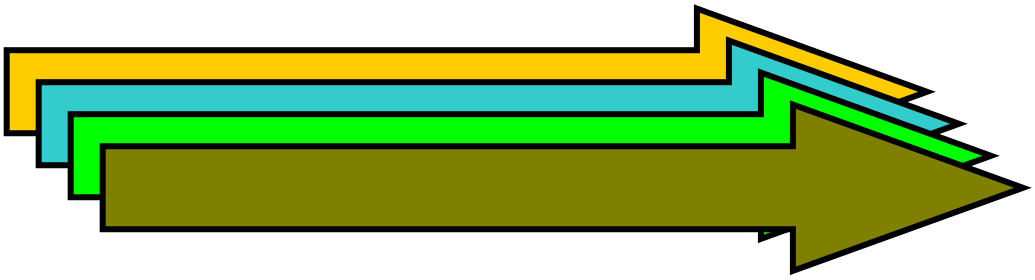
Creating Tomorrow……



a review of addictions programs operated by the Niagara Health System

The Agora Group
December 2010

The Agora Group
12 Peter Street Markham Ontario L3P 2A4
Phone: (905) 294-9762 Fax: (905) 294-8586 e-mail: agora@consultant-network.ca

TABLE OF CONTENTS

A NOTE TO THE READER

The Niagara Health System (NHS), through its Hospital Improvement Plan (HIP), has committed itself to improve quality of care across all NHS sites, services and programs. The HIP's key aim is to create a sustainable hospital system.

This addictions program review is part of the NHS plan to continue to meet local needs through efficient delivery of high quality programs and services. Information obtained through this review has highlighted strengths in the current programs, as well as opportunities for enhancement, expansion, and greater integration and efficiency.

The Agora Group team that conducted this program review wants to make it clear that most of the ideas for program enhancements or change that are put forward in this report came from personnel in the programs themselves, from their service partners and from clients whose suggestions were accompanied by statements of their admiration for the accomplishments of the NHS Addictions Service.

Managers and front line staff within the NHS Addictions Service exhibit justified pride in what they do, as well as eagerness to make NHS addictions programs even stronger than they currently are.

This program review is a statement of how to help meet aspirations long held by NHS Addictions Service staff and their partners, to make good programs even better.

A few words about this report's terminology will help the reader:

- This report uses the term **the NHS Addictions Service** to mean all addictions programs operated by the Niagara Health System, plus the administrative and support infrastructure directly involved in operating these programs.
- The report uses the plural word **"addictions"** wherever possible, to emphasize that addictions are not a monolithic whole. There are many addictions, each with its own unique characteristics. A discussion of the basic meaning of the term "addictions" is found in section 4 of this report.

It should also be pointed out that many of the changes and service augmentations suggested in this report will require new funding. This report believes this funding is justified, based on the personal, family and societal impact of addictions, and based on the savings and service improvements that would accrue to other hospital services, other health services, and broader community services that foster the well-being of people who live in Niagara Region.

EXECUTIVE SUMMARY

The Niagara Health System (NHS) is planning for enhanced alignment of its addictions programs, which include programs located in St. Catharines, Port Colborne and Fort Erie. Within its umbrella of addiction services, the NHS Addictions Service provides a strong continuum of care and support. NHS addictions programs include withdrawal management, methadone maintenance, problem gambling, intensive intervention for new mothers and access to primary care, and short-term residential treatment. Gender-specific programs reflect local population needs.

The NHS articulated vision for addiction services is to consolidate services and offer an integrated program approach, creating a centre of excellence in addictions treatment and recovery.

This addictions program review was commissioned to help NHS achieve these outcomes, by providing an independent view of the Niagara Health System's role in addictions services, the quality of current programs, how these programs might change and grow in future, what programs might be added or enhanced, and the connection between NHS addictions programs and other addictions programs, other related programs in the community and other NHS programs.

This program review relied on stakeholder input through interviews and focus groups, a literature review and a best practice review.

The review examined the nature of addiction, concluding that addiction is a health disorder that often manifests itself as a recurring condition that causes or complicates physical and mental health disorders. It is associated with a range of social deficits including homelessness, unemployment or under-employment, poverty, family dysfunction or disintegration, trauma, legal issues and social marginalization resulting from the stigma faced by people with addictions. It imposes substantial personal hardship on people who experience addictions and it imposes significant social costs on Canadian society.

Accordingly, meeting the needs of people with addictions in a person-centred way means meeting their needs directly related to the addiction, but also meeting a host of other health and social needs faced by the people with addictions.

This suggests that the needs of people with addictions cannot be addressed by the NHS Addictions Service without close links with physical and mental health resources within NHS, and close links with addictions services, mental heath services and other services in the broader community. Not all problems of addictions can be solved by the addictions service system, or even by the health and social services system.

Within that framework, the program review report recommends that the Niagara Health System should remain the provider of a range of addictions programs for special or complex need populations that focus on residential treatment and other addictions services (including withdrawal management, short-term residential treatment services, services to women with children and mothers-to-be, and primary care through nurse practitioners). It should limit its direct service to this mandate, while integrating its work with the work of other addictions programs and related programs serving Niagara Region.

In particular its links should be strong with:

- NHS mental health programs, with which it should develop a concurrent disorders plan
- NHS emergency services and urgent care services
- Community Addiction Services of Niagara (CAS-N)
- Community health centres in Niagara Region.

Service integration can be further achieved through the development of an addictions service plan, a mental health service plan, and a combined addictions and mental health service plan developed on a multi-agency basis with strong consumer input, and in a way which is consistent with broad planning parameters established by the Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN) and with provincial directional documents on addiction and mental health.

The report proposes that most NHS addictions programs be relocated into a purpose-built addictions centre, preferably on the grounds of the new St. Catharines hospital. If that is not feasible the site should be in downtown St. Catharines.

The program review report makes the following recommendations about NHS addictions programs:

Problem Gambling Web Site and Community Engagement Program	Divest this program to Community Addiction Services of Niagara
Branscombe House (women's residence)	Divest when feasible and assist it to develop a strategy to remain a residence or become a recovery home
New Port Centre residential treatment	Relocate to the addictions centre: maintain current bed numbers
Women's and Men's Withdrawal Management Services	Relocate to the addictions centre: maintain current bed numbers and augment with day/evening and phone-based withdrawal management, and plan for staged introduction of a medical withdrawal management program
ABC Program	Relocate to the addictions centre: expand its capacity
Nurse Practitioner Primary Care Program	Relocate to the addictions centre: expand its capacity
Methadone Program, St. Catharines	Relocate to the addictions centre
Methadone Program, Fort Erie	Maintain in Fort Erie
Methadone Program, Port Colborne	Relocate to Niagara Falls

The NHS Addictions Service should also consider several program expansions and additions:

- Development of a telephone-based withdrawal management/pre-treatment support/aftercare capacity
- Development of a joint outreach capacity with Community Addiction Services of Niagara in communities beyond St. Catharines where CAS-N already has a presence (rather than setting up separate NHS satellite offices)
- Establishment of an addictions family support services strategy in conjunction with other providers
- Creation of a broader nicotine addiction treatment program to augment nicotine addiction treatment currently offered at the New Port Centre site
- Establishment of a Hepatitis C clinic
- Assistance to the Canadian Hearing Society to help it create a province-wide network to serve hearing impaired people with addictions, with NHS providing residential treatment within that network
- Increasing case-spotting of elderly people with addictions problems who are in NHS beds or programs for non-addiction conditions.
- Working with all NHS departments to foster early intervention and referral for addictions services.

This report also suggests that the NHS Addictions Service should foster an internal debate on three tensions within its programs:

- Client choice, and client responsibility
- The nature of appropriate clinical supervisions within NHS addictions programs
- Experiential competence, and academic competence.

The report proposes as well that the NHS Addictions Service should:

- Create a Consumer Advisory Committee
- Put in place measures to support NHS addictions counsellors who wish to pursue certification
- Engage staff in developing and shaping opportunities and material to promote greater understanding of addictions programs within and beyond NHS.

As part of its approach to integration, NHS should work in partnership with other service providers to create and implement:

- A Niagara-wide addictions screening strategy
- A strategy for timely high quality assessments, re-assessments and referrals of people living with addictions
- A common categorization of concurrent disorders, followed by a plan (also with community partners) to produce either program integration or system integration to serve people with concurrent disorders.
- Service agreements in areas where collaboration exists or is under development. These service agreements may include agreements with specialized services elsewhere in the Hamilton Niagara Haldimand Brant LHIN, and may also include

service protocols between NHS addictions programs and other NHS programs such as mental health and emergency services.

As well, NHS addictions programs, mental health programs, emergency departments and urgent care centres should collaboratively develop a joint plan for providing addictions and mental health support in NHS emergency departments and urgent care centres.

The report proposes that the NHS Addictions Service should work with others to pursue a ***system*** of excellence, and not merely an NHS ***centre*** of excellence, in addictions service.

List of Recommendations

Recommendation #1(please see page 37)**:** The Niagara Health System should remain the provider of a range of addictions programs for special or complex need populations that focus on residential treatment and other addictions services (including withdrawal management, short-term residential treatment services, services to women with children and mothers-to-be, and primary care through nurse practitioners).

Recommendation #2 (please see page 37)**:** The NHS Addictions Service should divest its Problem Gambling Web Site and Community Engagement Program to Community Addiction Services of Niagara.

Recommendation #3 (please see page 38)**:** The Niagara Health System should develop a strategy to:

- Eventually divest itself of all formal responsibility for Branscombe House
- Assist Branscombe House to develop a strategy for either remaining a residence or becoming a women's recovery home, as an independent entity or as part of a larger organization
- Provide financial assistance to Branscombe House in securing an alternate site, given that its current site will not be available once the NHS Ontario Street site is sold.

Recommendation #4 (please see page 42)**:** The NHS Addictions Service should foster a debate among NHS Addictions Service staff on three tensions that need to be managed so addictions programs can maintain and enhance their quality:

- Client choice, and client responsibility
- The nature of appropriate clinical supervisions within the NHS Addictions Service
- Experiential competence, and academic competence.

Recommendation #5 (please see page 44)**:** The NHS Addictions Service should create and support a Consumer Advisory Committee whose Chair and members are all former or current consumers who have never worked as addictions program staff. The NHS Addictions Service should also set in place a process for occasional consultation with family members of people with addictions on service operation and design issues.

Recommendation #6 (please see page 45)**:** The NHS Addictions Service should put in place measures to support NHS addictions counsellors who wish to pursue certification. All newly hired addictions counsellors should be certified, or should be actively engaged in achieving certification, as a condition of employment.

Recommendation #7 (please see page 45)**:** The NHS Addictions Service should consider re-locating its Port Colborne methadone clinic to Niagara Falls.

Recommendation #8 (please see page 48)**:** The Niagara Health System should develop strategic plan components for its addictions services, its mental health services, for both components combined, and for integration of these components with other NHS services (including but not limited to emergency and urgent care services), ensuring that consumers and non-hospital service providers are engaged in this planning and incorporating the findings of the addictions services review into the planning.

Recommendation #9 (please see page 48)**:** The NHS Addictions Service should act as a catalyst and partner in initiating and carrying out Niagara-wide strategic planning for addictions services, mental health services and both components combined, and should help ensure that consumers and community service providers (including but not limited to health sector providers) are engaged as full partners in the planning.

Recommendation #10 (please see page 50)**:** The NHS Addictions Service should work in partnership with others to create and implement a Niagara-wide addictions screening strategy. The NHS Addictions Service should also help other hospital programs that encounter people facing negative and physical consequences of addiction to include screening for addiction as part of their core activities.

Recommendation #11 (please see page 51)**:** The NHS Addictions Service should work with other addictions service partners to develop a strategy for timely high quality assessments, re-assessments and referrals of people living with addictions. This strategy should be informed by knowledge about how mental health assessments and referrals are conducted (and should be conducted) in Niagara Region, so that opportunities for integrated assessments and referrals can be maintained or enhanced.

Recommendation #12 (please see page 52): The NHS Addictions Service should engage staff in developing and shaping opportunities and material to promote greater understanding of addictions programs by people within the addictions service system and by people beyond the system.

Recommendation #13 (please see page 55)**:** The NHS Addictions Service and NHS mental health programs, working together with their community partners, should develop a common categorization of concurrent disorders, then develop a plan (also with their community partners) to produce either program integration or system integration to serve people with concurrent disorders.

Recommendation #14 (please see page 57)**:** The NHS Addictions Service, NHS mental health programs, NHS emergency departments and NHS urgent care centres should collaboratively develop a joint plan for providing addictions and mental health support in NHS emergency departments and urgent care centres. In terms of addictions service support, this should involve provision of (and/or support for) screening, brief motivational counselling services and referral.

Recommendation #15 (please see page 59)**:** The NHS Addictions Service should work with community partners to develop service agreements in areas where collaboration exists or is under development. These service agreements may include agreements with specialized service elsewhere in the Hamilton Niagara Haldimand Brant LHIN, and may also include service protocols between the NHS Addictions Service and other NHS programs such as mental health and emergency services.

