NE LHIN Addiction Services Review:
Highlights and Provincial Implications

Prepared by: Brian Rush, PhD, and VIRGO Planning and Evaluation Consultants for the North East Local Health Integration Network (NE LHIN)

March, 2016

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Acknowledgements

The core VIRGO project team (Brian Rush, April Furlong and Chelsea Kirkby) would like to thank the members of the Addiction Services Review Steering Committee who helped navigate the regional process and provided valuable input along the way. The full set of Steering Committee members are identified in the Appendix.

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

A special thanks goes to LHIN outreach staff and the NE LHIN Mental Health and Addiction Lead Mike O'Shea, as well as to Sylvie Guenther who provided extensive support prior to her taking a new position outside the NE LHIN organization.

We would also like to thank the scientific staff at the Institute for Clinical and Evaluative Sciences (ICES) for their outstanding support in processing the request for special data analysis of health service utilization related to substance use by NE LHIN residents, and provincial rates for comparison purposes. Special thanks go to Dr. Elizabeth Lin, Marian Vermeulen and Li Shudong for their excellence and due diligence in fulfilling the request submitted on our behalf by the LHIN. Our formal acknowledgement follows.

"This study was supported by the Institute for Clinical Evaluative Sciences (ICES) which is funded by the Ontario Ministry of Health and Long-Term Care (MOHLTC).The opinions, results and conclusions are those of the authors and are independent from the funding source. No endorsement by ICES or the Ontario MOHLTC is intended or should be inferred. Parts of this material are based on data and information compiled and provided by CIHI. However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of CIHI."

Finally, we thank the many people across the NE region and beyond who contributed their time, knowledge and experience through interviews, completion of surveys and requests for information. Thank you!

Executive Summary

Continued financial 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. 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 identified mental health and substance use as a priority in its *2013-2016 Integrated Health Service Plan (IHSP)* as well as in its latest IHSP (2016-2019) which calls for "more access to mental health and/or addiction services." In 2015, the NE LHIN commissioned an environmental scan and research synthesis related to regional addictions services. Other complementary work in the region related to mental health services was also commissioned by the LHIN and other major stakeholders.

The overall goal of this project was to determine strengths and challenges within the current network of addiction 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.

This summary and overview of potential provincial implications has been prepared to highlight many of the strengths and challenges identified regarding the North East region's addiction services that, in many respects, mirror the situation at the provincial level. This is an opportune time to share the highlights and potential implications of the work in the NE LHIN, in the spirit of informing similar work across the province as a whole.

One important factor underlying the motivation to share the results of the work in the NE LHIN is that the project represents the "deepest dive" into a region's addiction services that has ever been undertaken in Ontario. The comprehensive methods are noted below and described in detail in the main regional report of the project. The approach included a blend of quantitative and qualitative data synthesized and contrasted to a set of key principles developed from the research literature on substance use treatment system design.

The following are highlights of themes identified through this review.

Strengths to build upon:

- Highly valued workforce
- High endorsement of a multi-sectoral systems approach
- Targeted funding in the past decade
- Elements of the core continuum of services exists in most areas
- Importance of self-help organizations:

Significant challenges and needs related to <u>system supports</u>

- Needs-based not population-based planning

- Funding challenges in the face of flat-lined budgets and increasing need and complexity
- Systems approach – yes! But more collaboration and collaborative planning is needed
- The need for more choice and representation for First Nation, Inuit and Métis (FNIM) people
- Performance measurement is weak
- Knowledge exchange and evaluation can be enhanced

Significant needs related to the service continuum

- Improved access to services but with more attention to current capacity challenges
- Improvements to screening and assessment and matching services to client needs
- Community withdrawal management services (WMS) and enhanced nursing supports in WMS
- Provincial review of residential services to ensure maximum benefit
- Enhanced community services, in particular outreach and transition support
- Enhanced transitions for youth to adult services
- Improved screening, brief Intervention and referral to treatment (SBIRT)
- Enhanced collaboration with addiction medicine and mainstream service providers
- Continued investment in supportive and other housing options
- Increased focus on Internet and mobile treatment/supports

Conclusion

Despite many strong features of the provincial and regional addiction treatment systems there are major challenges to be addressed. The “business case” for investing in addiction services is strong and quality improvement processes aimed at increased efficiencies are needed. That being said, new investment will also be needed to minimize and recover some of the exorbitant costs to society related to substance use, in particular the burden on the health, social service and justice systems.

