Appendix 10: Staged Model of Screening, Assessment and Outcome Monitoring