Recommendation #16 (please see page 60)**:** Officials from the NHS Addictions Service and NHS mental health programs should meet with officials of Niagara Region's four community health centres to explore programmatic cooperation. A representative of Community Addiction Services of Niagara should also be invited to the meeting.

Recommendation #17 (please see page 61)**:** The NHS Addictions Service should work with Community Addiction Services of Niagara, with NHS mental health programs and with any other potential partners (including NHS emergency departments and urgent care centres) to develop integrated service outreach sites in Fort Erie, Niagara Falls, Welland, Port Colborne and Grimsby.

Recommendation #18 (please see page 63)**:** The NHS Addictions Service should initiate a change process in pursuit of excellence, starting with a specification of what it needs in order to achieve excellent inputs, processes and outcomes.

Recommendation #19 (please see page 63)**:** The NHS Addictions Service should consider reframing the "**centre** of excellence" model so it becomes a "**system** of excellence" model for addictions, or for addictions and mental health, in Niagara Region.

Recommendation #20 (please see page 65)**:** NHS addictions programs should be located in a purpose-designed building on the grounds of the new NHS St. Catharines hospital. If this is not feasible or acceptable, NHS addictions programs should be located in a purpose-designed building in downtown St. Catharines. The following programs (along with NHS Addictions Service administrative offices and centralized building/program support services) would be located in the addictions centre:

- The Women's Withdrawal Management Service
- The Men's Withdrawal Management Service
- The Short-Term Residential Treatment Program (New Port Centre)
- The ABC Women's/Early Childhood Development program
- The Nurse Practitioner Primary Care Program
- The Out and About Methadone Program
- Any other specialized addictions-related programs added to the NHS Addictions Service portfolio (for example, a hepatitis C clinic).

Recommendation #21 (please see page 77)**:** The NHS Addictions Service should not increase the number of residential service beds it provides between now and 2019. However, alternative forms of withdrawal management should be added to its service portfolio, and expansion of the capacity of the ABC Program is warranted. As well, the workload of the Nurse Practitioner Primary Care Program has exceeded original expectations and it should be expanded.

Recommendation #22 (please see page 82)**:** The NHS Addictions Service should develop a day/evening withdrawal management program, it should explore the creation of telephone-based withdrawal management, and it should develop a phased plan for developing medical withdrawal management services.

Recommendation #23 (please see page 84)**:** The NHS Addictions Service should expand the use of telephone-based methods of providing pre-treatment and post treatment support as well as family support, should develop staff and/or volunteer competence in using telephone-based techniques, and should help to create a body of knowledge in telephone-based techniques.

Recommendation #24 (please see page 86)**:** The NHS Addictions Service should work with other addictions agencies in Niagara and with other Niagara service sectors such as mental health services, distress lines and child and family services to develop a family assistance plan focusing on families who have members living with addictions. Within the context of this plan, The NHS Addictions Service should then develop family programming that is consistent with the family assistance plan.

Recommendation #25 (please see page 87)**:** The NHS Addictions Service should create a nicotine addiction treatment program, to be provided initially to NHS clients under treatment for other addictions, but with the later possibility of:

- Opening this program to people who are not under NHS treatment for other addictions, or
- Working with other addictions agencies to help create an additional nicotine addiction treatment program that could be provided in/for other agencies.

Recommendation #26 (please see page 88)**:** The NHS Addictions Service should create a Hepatitis C Virus (HCV) Team, to improve access to care and treatment for patients with Hepatitis C.

Recommendation #27 (please see page 90)**:** The NHS Addictions Service should explore, with the Canadian Hearing Society's CONNECT Counselling service, the development of a sub-program within NHS's residential addictions treatment program to serve people who people who are Deaf, deafened and hard of hearing. This sub-program would be linked to community addictions programming to be provided by CONNECT Counselling in communities across Ontario.

Recommendation #28 (please see page 90)**:** The NHS Addictions Service should be an active and supportive partner in planning for future addictions services for elderly people in Niagara Region, and should enhance, if necessary, its case-spotting activities within the hospital to identify elderly people who enter hospital because of physical or mental health problems, but who have underlying addictions issues that cause or exacerbate their physical or mental health conditions.

Recommendation #29 (please see page 91)**:** The NHS Addictions Service should work with other NHS departments and programs to raise their awareness of addictions problems, provide these departments with tools to identify patients with early addictions, and help these departments to inform patients of options available to them to deal with their addictions.

1. INTRODUCTION

The deliverable for this project is a report with recommendations for the NHS operated services related to the future state of addictions services in Niagara (e.g., what services are required to meet healthcare needs of the population, how should they be organized, and who should provide the services).

The Niagara Health System (NHS) is planning for enhanced alignment of its addiction services, which include programs located in St. Catharines, Port Colborne and Fort Erie. Within its umbrella of addiction services, NHS provides a strong continuum of care and support. NHS programs include withdrawal management, methadone maintenance, problem gambling, intensive intervention for new mothers, access to primary care and short-term residential treatment. Gender-specific programs reflect local population specific needs.

The NHS articulated vision for addiction services is to consolidate services and offer an integrated program approach, creating a centre of excellence model. The benefits of this approach have been documented as part of the NHS Hospital Improvement Plan and include improved care delivery and improved efficiency of operation to allow for greater investment into delivery capacity. A Revised Addendum to the Hospital Improvement Plan proposed an NHS centre of excellence in addictions services to help to attract and retain health professions. Satellite services in Niagara's communities were also recommended in the Revised Addendum and were considered as part of this program review.

To support the consolidation of services onto one site, NHS has completed a functional plan that provides a thorough overview of the programs and their related space and staffing requirements. However other information and data were acquired through interviews, focus groups, document reviews and best practice reviews.

The review focuses on the following elements:

- Future population needs for addiction services
- Evidence based approaches to providing addiction services
- Identification of size and scope of services required
- Alignment within the Niagara Haldimand Brant Local Health Integration Network (LHIN)[1] strategic directions for mental health and addictions and the LHIN's Clinical Service Plan
- Confirmation of the preferred future model of service delivery based on population and referral population, NHS mandate, and optimal alignment with other providers of addiction services.

[1] The Hamilton Niagara Haldimand Brant Local Health Integration Network also serves Burlington and most of Norfolk County.

2. THE FRAMEWORK USED IN THIS REVIEW

This review based its information-gathering and analysis on five characteristics of program and system health:

1. Quality
2. Cohesion/integration
3. Efficiency
4. Capacity
5. Sustainability.

Quality means a high degree of benefit from, and accountability for, a service, with least harm to users and providers of the service and a high degree of timely access to the service for those who can benefit from it.

Cohesion/integration means the parts of a service or system work together to achieve the highest possible quality and efficiency of the service or system.

Efficiency means the provision of service at the lowest possible resource cost that is needed to provide the desired level of service quality and cohesion.

Capacity means the maximum amount and quality of service that can be provided by a service within the resource level available to it.

Sustainability is the degree to which a service can maintain desired levels of quality, cohesion and efficiency into the future.

These concepts formed the basis of project tools. However, to keep stakeholder engagement tools manageably simple, “capacity “and “sustainability” were considered to be sub-sets of “efficiency” (an efficient program or system can save resources that allow it to invest the savings in increased capacity; and an efficient program or system is more sustainable because it requires fewer resources than an inefficient program or system).

The review also recognized three levels at which quality, cohesion/integration and efficiency can be exhibited:

1. At the level of services **within NHS**
2. At the level of services **within Niagara Region**
3. At the level of services **within the Hamilton Niagara Haldimand Brant LHIN**.

While the review recognizes that quality, cohesion/integration and efficiency can also be exhibited at provincial, national and international levels, these levels were considered too distant for the purposes of this review to be used as major analytical levels in the review (even though provincial, national and international documents were reviewed for purposes of context).

3. THE TOOLS USED IN THIS REVIEW

This review relied on the following tools:

- **Interviews with key stakeholders.** Interviews were held with eleven people who work within the NHS Addictions Service, five people who work in other NHS programs or administrative areas, five people involved in addictions, mental health or related service delivery in other Niagara agencies, two people involved in addictions service provision in Hamilton and two people on the staff of the Hamilton Niagara Haldimand Brant LHIN.
- **Five focus groups**, held with former clients of the NHS Addictions Service (one focus group in Port Colborne and one in St. Catharines), with Niagara Addictions Service Program Advisory Committee members, with staff of NHS addictions programs in Port Colborne and with staff of NHS addictions programs in St. Catharines.
- **Review of local, regional, provincial, national and international documents describing addictions services and their relationship to other services.** Appendix Two summarizes a number of documents from NHS, from the LHIN and from provincial bodies that will shape addictions services in NHS.
- **Review of best and promising practices related to addictions services.** This review included an examination of addictions service best practices published by Health Canada, best practices identified in the Substance Abuse and Mental Health Services Administration Treatment Improvement Protocols (TIPS) series, selections from the National Institute for Clinical Excellence (NICE) best practices data base, and selected other best practices identified through an internet search.

4. CONTEXT: THE NATURE OF ADDICTIONS

This review's starting point is the people who experience addictions, and the nature of the problems they face.

This review uses the word "addiction" to mean a person's repeated use of substances, or repeated exhibition of certain behaviours such as gambling, that damage them or those around them, and which are difficult for the person to cease or curtail. We use the word "addiction" with the knowledge that the word is often used in a more restricted sense, to refer only to the most severe forms of substance use or behaviours – forms that are also sometimes called "dependence", characterized by:

- Seeking behaviour (for instance, only going to social events that will include using the substance/exhibiting the behaviour or only hanging out with others who use the substance/exhibit the behaviour)
- Tolerance (having to make use of increasing amounts of the substance/behaviour to achieve previous effects)
- Withdrawal symptoms (getting physical symptoms after going a short period without using the substance/exhibiting the behaviour)
- Using the substance/exhibiting the behaviour to relieve or avoid withdrawal symptoms (such as drinking to stop the shakes or to cure a hangover)
- Subjective awareness of the compulsion to use the substance/exhibit the behaviour or craving the substance/behaviour (whether they admit it to others or not)
- A return to using the substance/exhibiting the behaviour after a period of abstinence (such as deciding to quit drinking and not being able to follow through).

From a medical perspective, 47 substance use problems are defined and described within the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-TR, 2000) grouped into 12 classes:

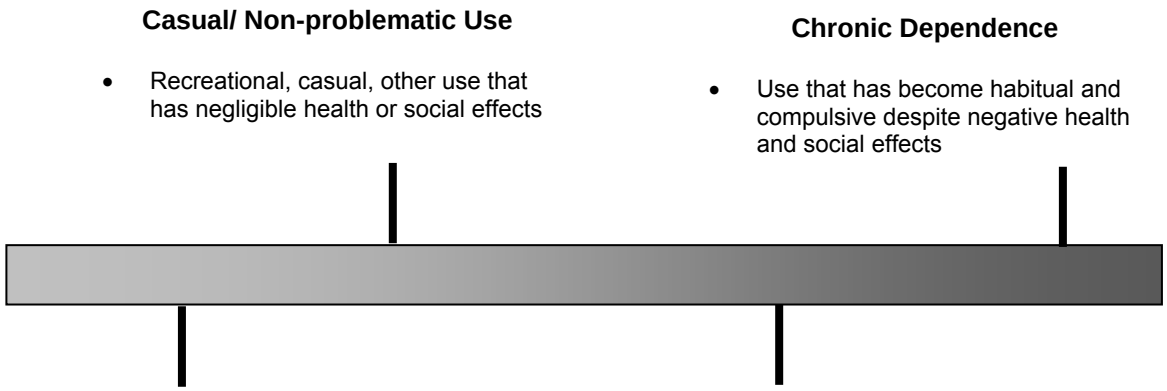
1. Alcohol
2. Amphetamine or similarly acting sympathomimetics
3. Caffeine
4. Cannabis
5. Cocaine
6. Hallucinogens
7. Inhalants
8. Nicotine
9. Opioids
10. Phencyclidine (PCP) or similarly acting arylcyclohexylamines
11. Sedatives, hypnotics, or anxiolytics
12. Polysubstance dependence and other or unknown substance–related disorders (which include most disorders related to medications or toxins).

Although the term "gambling addiction" is commonly used, pathological gambling is considered in DSM-IV-TR to be an impulse control disorder rather than an addiction.

The public health perspective uses another way to look at what this review calls "addictions", positioning addiction within a harm framework (and by extension, a harm reduction framework). The graphic below shows this way of looking at addictions, with specific reference to substance use (but applicable to non-substance behaviours such as problem gambling as well).