While enhanced collaboration and gradual integration with mental health services and other sectors, such as primary care, are valuable and need to move ahead, it is important to maintain the focus on addiction services within the context of these larger trends toward integration and a broader systems approach.

It is our hope that the experience on the NE LHIN with this “deep dive” into the region’s addictions services will be of value to key stakeholders and colleagues at the provincial and regional level in Ontario.

1.0 Introduction and Background

The significant health and social burden associated with substance use and addiction argues strongly for continued investment in substance use treatment systems at the regional level in Ontario as well as provincially and nationally. Over the past 10 years and more this investment has included treatment and support for people with concurrent disorders as well as special attention to a closer relationship between substance use services and mental health, primary care, and other service sectors.

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.

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 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 was that community needs be addressed in relation to the cultural diversity of the region, including the needs of the significant proportion of Francophone and First Nation, Inuit and Métis (FNIM) people, the latter being particularly challenged by well-documented substance use and mental health-related needs in many communities.

In setting its priorities, the NE LHIN considered local evidence that regional/local substance use 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 treatment system, the LHIN commissioned the present environmental scan and research synthesis of evidence-informed practice and policy for substance use treatment system design and delivery.

The overall goal of the project, conducted between May 2015 and March 2016, was 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[1], and to identify in what ways these networks of services can be enhanced.

It is important to highlight that many of the strengths and challenges identified regarding the North East regions' addiction services mirror the situation at the provincial level. These challenges are also shared by partner mental health service providers, again at the regional and provincial level. Several initiatives

[1] The region's five sub-regions or "hubs" are: Algoma, Cochrane, James Bay & Hudson Bay Coasts, Nipissing/Temiskaming and Sudbury/Manitoulin/Parry Sound. The main report includes "hub-level" summaries to facilitate planning in these sub-regions.

are underway provincially that are associated with the implementation of the current Ontario Mental Health and Addiction Strategy and a wide range of projects falling under Ontario's Drug Treatment Funding Program. There are also a host of relevant planning initiatives underway in most, if not all, of Ontario's LHINs that reflect the priorities given to addictions and mental health services. In short, this is a very opportune time to share the highlights of the work in the NE LHIN in the spirit of informing relevant work across the province as a whole.

As mentioned earlier one important factor underlying the motivation to share the results of the work in the NE LHIN is that it represents the "deepest dive" into a region's addiction services ever undertaken in Ontario.

2.0 Overview of Methods

In brief, key aspects of this "deep dive" included:

- significant engagement with not only LHIN-funded, but also 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;
- on-site visits with the large majority of addiction service providers in Northeastern Ontario, many operating in the context of blended mental health and addiction services, and which included group or individual interviews with managers and front-line staff;
- telephone interviews with addiction service providers and regional planners that could not be included in the site visits for a variety of reasons, resulting in direct input being gathered and collated from 100 planners, clinicians and managers, representing over 40 direct service providers;
- an on-line survey that offered another opportunity for stakeholder and public input (n=52);
- submission of detailed case descriptions from service providers to illustrate the complexity of cases which have become the norm in this sector rather than the exception;
- analysis of existing data on services provided and other administrative details on the region's addiction service providers in order to develop agency profiles and examine high-level gaps in the system;
- a wide range of secondary data that were accessed and/or developed for the project including information on population and economic trends; substance use trends; access to and use of substance use services as shown by ConnexOntario and DATIS information and, lastly, the most comprehensive set of regional data compiled to date in Ontario on health service utilization associated with substance use (from ICES);

- the ICES data also included detailed information on the use of physicians for medication-assisted treatment for opioid addiction, primarily methadone;
- use of community-level survey data from the comprehensive Researching Health in Ontario Communities (RHOC) and Five Views of a Journey projects undertaken by a CAMH research team and focused on the critical intersection of substance use, mental and violence/trauma; and
- consultation with provincial subject matter experts, in particular, consultation related to nursing and withdrawal management as well as medication-assisted treatment.