Spectrum of Psychoactive Substance Use

Adapted From *Every Door is the Right Door: a British Columbia planning framework to address problematic substance use and addiction*. British Columbia Ministry of Health Services. 2004



Casual/ Non-problematic Use

- Recreational, casual, other use that has negligible health or social effects

Chronic Dependence

- Use that has become habitual and compulsive despite negative health and social effects

Beneficial Use

- Use that has positive health, social, or spiritual effects, e.g. medical psychopharmaceuticals; coffee/tea to increase alertness; moderate consumption of red wine; sacramental use of peyote

Problematic Use

- Use that begins to have negative consequences for the individual, friends/family, or society

The concept of harm to self or others is a key element in the definition of addiction used in this review. Extensive work has been done in many jurisdictions to measure the degree of harm, both to health and to other forms of well-being such as social and economic well-being. For instance, a recent Canadian assessment related to health harm has shown the following:

"Single et al compared the deaths and diseases caused by alcohol, tobacco and illegal drug use in Canada. They found that alcohol tobacco and illegal drugs accounted for 20.0% of all deaths, 22.2% of years of all potential life lost and 9.4% of all admissions to hospital in Canada in 1995… Of all substance attributable mortality, tobacco was by far the largest contributor, making up 83% of deaths, while alcohol accounted for 16% and illegal drugs only 2% respectively. The PYLL (potential years of life lost) proportions reflect the younger age profile of deaths due to illegal drugs and to alcohol-related injuries, with alcohol making up 24% of PYLL, illegal drugs 5% and tobacco 71%. By any measure tobacco is the dominant contributor to health related harms."

A Public Health Approach to Drug Control in Canada: Discussion Paper. **Health Officers Council of British Columbia, October 2005**

1995 Mortality and Morbidity due to Illegal Drugs, Alcohol, and Tobacco in Canada	# of deaths	% of deaths	# of hospital admissions	% of hospital admissions	# of potential years of life lost (PYLL)	% of potential years of life lost (PYLL)
Alcohol	6,507	3.1	82,014	2.7	172,126	5.4
Tobacco	34,728	16.5	193,772	6.5	500,350	15.7
Illegal Drugs	805	0.4	6,940	0.2	33,662	1.1
TOTAL	42,040	20.0	282,726	9.4	706,138	22.2

Source: *A Public Health Approach to Drug Control in Canada: Discussion Paper.* Health Officers Council of British Columbia, October 2005, adapted from Single, E., et al. (2000). *The relative risks and etiologic fractions of different causes of death and disease attributable to alcohol, tobacco, and illicit drug use in Canada*. Canadian Medical Association Journal, 162(12).

The number of health problems caused by (or in part attributable to) addictions is large. A recent UK study on heavy alcohol use[2], for instance, identified:

- Eleven health conditions attributable wholly to alcohol (methanol and ethanol poisoning, mental and behavioural disorders due to alcohol, degeneration of nervous system due to alcohol, alcohol-induced pseudo-Cushing's syndrome, alcoholic polyneuropathy, alcoholic myopathy, alcoholic liver disease, alcoholic gastritis, alcoholic cardiomyopathy and accidental poisoning by and exposure to alcohol)
- Thirty-seven health conditions or misadventures in which the use of alcohol is a contributing factor (most notably chronic pancreatitis, assault, chronic liver disease, drowning, fire injuries, food obstructing the respiratory tract, malignant neoplasms of the larynx and lips, oesophageal varices and tuberculosis).

Alcohol is also recognized as a contributing factor in diabetes, female breast cancer and male colorectal cancer, and as a probable contributing factor to liver cancer and female colorectal cancer. A 2008 cancer fact sheet from Cancer Care Ontario (CCO) stated that alcohol consumption caused an estimated 6,160 new cases of alcohol-related cancers between 2000 and 2004 in Ontario, representing 7.3% of these cancers. CCO further notes that *"If the proportion of people consuming alcohol in Ontario were to be reduced by half, an estimated 3.5% of alcohol-related cancers could be eliminated each year, translating into approximately 3,000 less cases over a 5-year period."*[3]

Drinking during pregnancy can result in Fetal Alcohol Spectrum Disorder (FASD), comprising a range of physiological and neurological disabilities. Health Canada identifies FASD as the leading cause of developmental delay among Canadian children.[4]

Illicit drug use also produces unwanted health outcomes because of the substance used, the method of ingestion of the substance, or as a result of behaviour while under the influence of such drugs. These health consequences include abnormal heart rate, heart

[2] *Indications of Public Health in the English Regions: Alcohol*. Association of Public Health Observatories, August 2007
[3] *Cancer Fact: Alcohol consumption and cancer risk.* Cancer Care Ontario, Feb. 2008.
[4] *Health Canada. Fetal alcohol spectrum disorder: a framework for action.* Health Canada, 2003.

attacks, collapsed veins, bacterial infections of the blood vessels and heart valves, bronchitis, emphysema, lung cancer, exacerbated asthma symptoms, kidney damage or failure including hepatitis B and C, AIDS/HIV infection, strokes, paranoia, depression, aggression, hallucinations, infertility, cancer of the mouth, neck, stomach, and lung, premature birth, miscarriage, low birth weight, malnutrition, and intentional or unintentional self-harm including suicide and accidents.[5]

A World Health Organization review of drug-related mortality and morbidity notes that:

> "Illicit drug users have elevated rates of four main causes of premature death by comparison with age peers who do not use illicit drugs, namely, drug overdose, HIV/AIDS, suicide and trauma (including homicide, motor vehicle accidents and other forms of accidental death… There is little good evidence that allows quantification of the morbidity related to the use of illicit drugs, and it is not possible to make estimates of the burden of disease caused by morbidity resulting from illicit drug use."[6]

In terms of illicit drugs of choice for illicit drug users in Canada in 2008, cannabis was the most common drug of choice.

Annual prevalence of use as a percentage of the population aged 15-64, Canada, 2008[7]	
cannabis	13.6%
cocaine	1.9%
ecstasy	1.7%
amphetamines	1.5%
opiates	0.50%

However, treatment for illicit drug use in Ontario in 2009 showed that cocaine and opiates, while less prevalently used in the general population, figure more prominently in terms of primary drug abuse within Ontario's treatment population.

Primary drug of abuse among persons treated for drug problems in Ontario, 2009[4]	
cocaine	37.8%
cannabis	31.7%
opiates	18.5%
amphetamines	2.9%
ecstasy	2.7%

Use of nicotine exceeds the health toll of any other addiction. It causes or contributes to illness and death from lung cancer, cancer of the oesophagus and otolarynx, stomach cancer, liver cancer, chronic obstructive pulmonary disease, respiratory tuberculosis, stroke and ischemic heart disease.[8]

---

[5] *Medical Consequences of Drug Abuse*, National Institute on Drug Abuse, http://drugabuse.gov/consequences/index.html

[6] *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*: Chapter 13: Illicit Drug Use. World Health Organization, 2004.

[7] Source: *World Drug Report 2010*. United Nations Office on Drugs and Crime, 2010

[8] *Comparative Quantification of Health Risks: Global and Regional Burden of Disease Attributable to Selected Major Risk Factors*: Chapter 11: Smoking and Tobacco Use. World Health

The overall social burden imposed in Canada by problematic substance use is large:

> "Measured in terms of the burden on services such as health care and law enforcement, and the loss of productivity in the workplace or at home resulting from premature death and disability, the overall social cost of substance abuse in Canada in 2002 was estimated to be $39.8 billion. This estimate is broken down into four major categories in Figure 1. This overall estimate represents a cost of $1,267 to every man, woman and child in Canada, as indicated according to substance in Figure 2."[9]

Figure 1: Costs attributable to substance abuse by cost category in Canada, 2002[5]

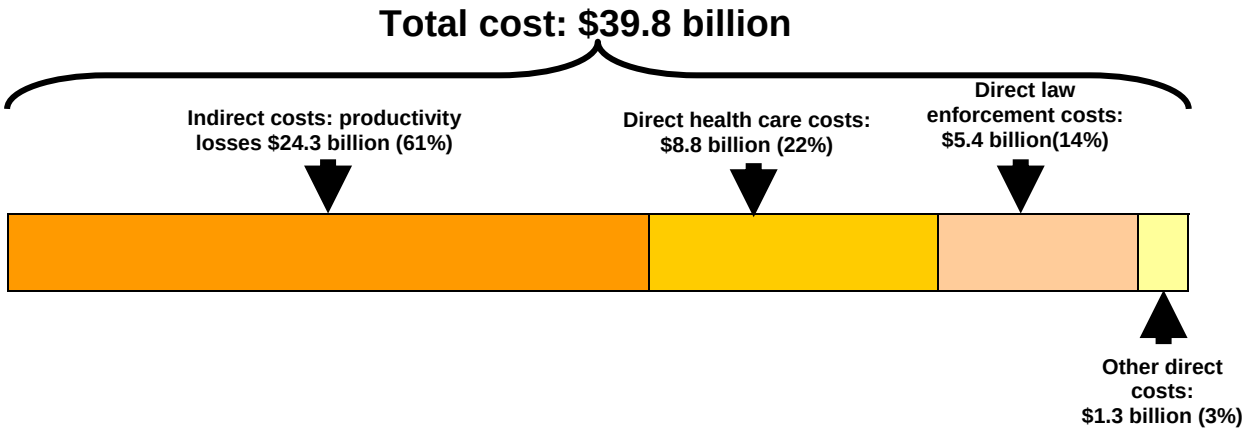
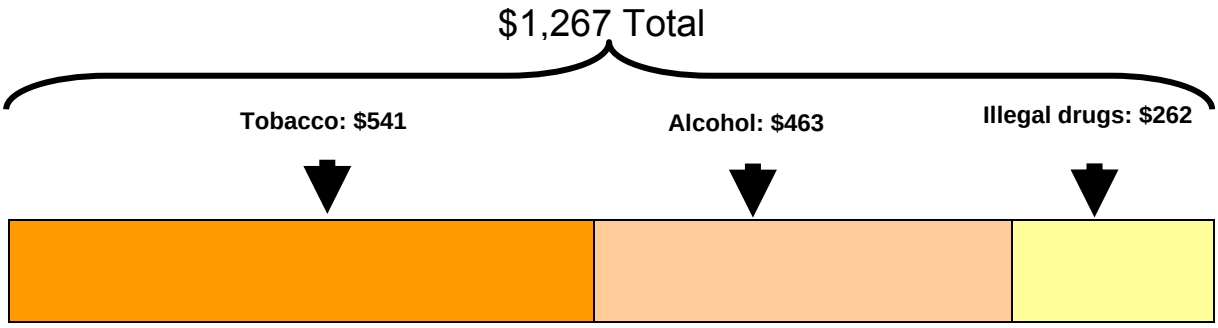


Figure 2: Per capita costs of substance abuse in Canada, 2002[10]



Organization, 2004.

[9] *The Costs of Substance Abuse In Canada 2002: Highlights.* Canadian Centre on Substance Abuse, 2006

[10] *The Costs of Substance Abuse In Canada 2002: Highlights.* Canadian Centre on Substance Abuse, 2006

"The impact of substance use and abuse on Canadian society in terms of health care, law enforcement, loss of productivity, research, prevention, well-being and safety of individuals and communities is increasingly significant. A recent study on the costs of substance abuse in Canada found that the total annual cost in 2002 reached $39.8 billion. Tobacco accounted for 42.7% ($17 billion) of that amount, followed by alcohol at 36.6% ($14.6 billion) and illegal drugs at 20.7% ($8.2 billion). The study's authors call attention to the fact that "behind this dollar figure is a dramatic toll measured in tens of thousands of deaths, hundreds of thousands of years of productive life lost, and millions of days spent in hospital." The study also reveals that deaths and illness resulting from the use of illicit substances have substantially increased in the last decade. In 2002, a total of 1,695 Canadians died as a result of using an illicit substance. The leading cause of death was a drug overdose (958 deaths) followed by drug-attributable suicide (295), and drug-attributable Hepatitis C (165) and HIV (87).

***Substance Abuse Issues and Public Policy in Canada: IV. Prevalence of Use and its Consequences.* Chantal Collin, Political and Social Affairs Division, Library of Parliament, 2006**

In short, addiction is a health disorder that often manifests itself as a recurring condition that causes or complicates other physical and mental health disorders. It is associated with a range of social deficits including homelessness, unemployment or under-employment, poverty, family dysfunction or disintegration, trauma, legal issues and social marginalization resulting from the stigma still faced by people with addictions. It imposes substantial personal hardship on people who experience addictions and it imposes substantial social costs on Canadian society.

Accordingly, meeting the needs of people with addictions in a person-centred way means meeting their needs directly related to the addiction, but also meeting a host of other health and social needs faced by the people with addictions.

This suggests that the needs of people with addictions cannot be addressed by the NHS Addictions Service without close links with physical and mental health resources within NHS, and close links with addictions services, mental heath services and other services in the broader community. Not all problems of addictions can be solved by the addictions service system, or even by the health and social services system.

4.1 Women and Addictions

Research reviewed by Health Canada demonstrates that women manifest addictions differently than men.

"Recent Canadian research (Health Canada, 1995; Health Canada, 1997, Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) identifies the following patterns of substance use among women.