Research synthesis and Best Practice Template: The results of the above data gathering and synthesis activities were then compared to best practices for substance use treatment system design, identified through a literature review. This process served identify areas of strength and opportunity for system enhancement across the region, and within each sub-region.

The research synthesis was organized around the following seven key principles:

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.

Principle 2: Collaboration across Multiple Stakeholders

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

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 report considered funding, planning and policy, performance measurement and knowledge exchange.

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.

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

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. We emphasized four sub-topics: (a) screening, assessment and placement matching; (b) withdrawal management services; (c) residential and community treatment services; and (4) access, outreach and transitions.

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. We emphasized four special topic areas with respect to evidence-based interventions: Screening, Brief Intervention and Referral to Treatment (SBIRT); medication-assisted treatment for opiate/opioid addiction; housing and internet and mobile-based services.

These seven key principles formed the basis of the Best Practice Template. The analysis approach was to summarize: "*what the research says*" and contrast that with "*what participants told us*", to yield strengths and challenges in the system and implications for system design and enhancement.

3.0 Key Findings and Implications

3.1 Highlights and Implications of Quantitative Data

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 aging at a faster rate that the rest of Ontario.
- There is significant diversity in the population mix, overall being about 11% FNIM and 22% Francophone, with both population groups showing significant sub-regional variation.
- Unemployment is high and 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.

- Survey data and the observations and opinions of diverse stakeholders suggest extremely high rates of prescription opioid addiction in many communities, especially among the on and off reserve FNIM population. In some First Nations communities this was described in epidemic proportions in some communities with declaring 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 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 this vast region are substantially higher than the provincial average.
- Over 4800 adults residing in the NE LHIN region (approximately 1% of the region's 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 (excluding methadone), 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. It is important to notes that a certain amount of funding for addiction services comes from other sources, for example, Health Canada for FNIM treatment centres and other services.
- Problem substances reported by clients include alcohol, cannabis, cocaine, and prescriptions opioids. Clients typically report multiple problem substances.
- FNIM people represent 11 % of the population yet comprise 30-35 % of the treatment population.
- With respect to withdrawal management, the vast majority of cases are in residential versus community withdrawal management.
- Based on a national needs based planning model, there is a need for more community day/evening treatment programs compared to residential. The ratio in the North East is current 2.4 to 1. A ratio closer to 4 to 1 is suggested by a national needs-based planning model.
- 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 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.
- 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 for immediate planning is to include leaders in addiction medicine in the process.
- FNIM people are significantly over-represented in the treatment population – one implication is that leaders and healers among this community also need to be more engaged in regional and local planning. There is also a high need for culturally appropriate services and cultural safety training.
- 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.

3.2 Highlights and Implications of Qualitative Data and the Best Practice Template

Wide range of regional strengths, opportunities and system gaps were identified using the research synthesis and an integration of the quantitative data above and the rich qualitative data from on-site observation, discussion groups, one-on-one interviews, submitted feedback and the on-line survey. While it is beyond the scope of this provincially-focused summary to identify all the many implications and recommendations, we note the value of the overall process for pinpointing very specific issues for system enhancement across the region and the specific sub-regions. These potential system enhancements ranged from specific service gaps such as withdrawal management, day/evening treatment, outreach and transportation, screening, brief intervention and referral to treatment (SBIRT), and youth transition services to name just a few illustrative areas, as well as systems supports such as policy and performance measurement, the need for collaboration and specific workforce related issues.

4.0 Provincial Implications

Below we identify several key strengths and challenges in the NE LHIN that, to a large extent, mirror the situation across most of Ontario and, as such have implications for planning and policy development at the provincial-level and in other regions of the province. Identifying these few points below is not intended in any way to diminish the importance of the many other areas of strength and needs for system enhancement.

4.1 Strengths to Build Upon

There are many strengths of the treatment system that need to be acknowledged and built upon.

Highly valued workforce:

The managers and staff members who are providing addictions treatment and support services are one of the greatest strengths in the system, often working in challenging circumstances and increasingly strained resources.

High endorsement of a multi-sectoral systems approach*:*

There was virtually universal endorsement of the system approach to addiction treatment among key stakeholders, an approach that essentially 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.