- Alcohol is the most common substance used and misused by women.
- Women, in comparison with men, are less likely to be current drinkers, and more likely to be former drinkers or lifetime abstainers.
- Women who are current drinkers drink less frequently and consume smaller amounts than men who are current drinkers.
- The proportion of women who completely abstain from alcohol is decreasing.
- Among women who are current drinkers, 6.2% report the occurrence of an alcohol-related problem in the past year.
- The most common problem women associate with "problem" alcohol use is related to impacts on physical health.
- Women most frequently drink with a spouse or partner.
- Women who drink a higher number of drinks per occasion tend to:
  - be younger;
  - have lower educational attainment;
  - have lower incomes;
  - be single or divorced;
  - be unemployed, a student or in a blue collar job.
- Women who report drinking more frequently tend to:
  - be older;
  - have higher educational attainment;
  - have higher incomes;
  - be single or divorced;
  - hold blue collar or managerial positions.
- In any age group, women are more likely than men to report the use of medications, especially psychoactive medications such as sleeping pills, tranquillizers and anti-depressants. The age categories reporting the heaviest use are 45 to 54 and 65+.
- Marijuana and hashish are the most common drugs used illegally by women.
- Except for marijuana, lifetime illegal use of drugs is relatively rare among Canadian women. Illegal use of drugs decreases with age and is almost non-existent after age 45.
- Cocaine, crack, LSD, amphetamines and heroin are used primarily by sub-group populations (e.g. street involved women). Because general population surveys usually miss these groups, the overall use of these drugs may be under-reported."

***Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems*. Health Canada, 2001**

Research reviewed by Health Canada also suggests that addictions can inflict a heavier toll on women than on men, and that women with addictions are more likely to have experienced childhood sexual abuse and victimization than the general population.

"Substance use impacts on women in a variety of ways, many unique to gender. A review of the literature suggests the following general themes:

- **The physical health of women is affected more severely and in a shorter period of time by intensive substance use** (in comparison to men). Women reach higher peak blood alcohol levels than men from equal doses per pound of body weight. Hill (as cited in Schliebner, 1994) reported that the average duration of excessive drinking before first signs of liver disorders, hypertension, obesity, anemia, malnutrition, gastrointestinal hemorrhage and ulcers requiring surgery is much shorter for women than for men). Other health effects include risk of HIV, osteoporosis and coronary disease. Physiological differences between men and women also make women more vulnerable to health effects of other drugs such as tobacco and benzodiazepines.
- **Women's reproductive physiology is uniquely affected by substance misuse.** Excessive drinking can affect the menstrual cycle, fetal development, child birth, menopause and sexual responsiveness.
- **Among women, mental health disorders are commonly associated with and exacerbated by intensive substance use.** Almost two thirds of women alcoholics have mental health problems. The most common disorders are anxiety, depression, phobias and panic disorders. Women alcoholics also report experiencing more depressive symptoms than male alcoholics physiologically (although alcohol itself has a depressant effect). However, depressive symptoms may persist after sobriety
- **Women who misuse substances are at high risk for suicide ideation and completion**
- **Women who misuse substances commonly experience sexual dysfunction.** Prevalence estimates of sexual dysfunction range from 20% to 100% depending on research. According to Wilsnack et al, sexual dysfunction in women is one of the strongest predictors of continued problem drinking. Impacts of substances on sexual functioning may vary according to the substances used.
- **Women who misuse substances typically experience low self-esteem**
- **Other health disorders are associated with women who misuse substances.** Eating disorders, particularly bulimia, frequently occur concurrently with alcohol problems

Specific characteristics appear to be associated with women who misuse alcohol or drugs. These are causative, rather than associated factors:

- **High rate of childhood sexual abuse.** The rate of historic sexual abuse is higher in women with drinking problems than in the general population. Estimates of the prevalence of incest, for example, range from 12% to 31%.
- **High rate of victimization.** Women who misuse alcohol are likely to have had a history of victimization in general (including physical violence). In a study of 472 women (ages 18 - 45), Miller et al. (1993) concluded that there is a strong linkage between victimization and the development of adult alcohol problems.

One of the most important differences between men and women is that they identify different reasons for using drugs or alcohol. Women typically see drugs/alcohol use as a method of coping with specific crises or personal problems. This perception determines their definition of 'problem,' identification of needs and their approach to seeking help."

***Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems*. Health Canada, 2001**

4.2 Concurrent Disorders

The term “concurrent disorders” refers to any combination of mental health and substance use disorders.

In Ontario, concurrent addiction problems are estimated to range from 15% to 45% among those receiving mental health services. Concurrent mental health problems are estimated to range from 75% to 100% among those receiving substance use services.[11]

Mental health services are generally more likely to see people with serious mental illness such as psychosis, while addictions services are more likely to see people with affective, anxiety and personality disorders.[12]

There is also evidence that the likelihood of having a concurrent mental health disorder increases with the number of substances used.[13]

[11] Rush, B. *Presentation to the Standing Senate Committee on Social Affairs, Science & Technology*, 2004

[12] *Current Practice in Management of Clients with Comorbid Mental Health and Substance Use Disorder in Tertiary Care Settings*. Commonwealth Department of Health and Aging. National Drug Strategy and National Mental Health Strategy – National Comorbidity Project. Government of Australia. 2003

[13] *Substance Abuse Treatment for Persons with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) 42*. Center for Substance Abuse Treatment, Substance Abuseand Mental Health Services Administration, 2005

5. CONTEXT: THE POPULATION OF THE REGION OF NIAGARA

In 2006 (the last census year) Niagara Region had a population of 427,421 spread across 12 area municipalities. A more detailed description of Niagara Region's demographics is found in Appendix One. As well, Section 14 of this review relates some of Niagara's socio-demographic characteristics to the calculation of projected future NHS program need.

Communities (least populous to most populous)	Population, 2006 census	Population aged 0-14 (%)	Population aged 65+ (%)	Median earnings, persons aged 15+ ($)	2001 to 2006 population change (%)
Township of Wainfleet	6,601	17.4%	13.9%	$26,384	5.5%
Township of West Lincoln	13,167	22.9%	10.0%	$27,865	7.3%
Town of Niagara-on-the-Lake	14,587	13.8%	24.1%	$22,440	5.4%
Town of Pelham	16,155	17.0%	16.6%	$31,056	5.8%
City of Thorold	18,224	17.6%	14.4%	$27,670	1.0%
Town of Port Colborne	18,599	15.1%	21.3%	$23,460	0.8%
Town of Lincoln	21,722	19.3%	17.4%	$26,350	5.4%
Town of Grimsby	23,937	18.0%	15.4%	$33,412	12.4%
Town of Fort Erie	29,925	16.6%	17.9%	$23,430	6.3%
City of Welland	50,330	16.7%	16.8%	$26,015	4.0%
City of Niagara Falls	82,184	16.7%	17.1%	$24,614	4.3%
City of St. Catharines	131,989	16.2%	18.0%	$24,345	2.2%
Total, Regional Municipality of Niagara	**427,421**	**16.8%**	**17.4%**	**$25,108**	**4.1%**

Source: Statistics Canada, 2006 Census of Population (does not incorporate a census under-count adjustment)

St. Catharines is the largest community in Niagara Region, comprising 30.1% of total population. The three largest communities (St. Catharines, Niagara Falls and Welland) comprise 61% of the Region's population.

In general, municipalities in Niagara Region have slower growth rates, lower incomes, and higher elderly populations than the Hamilton Niagara Haldimand Brant LHIN as a whole and Ontario as a whole. Niagara residents currently have lower incomes, fewer years of education and a higher proportion of seniors living alone, compared to the provincial average. According to the Canadian Community Health Survey, in 2003 Niagara residents displayed slightly higher rates of smoking, obesity and hypertension and lower rates of physical activity and a healthy diet, compared to the provincial average.

Niagara's towns with the highest growth rates and high median earnings (Grimsby and West Lincoln) are equidistant between the major urban concentrations in Niagara and Hamilton, but are more likely to use many pubic and private services in Hamilton than in Niagara Region.

6. CONTEXT: KEY DOCUMENTS SHAPING NIAGARA ADDICTIONS SERVICES

Key documents at three levels will shape the future of addictions services operated by the Niagara Health System:

1. Documents at the level of the Province of Ontario
2. Documents at the level of the Hamilton Niagara Haldimand Brant LHIN
3. Documents at the level of the Niagara Health System or the Region of Niagara.

The documents listed below are described in Appendix Three, along with an analysis of the implications of each document for the NHS addictions program review.

The following are the most relevant documents at the provincial level:

- *Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy: A discussion paper*
- *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (final report of the Ontario Legislature's Select Committee on Mental Health and Addictions)
- *Ontario Health Quality Council Report, Monitor 2010.*

The following are the most relevant documents at the level of the Hamilton Niagara Haldimand Brant LHIN:

- *Integrated Health Service Plan, 2010 – 2013*, Hamilton Niagara Haldimand Brant LHIN
- *Clinical Service Plan*, Hamilton Niagara Haldimand Brant LHIN.

The following are the most relevant Niagara Health System documents:

- *NHS Hospital Improvement Plan* and Related Documents
- *Review of The Niagara Health System Hospital Improvement Plan*
- *Revised Addendum to the Niagara Health System Hospital Improvement Plan.*
- *Niagara Health System Addictions Services Functional Program (2006).*

7. NHS ADDICTIONS PROGRAM PROFILES

The Niagara Health System operates a continuum of addiction services, including residential and day programs, programs with gender specific components, primary care, assessment and support services. These programs are offered at New Port Centre in Port Colborne, in several buildings considered part of the Ontario Street site of the NHS in St. Catharines, and in a methadone maintenance site in Fort Erie. Appendix Three provides schematic views of the Port Colborne and St. Catharines sites.

A key component of the NHS approach is the inclusion of a nurse practitioner providing primary care. This approach helps close the care continuity gap for clients who do not have a regular care provider and provides people with addictions with a proactive approach to their health, including screening, immunizations and health education.

New Port Centre is part of the provincial addictions system, and clients may be referred to New Port from all parts of the province. About 50% of New Port Centre's clients are from beyond Niagara Region. The primary sources of clients overall are the Hamilton Niagara Haldimand Brant LHIN area (including Niagara), Toronto and Waterloo. The majority of women clients at New Port Centre are from Niagara region.

With the exception of New Port Centre, the large majority of clients of NHS addictions programs are from Niagara Region, followed by those from elsewhere in the Hamilton Niagara Haldimand Brant Local Health Integration Network. Over 90 % of all clients in Withdrawal Management Services at the Ontario Street Site are from Niagara.

NHS men's and woman's withdrawal management services operate separately by gender and are located in two adjacent buildings. WMS, or Detox as it is commonly known, is accessible 24/7. As well, the daily support group sessions offered in each house are open to former clients and other members of the community. Some telephone support is provided by staff when they are not otherwise busy with clients.

In addition to this range of supports and services, NHS has been proactive in establishing other programs to support recovery and promote healthy behaviours. These include support for the establishment of Branscombe House, a residential facility supporting women for up to a year as they recover and integrate back into employment and the community. The ABC program – funded as part of the provincial government's Early Years initiative helps new mothers or mothers-to-be and their children aged 0 to 6, enabling good parenting skills while supporting the clients as they address their addictions. In 2008, NHS implemented a tobacco-free environment in all its addictions programs based on evidence that smoking is a gateway addiction. Other initiatives are being explored including programs for people with hearing impairment.

Based on current available information, there are no significant waiting lists for any of the NHS residential addiction programs. There is a lack of benchmarks or planning targets for addictions services and this issue is addressed later in the report (see Section 14), with considerations around projecting future level of need.

The ABC program is oversubscribed, so expansion of both space and staff should be explored by the hospital.

While there is no formal NHS concurrent disorder program, addictions counsellors work within the NHS Mental Health program as required, seeing a total of 296 clients in 2009/10. This service is provided three days a week, operating within all three NHS mental health units, to clients who have indicated a substance abuse problem upon admission and/or when the need is identified by mental health unit nurses or psychiatrists. Treatment plans discussed include possible admission to New Port Centre.

Client satisfaction is measured in most programs, with high ratings by clients. For example in the withdrawal management programs, 97% of respondents indicated that the quality of service was good/excellent. In terms of women's responses, 100% noted that they had learned where to get help. And 97% indicated they were more interested in getting help with their addiction after being served by the Withdrawal Management Program.

Detailed descriptions of NHS addictions programs are provided on the following pages.

7.1 Residential Addictions Programs

7.1.1 Withdrawal Management Men's Program, St. Catharines

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: 18 active	
CLIENTS: • Level 1 – 1155 • Level 2 – 581	Numbers have decreased slightly since 2008 when NHS implemented the tobacco-free program but NHS expects them to rise again
AVERAGE LENGTH OF STAY: • Level 1 – 2.07 days • Level 2 – 3.7 days	
ASSESSMENTS: 186 **STAFF TIME/CLIENT VISIT**: 2.96	
CLIENT COUNTY OF RESIDENCE: • 91% from Niagara • Next largest number from Hamilton.	
AVERAGE OCCUPANCY: • Level 1 – 109% • Level 2 – 54%	Level 2 occupancy was stable at about 90% between 2005/06 and 2007/08. For 2008/09 and 2009/10 occupancy declined to just over 50%.
WAITING LISTS: • See comments	NHS does not keep a WMS waiting list. Admission is deferred if no bed is available (client is asked to call back in a couple of hours).
STAFFING: • Core operation requires minimum of 2 staff per shift • Program Manager – 0.5 • Program staff – 11.22 • Nurse Practitioner: 0.125 between men's and women's per 05/06 report	

SERVICE DESCRIPTION:
• Provide intake, observation, withdrawal management, assessment and referral
• Includes 24/7 access, intensive case management, individual and group counselling.
• Admission criteria:
  • are intoxicated
  • are in withdrawal
  • are in crisis related to alcohol or drug use
• As tobacco is considered a gateway addiction, NHS Addictions Program is tobacco free and treats smoking addiction with the patch, etc.
• Clients arrive any time, day or night, self referred or escorted by family, friend or police (about 10 % are brought by police)
• Clients including post discharge have access to daily support group sessions; also open to others in community and persons waiting for or having completed New Port Centre treatment.
• Clients have access to a nurse practitioner for primary care needs and for acupuncture.
	No on-site security. NHS aims for 'home' type environment for residents.
	
	Less violence than in mental health beds, attributed to the non-institutional feel of the house.
	
	Infrastructure of hospital is important for their operation e.g. meals are provided by/delivered from the hospital.
	
	Staff concern that if service is separated from the hospital it would further isolate addictions as a health care issue
	
	Because of transportation issues in Niagara, the WMS provides taxi chits when necessary.
	
	No home support program but WMS does support some persons via telephone (resources for full telephone follow-up support are not available).

Additional data is collected by NHS related to client demographics (income, education), legal status of clients, client satisfaction, and primary diagnosis at time of admission.

7.1.2 Withdrawal Management Women's Program, St. Catharines

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: 14 active	
CLIENTS: • Level 1 – 511 • Level 2 – 241	Numbers have decreased slightly since 2008 when NHS implemented the tobacco-free program but NHS expects them to rise again.
AVERAGE LENGTH OF STAY: • Level 1 – 2.17 days • Level 2 – 3.39 days	
ASSESSMENTS: 90 **STAFF TIME/CLIENT VISIT:** 3.31	
CLIENT COUNTY OF RESIDENCE: • 92 % from Niagara • Next largest number from Hamilton.	
AVERAGE OCCUPANCY: • Level 1 – 76 % • Level 2 – 37 %	Level 2 occupancy was stable at about 60 % between 2005/06 and 2007/08. For 2008/09 and 2009/10 occupancy declined to below 40%.
WAITING LISTS: see comments	NHS does not keep a WMS waiting list. Admission is deferred if no bed is available (client is asked to call back in a couple of hours).
STAFFING: • Core operations requires minimum of 2 staff per shift • Program Manager – 1 • Program Staff – 11.22 FTEs • Nurse Practitioner: 0.125 between men's and women's per 05/06 report	

SERVICE DESCRIPTION:
• Provide intake, observation, withdrawal management, assessment and referral
• Includes 24/7 access, intensive case management, individual and group counselling.
• Admission criteria:
  • are intoxicated
  • are in withdrawal
  • are in crisis related to alcohol or drug use
• As tobacco is considered a gateway addiction, NHS Addiction Program has gone tobacco free; actively treats smoking addiction with nicotine replacement therapies such as the nicotine patch.
• Clients arrive any time, day or night, self referred or escorted by family, friend or police (Only about 10 % of clients are brought to WMS by police)
• Clients (including post discharge) have access to daily support sessions; also open to others in community and persons waiting for or having completed New Port Centre treatment
• Clients have access to a nurse practitioner for primary care needs, and also access to acupuncture.
	No on-site security. NHS aims for 'home' type environment for residents.
	
	Less violence than in mental health beds, attributed to the non-institutional feel of the WMS.
	
	Infrastructure of hospital is important for their operation e.g. meals are provided by/delivered from the hospital.
	
	Staff concern that if service is separated from the hospital it would further isolate addictions as a health care issue
	
	Because of transportation issues in Niagara, the WMS provides taxi chits when necessary.
	
	No home support program but WMS does support some persons via telephone (resources for full telephone follow-up support are not available).

Additional data is collected by NHS related to client demographics (income, education), legal status of clients, client satisfaction, and primary diagnosis at time of admission.

7.1.3 New Port Centre, Port Colborne

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: • Men's – 25 • Women's – 10	
CLIENTS: Admissions • Men – 283 • Women – 123	Numbers have decreased slightly since 2008 when NHS implemented the tobacco-free program but NHS expects them to rise again.
AVERAGE LENGTH OF STAY: • Men – 15.49 days • Women –15.66 days	Numbers indicate that most people complete the program.
CLIENT COUNTY OF RESIDENCE: • Approximately 65 % of men and 45 % of women are from outside the Niagara Region • The largest non-Niagara referral sources are Hamilton, followed by Metro Toronto and Waterloo	
AVERAGE OCCUPANCY: • Men – 71% • Women – 77%	Numbers have been declining since 2005/06 (90% average for men and women) to 2008/09. Numbers 2008/09 were low with about 65 % (average men and women) but seem to be increasing again for 2009/10 (this included the cancellation of one cycle due to H1N1)
WAITING LISTS: • New Port Centre residential program has a closed intake system, with a 17-day rotation. There is no waiting list for admission.	
STAFFING: • Program Manager - 1 • Program Staff – 18.11 based on current staffing level 2010/11	2 FTE staff allocated to manage client admissions; one clears for treatment (can arrange within 3 weeks as necessary) and one keeps connected through in-person, telephone or on line dialogue.

SERVICE DESCRIPTION:
• Residential program; operated on 18 day residential program
• 17 sessions (closed communities) each year
• Designated as a province-wide resource; thus many referrals come from outside of the area
• Short-term program with focus on stabilization, education, skill development and aftercare planning.
• Intensive program/policy allowing no visitors/ clients not allowed outside the facility grounds
• Treatment options – 3 modules – clients choose
  ◦ Women specific
  ◦ Self help
  ◦ Cognitive behavioural recovery skills
• Recreational activities – indoor and outdoor
• Self-contained site; residents not allowed beyond site while in treatment.
• Hospital's eating disorder clinic co-located on site.
• Nurse practitioner access for residents
	Staff perceptions of benefits of site:
	• near lake and very tranquil scenery
	• away from the 'centre of the town' or the city which is associated with risk behaviours
	Staff perceptions of issues with site:
	• not wheel chair accessible (although can bring person through hospital into one room that is equipped for accessibility)
	• distance to travel between this site and other services in St Catharines; combined with lack of public transportation
	
	Region of Niagara interested in acquiring the site as soon as possible for expansion of its seniors housing.

Additional data is available, including extensive information from client satisfaction surveys.

7.1.4 Branscombe House, St. Catharines

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: Residential housing	Housing for women who have been in recovery for at least thirty days. They can reside here for up to one year. Must show evidence of ongoing recovery-related activity.
CLIENTS: • Maximum of 7 residents at any time	
AVERAGE STAFF HOURS/ PER CLIENT VISITS: • Not applicable (see staffing line below)	
CLIENT COUNTY OF RESIDENCE: • (no stats provided; assume primarily local Niagara region)	
AVERAGE LENGTH OF STAY: 6 months to 1 year	
WAITING LISTS: N/A at present	Informal waiting list only, but there has not been anyone on it for several years.
STAFFING: • Informal supports only; house managed by residents. • NHS does assessments for admission, provides some amenities	There is no FTE assigned to its assessment work. The Team Leader in the Women's Withdrawal Management Service supervises it as part of her duties.

SERVICE DESCRIPTION:
• Branscombe Recovery Home is a 7-bed transition home for women in the early stages of recovery. While staying at the House they receive life skills training (via an abstinence-based program).
• Residents pay rent and collectively manage the house and food.
• Addictions Program pays for operating costs including rent, cable and cleaning supplies.
• Rent is equivalent to OW or ODSP allowances.
• Criteria for admission are:
  ◦ a minimum of 30 days of sobriety
  ◦ active involvement in recovery treatment program.
	Founded in 1996 in response to need for longer term residential support for women recovering from addictions issues. Premises donated.
	Facility self funded by residents through rent.
	Rent collected pays for the ongoing costs of the building; currently funds get pooled with hospital funds.
	Alternate provider includes the YMCA crisis house but they have a maximum length of stay of 30 days and is not abstinence-oriented.
	Need for recovery home for women.
	Potential exists for more funds to be available for Branscombe or for an expanded Branscombe/recovery home. Funds will come as part of a bequest so uncertainty exists around the timing of this funding.

7.1.5 Nurse Practitioner Primary Care Program

This program is listed as a residential program because if its role in providing support to clients in NHS residential addictions programs (New Port Centre and both withdrawal management centres), although the nurse practitioners do not limit their role to serving residential clients.

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: n/a	
CLIENTS: • Nurse practitioner, New Port Centre site (Port Colborne): 1848 primary care visits (2008/09 stats). • Nurse practitioner, Ontario Street site (St. Catharines): 3055 primary care visits/ methadone (2008/09 stats).	
WAITING LISTS: No waiting list. Clients are given an appointment upon referral.	
STAFFING: • New Port site (Port Colborne) – one nurse practitioner • Ontario Street site (St. Catharines) – one nurse practitioner	
PROGRAM DESCRIPTION • Nurse practitioners provide primary care for clients in NHS addictions programs (WMS, ABC and the New Port Centre) but also see some clients referred from the NHS mental health program • Provides basic screening for diseases, vaccinations, treatment and education. • The program also provides support to system partners (i.e. Start Me Up) • Nurse practitioners do not have hospital admitting privileges. They do refer to NHS emergency departments and urgent care centres if client need is outside their scope of practice. Nurse practitioner care reduces visits to emergency departments and urgent care centres. • NP works closely with physicians in NHS Methadone clinics, Eating Disorders Clinic, Hepatitis C Clinic and in consulting appointments for clients.	Nurse practitioners are key supports to the operation of NHS addictions programs. Many NHS addictions clients do not otherwise have regular or appropriate access to primary care. Important link to longer term recovery and healthy behaviours. Nurse practitioners refer to NHS emergency departments and urgent care centres as indicated. They have collaborative practice agreements in place. They refer to outside physicians where indicated.

7.2 Non-Residential Addictions Programs

7.2.1 A Better Choice (ABC), Early Childhood Development, St. Catharines

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: Not applicable. ABC is day treatment	
CLIENTS: • Assessment – 71 • Community Treatment – 122	Treatment numbers are higher than assessment numbers because parenting programs are offered to the community at large. Non-addiction clients and male clients with CAS involvement do not require assessment, but benefit from the parenting course.
AVERAGE STAFF HOURS PER CLIENT VISIT: • Assessment – 3.11 hours • Community Treatment – 12.46 hours	
CLIENT COUNTY OF RESIDENCE: Clients for both assessment and program components are from the Niagara area. Of active clients (2009/10): • 51 % are from St Catharines • 24 % are from Niagara Falls • 9 % are from Welland.	Many clients are given taxi chits to attend sessions. Some clients are referred to the program through New Port Centre or the NHS WMS.
AVERAGE TIME IN PROGRAM Case specific; based on client case management approach (done with CAS worker and collateral contacts)	
WAITING LISTS: No waiting list kept but cancellation list helps reduce wait times.	The program is currently oversubscribed. Initial program proposal indicated a client would be seen within 72 hours of contacting the service. Current initial intake wait is approximately one month.
STAFFING: • Clinician (social worker with addictions training) – 1 FTE • Child care worker – 0.6 FTE • Nurse practitioner access	
SERVICE DESCRIPTION: • Provides intensive case management, social supports, life skills, counselling, treatment and advocacy, referral to pregnant or parenting women with concerns about substance abuse. • Also provides infant stimulation, parenting skills, and education on age appropriate play. • Transportation assistance provided via taxi payments, bus tickets or outreach contact	Funded via Ministry's Early Years Program funding Designed to address the health, education and social support needs of pregnant and parenting women and their children aged 0 – 6, and to improve birth outcomes for women and their babies. Good link with Family & Children's Service Niagara (CAS).

7.2.2 Out and About Methadone Withdrawal Program, St. Catharines

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: Not applicable. Out and About is day treatment.	
CLIENTS: • Methadone Treatment – 158 • Assessments – 31	
AVERAGE STAFF HOURS PER CLIENT VISIT: • Treatment – 19.7 hours • Assessment – 3.7 hours	
CLIENT COUNTY OF RESIDENCE:	
WAITING LISTS: No	
STAFFING: • Clerical – 0.8 FTE • Physician – 1 (OHIP-covered) • Nurse practitioner – 1 FTE	
SERVICE DESCRIPTION: • This program provides physician supervised harm reduction. • It provides methadone maintenance treatment to assist clients with opiate/opioid addictions. The goal of the program is to help the client to achieve stability and functionality in their community. • Complete care of the client is facilitated through the coordination of services between this program and external health care and social service providers. For those without a family physician, primary health care is provided by a nurse practitioner (in collaboration with the Primary Care Clinic). • It operates as a drop-in clinic. • It has an ongoing relationship with the hospital pharmacy to provide methadone efficiently. • It offers other supports such as job referrals.	Highly dedicated physicians. Low level approach to signage – focus is on Out and About – meant to be user friendly and to avoid stigmatization. Currently this program operates out of 151 Ontario Street (space shared with the ABC program).