Included in this system approach, and also highly endorsed is the connection between prevention and health promotion work, including reduction of stigma and discrimination, and the treatment and support system. This can be facilitated by using the tiered framework as a planning tool and by acknowledging that a healthy community (i.e., strong social and community capital) is critical to the success of treatment and recovery at the individual level (i.e. community capital becomes essential recovery capital).

This endorsement provides a solid base for building multi-sectoral policy and strong collaborations, including health and mental health, social services, justice, education and public health to name only a few broad sectors.

Targeted funding in the past decade:

The addictions system has benefited from provincial/regional investment that has typically been targeted at specific populations or types of services (e.g., youth, concurrent disorders, pregnant and parenting women, opiate related support, safe beds and supported housing). Some of these enhancements have not only helped build addictions treatment capacity but also encouraged increased collaboration with other sectors, for example, family and youth services, as well as addiction medicine and mental health services.

Elements of the core continuum of services exist in most areas:
The province as a whole, and most regions, has a strong foundation of addiction services upon which to build. While jurisdiction-specific gaps, and more investment is needed to maintain service capacity(see below), the main implication is to focus planning on system coordination/collaboration, access and transitions and ensuring that current resources are being used to maximum benefit.

Importance of self-help organizations*:*
Self-help groups are excellent examples of peer support, a widely acknowledged 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.

4.2 Challenges and Needs

The Tiered Framework for conceptualizing and planning mental health and substance use systems articulates a helpful distinction between the *service*s needed to address the full continuum of needs in the community and the system-level *supports* needed to ensure the services are of high quality, efficient and effective. We separate challenges related to supports and service below.

4.2.1 Challenges and Needs for System Supports

Needs-based not population-based planning:
The data from the NE LHIN review suggest a community need for substance use services significantly higher than the provincial average. This is clearly evident, for example, in the consistent doubling of almost all indicators of health service utilization related to substance use. Many other contextual factors also point to unique needs of the region including the aging population and significant challenges to service delivery posed by rural and remote geography, weather conditions etc. The main implication is the need for needs-based funding formulas for substance use services and undoubtedly mental health service broadly. Using a strictly population-based formula for funding at the provincial level would significantly disadvantage the NE LHIN as it would many other parts of the province with similar challenges and unique strengths.

Funding challenges in the face of increasing need and complexity:
The current funding challenges in the addiction treatment system primarily reflect the lack of basic increases to budgets for several years despite rising costs, and the gradual but very real erosion in service capacity (FTEs, programs) that has been required to manage the increasing shortfall. Importantly, this erosion of capacity has occurred in concert with increasing community needs and case complexity, for example, the typical presentation now includes 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, treatment capacity is shrinking while the level and complexity of community need appears to be increasing.

A related challenge is the increasing difficulty with workforce recruitment and retention due to the significant wage disparity between partner mental health services, both community and hospital-based. This compounds existing recruitment challenges in some rural and remote parts of the province (e.g., Francophone managers and staff) but has even deeper implications for making system enhancements through implementation of more evidence-informed practices (e.g., available staff for back-fill during training, maintaining staff qualifications, need for clinical supervision).

Systems approach – yes! But more collaboration and collaborative planning is needed:

There are three areas in particular where collaborations with respect to addictions services can be enhanced.

- Improved relationships are needed between hospital-sponsored and non-hospital sponsored services in the interest of ensuring equitable and effective use of resources, as well as case continuity at the client and family level. Tensions between these sectors exist in the larger context of pressure to "medicalize" addiction services in the face of increasing case complexity and high use of health services associated with substance use. However, there are many effective models of collaborative care that can deal with highly complex cases while maintaining a focus on community-based care. Enhanced medical supports (i.e., nursing expertise) can also be built into community services thereby reducing the need for transition to hospital for many cases needing basic medical attention and monitoring.

  Advantages of community-based care include greater service capacity per dollar spent; more flexible services, for example, increased reach through outreach services; higher comfort level for FNIM people and others who are challenged by stigma and discrimination in hospital settings and who also need strong community supports to sustain recovery; and a stronger connection to prevention and health promotion work in the community. Experience is also commonly reported that non-hospital based services are more accountable to the community at large and better protected from hospital deficit reduction needs.