7.2.3 Methadone Clinic, New Port Centre, Port Colborne

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: Not applicable. This methadone program is day treatment.	
CLIENTS: • Methadone clinics – 244 (This includes support to the methadone clinic in Fort Erie.) • Smoking Cessation – Tobacco treatment is embedded in the residential treatment program	
AVERAGE STAFF HOURS PER CLIENT VISIT: **ASSESSMENT/TREATMENT PLANNING:** • Methadone clinics – 12.17 hours	
CLIENT COUNTY OF RESIDENCE:	
WAITING LISTS: No	
STAFFING: • Coordinator – 1 FTE? (No staffing hours are charged to this program; it is supported from the residential budget) • Physician - 1 (OHIP covered) • Nurse practitioner access (as part of the nurse practitioner program at New Port Centre	
SERVICE DESCRIPTION: • This program operates at New Port Centre. • It operates as a drop-in clinic. • It has an ongoing relationship with the hospital pharmacy to provide methadone efficiently. • It offers other supports such as job referrals and life skills training. • It provides access to primary care via the nurse practitioner.	Highly dedicated physician. Low level approach to signage, to be user friendly and to avoid stigmatization. .

7.2.4 Problem Gambling Web Site and Community Engagement

Program Description Based on 2009/10 data	Context/Comments Based on Site Visits, Other
BEDS: not applicable.	
CLIENTS: • The program target clientele is ethnocultural communities. Web site hits are recorded and reported in Operating Plan. Final report 2009/10 indicated 247,628 successful website requests. 12,772 successful page requests for the same period.	NHS staff do follow-up with any phone requests. However, this program does not provide treatment.
STAFFING: • 1.2 FTE (.2 clerical)	
PROGRAM DESCRIPTION: • Provides on-line education and support for persons in ethnocultural communities who are struggling with addiction to gambling. • Program goal is to provide a culturally and linguistically appropriate problem gambling website (with service in 12 plus languages). The site provides information, education and prevention resources regarding gambling and problem gambling behaviours. • Staff also does community engagement and education and participates in other relevant initiatives.	Has not led to increase in client volumes into other NHS addictions programs, despite information and having different ethnocultural persons on staff at those programs.

8. OTHER ADDICTIONS PROGRAMS IN NIAGARA REGION

The NHS Addictions Service is part of a larger set of addictions and related programs that serve people in Niagara Region. Appendix Four provides a list and descriptions of addictions services in Niagara Region, drawn from The Drug and Alcohol Registry of treatment (DART) for addictions programs.

The DART data base uses a different and more fine-grained way of identifying programs than most agencies use. For instance, NHS operates seven programs delivered through nine access points. However, based on the way the DART database defines programs, NHS is listed as providing 18 programs.

The reader should note too that some of the information in the DART database is inaccurate and should be interpreted with caution. For instance, the days and hours of operation of some programs as listed in the databases reflect the time when the administrative offices are open, not the times at which services are actually delivered.

This database only lists organizations and programs funded by the Ministry of Health and Long-Term Care. For example WARM (Women's Addiction Recovery Mediation) is not listed, nor are the YWCA's women's addiction-related services, even though both agencies are major contributors to the wellbeing of women with addictions in Niagara.

9. WHAT STAKEHOLDERS SAID

Patterns within the comments made by stakeholders during this review are cited throughput the sections of this program review report. However, the comments also lent themselves well to a SWOT categorization (strengths, weaknesses, opportunities and threats), shown below.

SWOT Analysis – Based on Feedback at Key Informant Interviews/Focus Groups	
STRENGTHS	**WEAKNESSES/CHALLENGES**
• Detox is very accessible • Residential treatment option is an important area resource • Program Director goes the extra mile to be a player at planning local and provincial tables, and to ensure programs meet local needs and expectations • High rating from client satisfaction surveys • Current approach diverts clients from ER • Staff at both sites able to do assessments to avoid delays for urgent cases • Nurse practitioner in programs help provide primary care for persons with no other access or who have not had regular screening or preventative care such as immunizations); helps avoid visits to ER • New Port Centre site is very client friendly – site itself aids in recovery because of the tranquil setting and lack of distractions • OSS site very accessible to other addictions and social services; clients can walk, be escorted, or short taxi trip • Separate programs for women important local resource; aids recovery of women who have been in stressful situations • Diversity of staff experience • Strong working relationship between ABC program and Family and Child Services • No smoking approach within NHS programs sends strong message on addictions • Staff willing to help support clients by phone, when time allows • Current model of delivery ('houses' for different client groups) works well – this non-medical and non stigmatized environment supports client anonymity, safety, recovery overall and reintegration into the community	▪ Distance between Ontario Street site and New Port Centre site makes it very difficult for staff alignment and for shared services or operations ▪ Ontario Street site with multiple houses is not efficient; 'paying people to watch people sleep' ▪ Addictions clients show up at NHS Emergency Rooms; some are very frequent users ▪ Two data systems (hospital and addictions Catalyst reporting system) create challenge in tracking clients and measuring outcomes ▪ Staff in addictions programs (NHS and other community providers) do not always feel respected by colleagues in other hospital program areas, particularly emergency programs ▪ Stigma of addictions seems to be present in other parts of NHS, e.g., "addictions clients are not welcome and do not need to be here". ▪ Communications/protocols between addictions and rest of NHS are not always timely or aligned ▪ Niagara faces new/accelerated trends, e.g. addiction to oxycontin and poly-substances. NHS needs new approaches to address these with other partners, especially primary care partners ▪ Capacity to provide the full continuum of care for persons with addictions – need recovery homes especially for women, need more services in Niagara Falls, need for transitional housing ▪ Emergency room environment misaligned for addictions patients; e.g. target time from admission to discharge is 4-8 hours but addictions patients need more time than this to withdraw; medical needs may only become apparent after several hours of withdrawal; persons withdrawing from alcohol may die but emergency departments move them out too quickly ▪ Transportation to WMS is a burden for people living outside of St. Catharines ▪ need more strategic addiction service planning ▪ need to have common policies for clients across all NHS programs (e.g., smoking policies, policies re: attending outside support groups while receiving NHS addictions service)

SWOT Analysis – Based on Feedback at Key Informant Interviews/Focus Groups	
OPPORTUNITIES	**THREATS**
▪ Number one opportunity - release resources through program consolidation. Co-location on one site has been approved by NHS ▪ Shared space will allow for innovative use of staff, as well as facilitate staff training opportunities (at least within the program) ▪ Better to locate downtown to be closer to clients ▪ Look outside the traditional box of health funded agencies e.g. consider YWCA interest in working with NHS to develop transitional housing for women with addictions ▪ Look at offering day WMS and community WMS as is done in Hamilton ▪ New CHC in St Catharines and other CHCs in Niagara can be major partners in the prevention and treatment of addictions; co-planning should maximize opportunities between NHS and CHCs ▪ Look at opportunities to share space and resources with other agencies that deliver addictions services or related services ▪ Engage with clients and former clients to validate program approaches and outcomes ▪ Proactively identify persons with addictions who regularly come to emergency rooms, target programs to support them outside of the emergency room setting ▪ Co-location of addictions with new hospital site and Mental Health could be useful for diverting clients from ERs ▪ Urgent care centres present opportunity for education and outreach – staff at addictions program to support them, e.g. staff peer support and referral; shared learning opportunities focused on prevention and secondary prevention (could be aligned with efforts to reach out and work with CHCs) ▪ Hospital may want to consider new approaches for clients in detox situations in ERs, what approach is consistent with risk management/patient safety (e.g., step down unit with appropriate staffing) ▪ NHS should develop a formal concurrent disorder program and help train others in the community (as is done in Hamilton) ▪ Management should consider more individual care planning at New Port Centre. ▪ Enhance staff competencies through training and certification	• Number one threat - no new site for addictions programs has been confirmed; “clock is ticking” • Some other providers wonder about hospital commitment to staying in the addictions service field • If addictions not located on new hospital site, may hinder efforts to improve the integration with other hospital programs such as Mental Health, women’s programs, chronic care etc. • Locating on new site will make it difficult for clients to reach them given transportation issues • Access for Niagara addictions clients to psychiatry is still lacking, despite commitments from Hamilton providers and LHIN to work on issue; “sessional fees sitting unused”, so there is no obvious immediate solution to the problem • NHS fixation on beds – this “edifice complex” hinders creative planning with community based providers • Financial and other impacts from program consolidation as several unions are involved • No overall plan for addictions services delivery in the LHIN or in Niagara; in absence of these plans, *ad hoc* decisions and assumptions may be made about programs and capacity, and roles within the care continuum • Clients are at risk when they are not supported adequately after treatment and when the results of cross referrals from other agencies are not known • Addictions system’s fear of a takeover by the mental health sector hampers attempts to integrate the two systems

10. SHOULD NHS CONTINUE TO OPERATE ADDICTIONS PROGRAMS?

Before this review examines quality, integration and efficiency related to NHS addictions programs, it is worth asking whether NHS should remain a major provider of addictions services in Niagara Region. Should it divest itself of some or all of its addictions programs?

The answer may lie in the nature of addictions as a disorder which – in many but not all instances – produces profound physical health, mental health and social consequences, or makes it more difficult for people with addictions to address co-existing physical, psychological and social difficulties.

People living with addictions at the upper end of the severity scale often require intermittent or ongoing contact with fairly complex secondary or tertiary resources to address their addictions problems, and associated resources to address their physical and mental health – such as inpatient or outpatient care in areas such as psychiatry, chronic liver disease care, diabetes care and cardiac care.

Since resources to address complex physical and mental health conditions are most often found in hospital settings, it is reasonable for a hospital to operate intense addictions services, while also linking people needing these intense addictions resources to the physical and mental health resources that the hospital provides.

As well, hospital-sponsored addictions services can make a contribution to hospital emergency services by providing rapid access to addictions expertise – an issue addressed in more detail later in this program review.

Recommendation #1: The Niagara Health System should remain the provider of a range of addictions programs for special or complex need populations that focus on residential treatment and other addictions services (including withdrawal management, short-term residential treatment services, services to women with children and mothers-to-be, and primary care through nurse practitioners).

One NHS program, however, does not seem to be closely linked to the addictions service role specified above for NHS. This is its Problem Gambling Web Site and Community Engagement Program. While this program does serve a special population (i.e., people from many ethnocultural backgrounds), it does not seem closely related to the NHS Addictions Service portfolio or other hospital programs. This program should be divested to an agency in Niagara that is already involved in formal problem gambling treatment, since the problem gambling web site can act as the basis for early identification of people who may need problem gambling counselling. Divestment of the program to Community Addiction Services of Niagara would be appropriate since CAS-N provides problem gambling assessment, treatment and support services in five communities in Niagara Region.

Recommendation #2: The NHS Addictions Service should divest its Problem Gambling Web Site and Community Engagement Program to Community Addiction Services of Niagara.

Branscombe House, another addictions program affiliated with NHS, poses special issues. Branscombe House is a residence for women, with a recovery focus. However, it is not staffed to act as a recovery home. There is no recovery home for women in Niagara Region (although there is a recovery home for men), and the absence of a Niagara recovery home for woman was identified as a need by several stakeholders during the engagement phase of this review.

Branscombe House may well be a candidate to become a recovery home for women in future, given its current emphasis on recovery philosophy and practices. But if it does become a recovery home, there is no reason it should be affiliated with the Niagara Health System – and as a residence, it is not a good fit with the NHS Addictions Service mission.

On the other hand, NHS may choose to maintain a sense of responsibility for Branscombe House during a transition period. Since Branscombe House may be forced to close when the Ontario Street site is sold, NHS may wish to maintain support for Branscombe House (primarily financial support in providing an alternate non-hospital site for Branscombe House) until NHS can divest itself of all formal responsibility for this facility via transfer of responsibility to an independent board or to another organization willing to "adopt" Branscombe House.

Recommendation #3: The Niagara Health System should develop a strategy to:

- Eventually divest itself of all formal responsibility for Branscombe House
- Assist Branscombe House to develop a strategy for either remaining a residence or becoming a women's recovery home, as an independent entity or as part of a larger organization
- Provide financial assistance to Branscombe House in securing an alternate site, given that its current site will not be available once the NHS Ontario Street site is sold.

.

11. QUALITY IN NHS ADDICTIONS PROGRAMS

11.1 Quality Strengths

Earlier, this review provided the following definition of quality that was used in administering project engagement tools:

> **Quality** means a high degree of benefit from, and accountability for, a service with least harm to users and providers of the service and a high degree of timely access to the service for those who can benefit from it.