- Closer attention needs to be paid in the planning process to collaborative care between addiction services and primary care. Collaborative care models between primary care and addictions services (and mental health services) are very well supported in the research literature as are well-validated models

of screening, brief intervention and referral to treatment (SBIRT). Collaborative primary care models are also helpful in a stepped care model of system design with a step down to primary care for monitoring and support following intensive treatment or integrated care with medication management.

- Lastly, with respect to collaboration, the optimal relationship between mental health and addiction services needs to be better specified. Collaboration, and in many instances both functional and structural integration, are occurring at a gradual pace across the province. This gradual process of integration should continue in situations that makes sense from the point of view of cost efficiencies AND improved access and outcomes for clients and families. Experience suggests, however, that there remains a need for strategies to protect addiction capacity and competencies in the context of this gradual integration process. Provincial leadership is also needed to articulate the rationale and pros and cons for policy which covertly or overtly imply separate funding streams for one "sector" versus the other. If the medium to long term vision is one integrated system, then separate streams of funding and disparate wage levels, for example, are ultimately inconsistent with this highly integrated system view.

FNIM people and the need for choice and representation:

The results of the addictions services review in the NE LHIN highlighted the disparity between the fact that FNIM people make up an estimated 30% of the total client population in the specialized addictions treatment services compared to about 11% of the regional population as a whole. This situation is mirrored to some degree in all parts of Ontario, including urban areas, and reflects similar disparities in incarcerated populations and the justice system at large, including child custody and the CAS.

There is no shortage of evidence concerning the high level of need in the FNIM population, with some communities at virtually epidemic levels of prescription opioid addiction layered on top of inter-generational trauma, alcohol and other drug abuse, extremely high rates of suicide and many other health and social challenges such as low employment and poor housing.

While there is growing and significant support in the addiction treatment system for culture-based treatment, experiences of stigma and discrimination in mainstream health services and some addiction services are commonly reported. Much more needs to be done within many programs to ensure cultural safety, education about traditional healing alternatives and offering choice for people seeking help. There is also a need for more support and engagement of FNIM leaders, organizations and traditional healers in planning provincial and regional treatment system enhancements.

Policy direction is also needed at the Ministry and LHIN-level regarding financial support for FNIM-oriented addictions and mental health programs. Specific needs include more 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 residential services often far from their community; the need to support land-based as well as 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.

Performance measurement is weak

One of the most significant challenges in the support system underlying addiction services is the current inability to answer even the most basic questions related to access, cost, services provided and outcomes being achieved. This significantly hampers system-level quality improvement activities as well as the development of a solid business case for increased investment in addictions services.

While the current provincial initiative to develop a core set of performance measures for addiction and mental health services will be helpful, the resulting indicators are to be "high level". A process is needed to "clean up" costing and other measures related to program operations at the provincial and regional level so as to provide better benchmarking, planning and accountability data. In this regard the data collection and reporting protocol being advanced across the province by Dr. Garth Martin and through the DTFP implementation should be adopted on a wide scale. Better tracking is also needed of Francophone status and not just language of preference, but also primary linguistic affiliation and identification of Francophone status.

Support also needs to continue for the provincial roll-out of the Ontario Perception of Care (OPOC) -MHA tool since, as its use becomes institutionalized and routine comparative data become available across addictions and mental health services, the resulting information 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, such as Monarch Recovery Services and Jean Tweed Centre as well as Homewood Health Services which is building upon the strong foundation laid by Ontario and national DTFP work. The newly mandated screening and assessment tools that are replacing ADAT also provide a solid foundation for future and much needed work on outcome monitoring.

Knowledge exchange and evaluation:
More options need to be operationalized for sharing of information and innovative practices across the province. Planning for provincial and/or regional scale-up of innovations as identified in the NE LHIN, but which no doubt exist across Ontario[2], are also critically important. EENET sponsored by CAMH is a critical provincial resource in this regard as well as the knowledge, expertise and existing infrastructure in CAMH for implementation science can be very helpful and used more strategically for achieving core targets for treatment system enhancement.