Few objective level-of-benefit measures exist or are used in the addictions system in general. However, most NHS addictions programs administer surveys to clients gauging degree of client satisfaction with programming and that gauge clients' perceptions of level-of-benefit. Responses are analyzed and interpreted by NHS staff. Levels of client satisfaction and perceived level-of-benefit are generally very high for NHS addictions programs.

External stakeholders generally hold NHS addictions programs in high regard: a number of stakeholders expressed this high regard even though no specific question relating to level of regard was posed during interviews and focus groups. In particular, the Regional Director responsible for the NHS Addictions Service was frequently cited by external stakeholders as a credible and competent partner with points of view enriched by service in addiction and related activities at the provincial level as well as the local level.

As well, several other indirect measures of quality emerged during the review:

- People in managerial positions within the NHS Addictions Service seemed aware of, and interested in, best practice literature related to their portfolios.
- Several front-line staff conveyed best-practice documents to the review's consulting team that suggest an interest in and knowledge of best practices is not uncommon among NHS Addictions Service staff.
- In focus groups and interviews, staff expressed strong interest in learning more about what other service providers within the broader system do. They also expressed an interest in making other providers more knowledgeable about what NHS addictions programs do.
- In focus groups, several staff expressed interest in applying their skills more fully by participating in clinical endeavours in the workplace in which they are not currently involved.

Quality issues were sometimes raised in terms of what the full array of hospital and community services do, or should do, to improve client outcome, not just what NHS addictions services do. This suggests a breadth of vision that recognizes the importance of beyond-the-walls partnerships to achieve quality. One part of an interrelated array of services will not be able to maintain its quality if quality is low in other parts, or if some necessary parts are missing. This will be discussed further in the "cohesion and integration" section of this review.

The NHS Addictions Service should be commended for a number of approaches to quality. Four in particular stand out:

- The inclusion of nurse practitioners in many of its programs. This creates a link to primary care and helps NHS to address the fact that many of its clients have profound physical and psychological health problems. These problems can be addressed in a coordinated way through the efforts of nurse practitioners working in teams with other NHS Addictions Service staff and with staff from other NHS programs as well as other programs in the community.
- Its approach to nicotine use. This approach makes a start at addressing the significant mortality and morbidity results of nicotine addiction. While its initial approach is still a work in progress and while NHS still needs to reconcile its non-nicotine-use policy with policies elsewhere in NHS, it has made a good start.
- NHS addiction service outreach to NHS mental health services through the presence of on-site addictions program workers on psychiatric units.
- Continued NHS addictions program activities to help the community develop and provide a range of women's addictions services, including collaboration with other agencies to provide service to vulnerable groups of women such as sex trade workers.

.

In terms of the service access component of quality, the NHS Addictions Service has a high degree of quality because or the absence of waiting lists for most programs. Service access issues still remain because of problems of access to services for people some distance away from services. NHS helps address this through subsidizing taxi fares. However, in terms of access to residential services, it is not feasible to decentralize these services to local communities. Several strategies for fostering greater access through innovations such as a telephone-based pre-treatment and post-treatment support and withdrawal management support, as well as community withdrawal management, are outlined later in this program review report.

Another access support is the presence of a New Port Centre staff member who can assist Niagara's francophone community.

11.2 Tensions Related to Quality

Inevitably, any program review identifies tensions that exist within a program or organization. Tensions are not necessarily a sign of organizational ill-health or deficit. They are normal in any organization, and tension management can be one of the engines for creativity within the organization. This review does not propose how these tensions should be resolved – in part because they may need to be creatively managed rather than resolved, and in part because these tensions should be debated more fully within the NHS Addictions Service, since they are embedded within the very culture of addictions programs. And while organizational culture may be seen as the "soft" side of quality, it is the bedrock on which quality rests.

Three tensions within the NHS Addictions Service were identified as a result of the review's stakeholder consultations. They are discussed below.

11.2.1 Client Choice, and Client Responsibility

On the one side of this tension are those stakeholders who say that actions have consequences, and that many people who are receiving addictions treatment need to improve their ability to perceive and manage the consequences of their actions. These stakeholders would say that it is appropriate for negative consequences to be imposed, for instance, when clients violate reasonable and therapeutically sound rules during treatment, or violate rules established and supported by the group or "community" undergoing treatment. They would argue that imposing reasonable consequences is therapeutic learning, not punishment.

On the other hand, others argue that client choice is an important part of contemporary addictions treatment, and/or that some leeway in accepting (if not condoning) different behaviours from different clients (within limits consistent with safety) is a recognition of the uniqueness of each client and of each client's own vulnerability. They believe that the absence of "right behaviour" may be part of the addictions disorder, rather than a reason to impose consequences that may be seen as punishment, not therapy.

Any debate on client choice vs. client responsibility within the NHS Addictions Service should be conducted with client input. Clients or former clients should be actively engaged in the debate.

11.2.2 Clinical Supervision

Some internal stakeholders suggest that there is insufficient access to clinical supervision within the NHS Addictions Service, that access to clinical supervision needs to be improved within NHS addictions programs, and that minimum educational qualifications for people conducting clinical supervision should be established. Others argue that in terms of clinical supervision at New Port Centre, a major reduction in the number of supervisors took place several years ago, and that NHS should continue to encourage individual problem-solving by staff, rather than micro-supervision.

Any debate on clinical supervision within the NHS Addictions Service might want to use *TIP 52: Clinical Supervision and Professional Development of the Substance Abuse Counselor: A Treatment Improvement Protocol Tip* as a resource during the debate. This would help create common ground for the debate. This document is one in a series of addictions best practice documents issued by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Tip 52 can be accessed at http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=hstat_tip52.

11.2.3 Experiential Competence, and Academic Competence

This tension exists in a large number of addictions services across North America.

One side of this tension would argue that staff with personal experience with addictions bring exceptional insight to counselling work, but they are often treated as less than equals by fellow staff members who have more extensive academic qualifications. Others argue that, while personal experience with addictions may be an asset, it does

not replace higher levels of formal training, and that in at least some instances, people who have personally experienced addictions bring "baggage" with them to the counselling function.

This tension may be more challenging if people on the experiential side are (or are purported to be) more likely to be people espousing the abstinence approach, while those on the side stressing high levels of formal training are (or are purported to be) more likely to espouse harm reduction.

> "Whether or not counsellors have themselves had a drug or alcohol problem appears to have little bearing on their professional abilities. However there is some evidence that a staff team which brings together counsellors who are in recovery with others who have no history of problematic substance use can be particularly effective."
>
> ***Rehab - What works? 20 things you should know about rehabilitative treatment for substance dependency*** **(summary of research findings). European Association for the Treatment of Addiction (undated)** http://www.eata.org.uk/uploads/File/What%20works%20(20%20things%20about%20rehab).pdf

Any debate on this tension within the NHS Addictions Service should begin with mutual learning about what the other "side" actually does and what it believes, since this tension may in part be based on unwarranted stereotypes about what each position entails.

Recommendation #4: The NHS Addictions Service should foster a debate among NHS Addictions Service staff on three tensions that need to be managed so addictions programs can maintain and enhance their quality:

- Client choice, and client responsibility
- The nature of appropriate clinical supervisions within NHS
- Experiential competence, and academic competence.

11.3 Open vs. Closed Intake and Discharge at New Port Centre

New Port Centre, the NHS short-term residential treatment program, operates based on a three week treatment cycle. Eighteen days within this cycle involve treatment activities provided for a group of clients who all enter and leave the program at the same time. In the time between the end of one cycle and the beginning of the next cycle, New Port staff complete administrative work related to client service in the past cycle, prepare for the next cycle, and participate in staff meetings and educational sessions as needed.

During this review, two stakeholders suggested that New Port Centre should instead operate on an open intake and discharge model. Under this model, clients could enter treatment at any point at which they judged to be ready for treatment, and would leave the program when they are deemed to be ready to leave.

This program review has not been able to locate any body of best practice evidence indicating the advantages and disadvantages of the open and closed intake/discharge models in addictions residential treatment. However, anecdotal evidence from providers suggests that both approaches have advantages and disadvantages.

Closed intake/discharge:

- **Advantages:**
  - Allows positive group dynamics and group norms to develop within a treatment population whose members share a common experience of orientation to, participation in, and separation from a group
  - Allows for positive expectations to be developed within group members related to positive outcomes within a specified period of time (potentially useful for people who function best within environments with structured expectations)
  - For people waiting to enter a treatment cycle, pre-entry motivational support provided within a wait time of predictable length for each client may maximize clients' readiness to participate in, and benefit from, treatment.
- **Disadvantages:**
  - Can lead to discounting the individual's unique needs and capacities, in favour of a bias towards treating all people the same
  - Can lead to unnecessarily long waits to enter treatment (a client cannot enter treatment the next group cycle begins) – waits during which a potential client's motivation to participate can erode (particularly if she is not provided with motivational support during the pre-entry phase)[14]
  - Leads to under-utilization of resources when people drop out of treatment during a cycle and their spaces in the treatment facility cannot be filled until the next cycle begins.

Open Intake/Discharge

- **Advantages**:
  - Allows clients to enter and leave a program at any appropriate time, rather than at arbitrary times dictated by cycle dates
  - Allows newer clients to witness and emulate success they see in clients who are further along in the treatment process
  - Minimizes empty treatment slots, since an empty slot can be immediately filled rather than waiting for a new cycle to begin[15]
  - Allows for greater concentration on the needs and adaptive rhythms of the individual in treatment, since he is not "one in a herd".
- **Disadvantages:**
  - Can lead to longer stays than necessary, in the absence of structured expectations of success within a defined period
  - It may be more difficult to use the dynamics of shared group experience as a therapeutic tool (since clients do not experience common development phases in treatment at the same time).

[14] Given that the New Port Centre cycle is a relatively short cycle and has no waiting list, the maximum normal wait time for entry is three weeks, and New Port Centre provides motivational support during this waiting period.

[15] Current average lengths of client stay for New Port clients (15.49 days for men and 15.66 days for women) suggest that its client drop-out rate during treatment is currently relatively low and is not significantly higher for either gender. However, the NHS Hospital Improvement Plan indicated that for 2006/07 and 2007/08, the average length of stay at New Port Centre (not broken down by gender) were 14.2 days and 13.91 days (i.e., significantly lower than the current average length of stay figures indicate), suggesting drop-out rates may have been more of a problem in the past.

In the absence of a best practice knowledge base on the issue, this program review report does not recommend one option over the other. However, this report wishes to flag the issue for potential future discussion within the addictions service system itself (perhaps through Addictions Ontario and the Ontario Federation of Community Mental Health and Addiction Programs).

11.4 Consumer Involvement in Shaping NHS Addictions Programs

Many provincial-level, LHIN-level and Niagara-specific documents that were examined as part of this program review point to the need for client-centred services and systems, and for client involvement in shaping the system as well as exerting control and choice over the services they receive.

The NHS Addictions Service should be commended for including consumers within its Program Advisory Committee. This program review report suggests that the NHS Addictions Service go one step further by creating a Consumer Advisory Committee, chaired by a consumer and with members who are consumers (defined as people who are, or have been, clients of any addictions service). This helps avoid the possibility that consumers will be unintentionally intimidated by addictions workers or administrators in a mixed-member advisory body.

No person who is a former client and who is or has been an addiction counsellor should serve on this committee. While some addictions workers may identify themselves as former consumers as much as they identify themselves as providers, it may be their provider hat that is most visible to other members of the committee.

It makes sense to ask whether family members of people with addictions should also be allowed or invited to serve on such a committee. We recommend against this. While family members and people with addictions may often be in accord in terms of addictions treatment issues, each group still comes from a slightly different perspective. It may make sense to limit the committee to consumers, while also putting in place a process for occasional consultations with family members on service operation and design issues, as a way to ensure their perspective is not lost. This could be augmented on occasion by Consumer Advisory Committee meetings to which people who are family members of people who live with addictions can be invited as participating guests.

Recommendation #5: The NHS Addictions Service should create and support a Consumer Advisory Committee whose Chair and members are all former or current consumers who have never worked as addictions program staff. The NHS Addictions Service should also set in place a process for occasional consultation with family members of people with addictions on service operation and design issues.

11.5 Range of Therapeutic Techniques

The NHS Addictions Service appears committed to the use of a range of therapeutic techniques. However, several stakeholders expressed concern that these techniques are not always applied within the context of trauma-informed counselling, an approach that helps clients who have experienced physical or mental trauma to deal with how the trauma has influenced their addictions-related behaviours. This often is an adjunct to cognitive behavioural therapy, and is considered particularly appropriate for women, given the high prevalence of past trauma among women in addictions treatment.

NHS Addictions Service management have assured the program review that the programs are committed to, and use, trauma-informed techniques. However, we draw the concern expressed by several internal stakeholders to their attention in case they wish to investigate this concern further.