There should also be more province and region-wide evaluation activity, particularly around pilot projects with an aim to identify evidence-informed practices and scale up as appropriate (e.g., evaluation of community withdrawal management, transportation options, screening and brief intervention in primary care).

Also in the context of knowledge exchange, more attention needs to be devoted to the human resource challenges across the province as the health of that workforce is critically linked to uptake and sustainability of evidence-informed practice. There should be a provincial assessment of strengths, needs and proposed solutions to the human resource challenges existing across the system, for example, related to wage parity, enhancing nursing capacity in addiction services, and challenging in recruiting Francophone managers and staff. Opportunities for cross training with workers in mental health and/or multi-disciplinary primary care settings should also be identified, as well as support for self-care and capacity building of staff and managers.

4.2.2 Challenges and Needs Related to the Continuum of Care

Improved access to services but more attention to current capacity challenges
There have been consistent calls across the province for improved access to addiction (and mental health) services and this was salient in the NE LHIN review as well. That being said, and while some initiative are underway in selected sub-regions regarding more centralized or coordinated access there were also several cautionary notes sounded in terms of the capacity of the current system to actually absorb an increased caseload. Thus, efforts to "improve access" needs to be considered from several points of view, including enhanced capacity for screening and assessment, wait-list management, making the system much more efficient and increasing treatment capacity in particular community non-residential treatment capacity.

It is important to acknowledge the ongoing and important role for ConnexOntario as a provincial resource aimed at facilitating access to treatment and support and in light of the increasingly regionally-focused models of centralized/coordinated access.

[2] A few examples in the NE LHIN included: META-PHI, Harm Reduction Home, Single Session Therapy, and Walk in Services.

A provincial scan of centralized access models in Ontario, as well as a comprehensive review of evidence concerning key features and effectiveness of such models, is nearing completion by Brian Rush and Birpreet Saini for Addictions and Mental Health Ontario and the Centre for Addiction and Mental Health. This will inform future efforts regarding centralized access including future evaluation work needed since the evidence is far from clear on the outcomes associated with these models.

Improvements to screening, assessment and matching services to client needs: Priority in this aspect of the care continuum should be to support the current implementation of 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 majority of LHINs. This process of implementing evidence-informed tools for screening, assessment and treatment matching will need leadership and support to continue past the current period of funded implementation supports, due to terminate at the end of 2016.

One of the particular challenges during the current implementation is the specific mandate and related resource base that supports implementation of the new tools within only LHIN-funded addiction services. This, of course, has unintentionally prompted challenges and potential tensions among non-LHIN-funded services, including FNIM services, who have been using the now outdated ADAT tools as part of their assessment and referral process. The process to secure additional resources for the roll-out of these much needed tools must consider both LHIN-funded and non-LHIN funded services.

It also needs to be more widely recognized that, beyond the high clinical value for treatment planning/matching to come from the new screening and assessment package, these new tools will provide important and currently unavailable performance measurement data for the system as a 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.

Community withdrawal management and enhanced nursing supports: There are three main implications from the NE LHIN addiction services review for Ontario' withdrawal management services.

The first is to explore more opportunities for community withdrawal management building on success with this cost-effective non-residential model. There are a number of Ontario communities where community withdrawal management is a

very viable option, for example, taking advantage of natural synergies that exist between the local CMHA with existing nursing and supportive housing capacity and local addiction services with a strong outreach capacity.

The second is to enhance the level of nursing supports in the province's residential withdrawal management services. There is considerable experience accumulating across the province in this regard and a province-wide investment in this area would be a very cost-effective approach to increasing safety and minimizing risk in the management of the increasingly complex cases being seen in these settings. Further, enhanced nursing supports for withdrawal management is routine best practice in many other parts of Canada and a well-established strategy for minimizing the cross-traffic between the withdrawal management services and the local emergency departments. The cross-traffic is 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.

A third implication is to carefully monitor the results of an ongoing research project known as META-PHI, being led by Dr. Mel Kahan, and which 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. This model is exemplary as it is operating at the intersection between hospital and community and integrating evidence-based treatment for opioid addiction and mainstream addiction services, including withdrawal management.

Provincial review of residential treatment services:
While there are several outstanding strengths in both the community and residential treatment programs across the province, a recommendation was made in the NE LHIN review for a deeper and more operationally-oriented review of the region's residential treatment services. This review should be extended to the province as a whole.

This particular focus on the province's residential treatment sector is not meant to downplay their importance but rather comes from the spirit of ensuring that those services are being used to optimal efficiency given the following observations and considerations:

1. they consume the largest share of the provincial resource base for addictions treatment;
2. the extant research evidence that shows community (non-residential) services to be the more cost-effectiveness choice for the large majority of clients and, therefore, the need to match clients very carefully in the assessment and treatment planning and stepped care process; reported slippage in the application of the referral criteria for residential services embedded in ADAT and which now need to be re-developed with the new screening and assessment tools;
3. the available evidence concerning moderate to low program completion rates;

4. the high cross-regional utilization of Ontario's residential services at a time when the LHIN's are developing essentially LHIN-focused access models;
5. disparate policies regarding access to these services for people on methadone or Suboxone and which puts inequitable pressure on some services, and the LHINs that fund them, that are more welcoming to medication assisted treatment;
6. wide variation in program content and operating characteristics vis a vis retention and transition supports and enhanced in-house nursing supports as per the withdrawal management services;
7. and finally the poor status of even the most basic administrative, operational and outcome data by which one can describe the current state of affairs and make appropriate decisions related to all of the above factors.

Enhanced community services, in particular outreach and transition supports*:* Notwithstanding the many excellent examples of outreach services in the NE LHIN, making enhancements to this outreach capacity was identified as the number one priority for overall system enhancement in the region. There are many dimensions to this high need for outreach services that echo across much of the province, including:

- the aging population and the recognized value of outreach services for this and other populations including marginalized populations;
- the rural and remote nature of much of the province 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 such as related to child custody; and
- 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.

Enhanced transition supports for youth to adult services**:**
There is a well-documented need for enhanced support for transition from youth to adult services and this was evident in the NE LHIN review. 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.

Improved screening, brief Intervention and referral to treatment (SBIRT):
This significant gap in the treatment continuum is evident across the province despite a large literature to draw upon for program development and evaluation as well as Canadian-based models and expertise to draw upon[3].

There is also a need for more investment and pilot work in Ontario with respect to addiction liaison nurses strategically placed in the emergency departments in light of research evidence and very positive experience elsewhere in Ontario and other parts of Canada (Quebec in particular) and with appropriate, and well-timed, evaluation criteria in place.

Enhanced collaboration with addiction medicine:
Aside from a strong recommendation for increased engagement of addiction medicine experts in the regional (and provincial planning processes) there is a need to inventory and assess benefits and scale-up potential of the many collaborative care that currently exist in many communities . A case in point is the already-mentioned META-PHI project operating in Sudbury and several other Ontario communities. While this example is a large-scale research project there are several other examples of formal and informal collaborative care models between addiction medicine and LHIN-funded services at play across the province for which little information is available or synthesized. There is also a need for better education across the provincial treatment system as whole on the pros and cons of methadone-assisted treatment versus Suboxone assisted treatment. For example, based on current evidence more support should be lent to emergent efforts for using Suboxone including through now well-establish community-level interventions (e.g., in First Nations communities).

Continued investment in supportive housing and other housing alternatives:
Housing is so integral to the overall needs of the population with substance use and mental health issues that it needs to be considered an integral aspect of treatment system enhancement. There is a need for continued investment in supported housing while recognizing the increasing complexity of cases and an associated increase in the required level of support. This has resource implications that need to be acknowledged and fleshed out.

Also with respect to housing, the effectiveness of the new Harm Reduction Home in Sudbury should be closely monitored for potential scale up in other parts of the province. Not only does it represent an excellent harm reduction approach, it clearly illustrates the need to consider housing needs along a very wide spectrum.

[3] The national expert in this area is Dr. David Brown from Manitoba who has been active in many provinces in wide-scale system improvement initiatives related to SBIRT.

Increased focus on Internet and mobile treatment/supports*:*
The research evidence is building rapidly with respect to "e-options" for addictions and mental health treatment and support. Looking towards the future, all experts in this area agree that these technologies hold the promise of significant increasing the reach and effectiveness of these services – not as a full-on replacement to the current service model but rather as a complement to it. It was recommended in the NE LHIN review that a sub-committee of the emerging planning structure take on this topic with earnest. This should be echoed at the provincial level bringing forward ideas and identified innovations that should be pilot tested and evaluated and incorporated into provincial planning in the next 3-5 years. This could build upon current examples developed or underway in the NE region and elsewhere. There is also considerable potential for synergy with existing projects and expertise within several provincial organizations, including a current DTFP project on youth and e-technology.

5.0 Conclusion

Despite many strong features of the provincial and regional addiction treatment systems, there are major challenges to be addressed. The "business case" for investing in addiction services is very strong and both increased efficiencies and new investment will be needed to reduce but also recover some of the exorbitant costs to society related to substance use, in particular, the burden on the health, social service and justice systems.

While enhanced collaboration and gradual integration with mental health services and other sectors such as primary care are valuable it is important to maintain a strong focus on addiction services within the context of the larger trends towards integration and a broader systems approach.

It is our hope that the experience of the NE LHIN with this "deep dive" into the region's addictions services will be of value to key stakeholders and colleagues at the provincial and regional level in Ontario.

6.0 Appendix: NE LHIN Addiction Services Review Steering Committee – Membership List

Sub-region	Name	Alternate
Algoma	Jane Sippell Director, Clinical Programs Sault Area Hospital 750 Great Northern Road, Sault Ste. Marie, ON P6B 0A8 Phone: 705-759-3434 ext. 4117	Barbara Ridley Patient Care Manager, Sault Area Hospital 750 Great Northern Road, Sault Ste. Marie, ON P6B 0A8 Phone: 705-941-1540
Algoma (East)	Ralph Regis Director Oaks Centre Director 9 Oakland Boulevard, Suite 2, Elliot Lake, ON P5A 2T1 Phone: 705-461-4508 ext. 300	Jane Sippell (Above)
Cochrane	Harry Jones Executive Director Jubilee Centre 140 ouest, avenue Jubilee Avenue West Timmins, Ontario, P4N4M9 Phone: 705-268-2666	Marielle Cousineau Executive Director 29 Byng Ave, Ste 2, Kapuskasing, ON P5N 1W6 Phone: 705-338-2761
Nipissing	Laurie Wardell Director, Addictions & MH NBRHC 50 College Drive, P.O. Box 2500, North Bay, ON P1B 5A4 Phone: (705) 474-8600 ext. 2538	Lise LeBlanc Program Manager Alliance Centre West Nipissing Hospital 725 Coursol Rd Sturgeon Falls, ON P2B 2Y6 Phone: 705-753-3110
Sudbury	Kathryn Irwin-Seguin CEO Monarch Recovery Services 405 Ramsey Rd. Sudbury,ON P3E 2Z3 Phone: 705-674-4193 ext. 223	N/A
James Bay	Deborah Hill Vice President of Patient Care & Chief Nursing Executive WAHA 19 Hospital Drive Moose Factory, ON POL 1W0 Phone: 705-658-4544 ext. 2294	Andrew Uschenko Director, Community MH&A Program,WAHA 19 Hospital Drive Moose Factory, ON POL 1W0 Phone: 705-336-2164 ext. 422
FNIM	Dorothy Kioke Executive Director Sagashtawao Healing Lodge Box 99, 100 Quarry Road Moosonee, ON P0L 1Y0 Phone: 705-336-3450	N/A
Manitoulin	Barb A. Deschamps Manager Manitoulin Health Centre 11 Meredith St. Little Current, ON P0P 1K0	Pat Morka CNO & VP Clinical Services Manitoulin Health Centre 11 Meredith St. Little Current, ON P0P 1K0

Sub-region	Name	Alternate
	Phone: 705-368-2300	Phone: 705-368-2300
MPS	Shane Tabobondung Addiction Team Leader CMHA Muskoka-Parry Sound 87 Main Street East P.O. Box 40 Sundridge, ON P0A 1Z0 Phone : 705-746-4264 ext. 292	N/A
Language	Sylvie Sylvestre Community Engagement and Planning Officer Réseau du mieux-être francophone du Nord de l'Ontario (RMEFNO)	N/A