11.6 Staff Certification/Credentialling

Whether the NHS Addictions Service pursues the goal of becoming a centre of excellence, or a part of a system of excellence (an issue discussed later in this report), the excellence of the resources it applies to helping people with addictions is crucial. The most important of these resources is the people who work within NHS addictions programs. One way of helping to ensure staff excellence if to encourage or require all staff to be or certified or credentialed.[16]

It is this review report's understanding that not all addictions counsellors within the NHS Addictions Service have achieved certification.

Recommendation #6: The NHS Addictions Service should put in place measures to support NHS addictions counsellors who wish to pursue certification. All newly hired addictions counsellors should be certified, or should be actively engaged in achieving certification, as a condition of employment.

11.7 NHS Methadone Clinics

Since access is considered a dimension of quality, it is useful to determine whether the locations of NHS methadone clinics best suit client needs. At present, NHS operates a methadone clinic in St. Catharines, a clinic in New Port Centre (Port Colborne) and a clinic in Fort Erie at the Douglas Memorial Hospital site.

Since this report recommends that New Port Centre move to a multi-program site in St, Catharines, it questionable whether the methadone clinic in Port Colborne should remain in that community. Since Niagara Falls is the second largest community in Niagara Region and since it does not have a methadone clinic, the NHS Addictions Service should consider re-locating the Port Colborne methadone clinic to Niagara Falls. Recently, a private methadone clinic considered opening a branch in Niagara Falls. This was apparently discontinued as a result of public concerns in Niagara Falls about the proposed location of the private clinic. However, a methadone clinic located at the NHS Niagara Falls hospital site may be appropriate and acceptable to the community.

Recommendation #7: The NHS Addictions Service should consider re-locating its Port Colborne methadone clinic to Niagara Falls.

[16] This program review report assumes that all NHS addictions program staff who are members of regulated health professions in Ontario (nurses and social workers for example) are members of their appropriate regulatory colleges.

12. COHESION/INTEGRATION AND NHS ADDICTIONS PROGRAMS

12.1 Planning as a Tool for Cohesion and Integration

Planning can be a tool for cohesion because it specifies who will do what, separately and together. It thereby reduces longer-term disjunctions that occur when there is no clarity on these issues.

This program review was carried out in the absence of:

- A Niagara Health System addictions services plan
- A Niagara Health System addictions and mental health services plan
- A Niagara Health System plan for integrating mental health and addictions into its full array of services (including but not limited to emergency and urgent care services)
- A Region of Niagara addictions services plan
- A Region of Niagara addictions and mental health services plan.

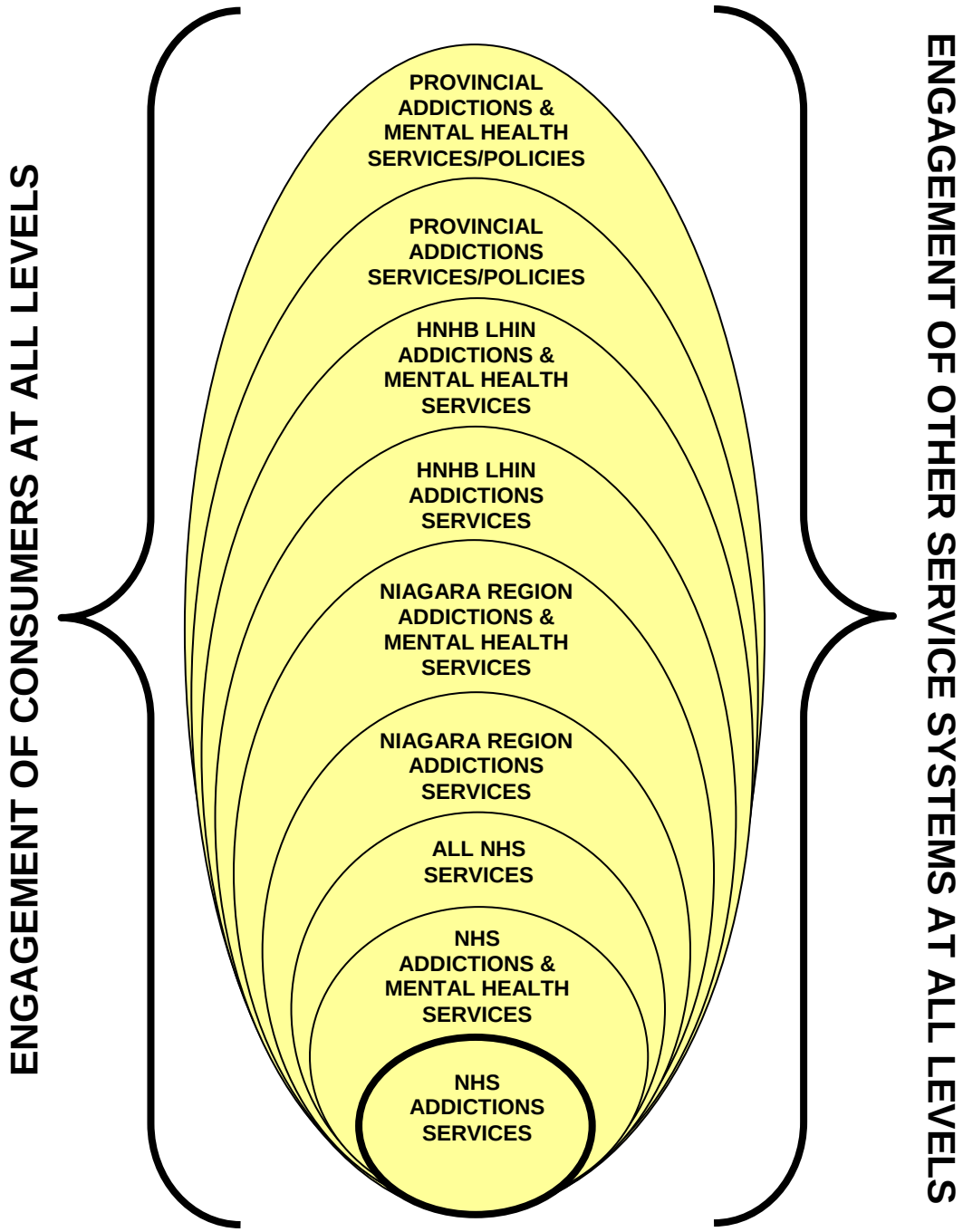
While addictions and mental health planning-related work has been done at the level of the Hamilton Niagara Haldimand Brant LHIN and a structure exists at that level (the LHIN's Addictions and Mental Health Program Advisory Group) to coordinate and foster future planning, the results of these LHIN-level initiatives are not yet fine-grained enough to be a detailed blueprint for NHS or Niagara Region. However, the LHIN's Mental Health Program Advisory Group issued a very useful report that provided:

- A statement of strengths and challenges for addictions and mental health services
- A statement of factors most likely to increase or decrease the future demand
- Model principles for the mental health and addictions model
- A model for co-ordinating and analysing mental health systems
- An assessment/description of the PAG service delivery model using LHIN criteria
- A description of pre-requisites, enablers and challenges to implementation.

Strategic planning for addictions and mental health at the level of the LHIN and of its constituent parts, and of organizations within these constituent parts, is complex and can look from the outside like a confusing beehive of activity (see next page).

The NHS Addictions Service need not necessarily wait for definitive guidance from upper levels of planning before embarking on strategic planning at the five levels cited above. For three of five levels (NHS Addictions Service, NHS mental health service, and integration of both with other NHS services), much has already been done and NHS can clearly coordinate the process of extending current planning with the involvement of clients and external stakeholders. In two of the five (Niagara-wide addictions planning and Niagara-wide addictions and mental health planning), The NHS Addiction Service can act as co-leader with other local service partners in a way which does not imply that NHS is the only leader or that senior partner. It can be done in a way that recognizes NHS as only one participant, and not always the pre-eminent participant, in meeting community needs. Based on stakeholders' perceptions of NHS Addictions Service leadership expressed during this program review, these leaders seem to have the credibility necessary to help make strategic planning a community endeavour, not a perceived take-over by the hospital.

THE PLANNING BEEHIVE



This beehive is drawn from the perspective of the NHS Addictions Service. Every other agency or stakeholder will have its own perspective from which it looks on the beehive.

Recommendation #8: The Niagara Health System should develop strategic plan components for its addictions services, its mental health services, for both components combined, and for integration of these components with other NHS services (including but not limited to emergency and urgent care services), ensuring that consumers and non-hospital service providers are engaged in this planning and incorporating the findings of the addictions services review into the planning.

Recommendation #9: The NHS Addictions Service should act as a catalyst and partner in initiating and carrying out Niagara-wide strategic planning for addictions services, mental health services and both components combined, and should help ensure that consumers and community service providers (including but not limited to health sector providers) are engaged as full partners in the planning.

These planning endeavours would also be a way to solidify and expand the role of NHS Addictions Service front-line staff in shaping the future.

12.2 Integrated Screening, Assessment and Referral

12.2.1 Screening

Earlier, this program review report described the prevalence and often devastating effects of addictions on individuals, communities, agencies and society. Yet despite these effects, very few people seek help for addictions problems.

"Recent Canadian and US studies suggest that, among adults reporting ever having had alcohol problems, only 5%-28% say they have sought help for drinking from either informal sources (friends, family members, self-help groups) or from professionals, and only 1.2% to 9% report seeking help from specialized addiction services (Weisner, Greenfield and Room, 1995; Rush and Tyas, 1994). Of those who do seek help for alcohol problems, the majority (70%) report doing so from Alcoholics Anonymous or other mutual-aid groups. This may be due to addictions agencies having a relatively low profile within the general population, whereas more people are aware of AA….

In Canada, few (3%) users of illicit drugs, identified in a population survey, reported seeking any kind of help for drug problems (Rush and Tyas, 1994)."

***Best Practices: Substance Abuse Treatment and Rehabilitation*. Office of Alcohol, Drugs and Dependency Issues. Health Canada, 1999**

Stigmatization, denial, a sense of helplessness, and lack of knowledge of the service system are reasons why people do not seek assistance with addictions problems

Best practice literature provides insight into why some people do seek help.

(emphasis added via bold font in following quotes)

"A follow-up study (Hingson et al., 1982) showed that the decision to seek treatment was related to increased **negative social and personal consequences** rather than demographic characteristics or levels of drinking."

"Within the general population, and across all three surveys, help seeking, going to AA and going to alcoholism treatment programs were more common among males, and especially males between 18 and 49 years of age. Lifetime help-seeking was also related to lifetime levels of alcohol dependence and **adverse social consequences**. **A measure of negative social consequences of drinking was the best predictor of help seeking**."

"In the general drinking population, those seeking help for alcohol problems were more likely than members of the general population to be male, aged 35 to 54, not to have completed high school, earning less than $20,000 a year, separated or divorced, living in the Prairies (Alberta, Saskatchewan, Manitoba) and **not working**. Among those using illegal drugs, help seekers were more likely than members of the general population to earn less than $20,000, not to have completed high school and to be **divorced or separated.**"

"Unpublished analyses using data from the mental health supplement of the 1990 Ontario Health Survey showed that help seeking was far more common among those with **both a substance abuse and other mental health disorder** (co-morbidity) than among those with only a substance abuse disorder."

"Bardsley and Beckman (1988) compared alcoholics in treatment with others not in treatment who were recruited by the treated group and through publicity efforts. The results showed that the decision to enter treatment was predicted by perceptions of the severity of the drinking problem and by the number of 'unusual' events in the previous month (e.g. **conflicts with spouse, new physical symptoms, car accidents**)."

***Best Practices: Substance Abuse Treatment and Rehabilitation*. Office of Alcohol, Drugs and Dependency Issues. Health Canada, 1999**

If the best predictors of help-seeking are adverse social and physical consequences, it makes sense to engage people who have sought help for these adverse consequences so they can be identified and encouraged to seek help not only for the consequences, but for the root problem as well. This is where screening becomes important.

Screening for addictions problems can and should be carried out in a variety of settings, including but not limited to primary heath care settings (physicians' offices, family health teams and community health centres for example), within community agencies of all kinds that serve populations likely to include a number of people with addictions problems, and within hospital departments that serve people likely to exhibit health disorders associated with addictions.

A coordinated Niagara-wide screening strategy is needed, to ensure that:

- State-of-the-art screening tools are available in all settings
- People in these settings know how to use screening tools
- Providers are motivated to use the tools
- Screening sources have immediate access to follow-up for at-risk or in-risk clients identified by screening.

The NHS Addictions Service can play a key role by working in partnership with others to create and implement a Niagara-wide screening strategy. Most specifically, the NHS Addictions Service can also play a key role in helping other hospital programs that encounter people facing negative physical and psychological consequences of addiction to include screening for addictions as part of their core activities. In some instances, this may mean that NHS addictions programs carry out the screenings in other hospital departments – but screening tools are simple and easy enough to administer that non-addictions program staff can usually administer them with little effort or time involved.

Recommendation #10: The NHS Addictions Service should work in partnership with others to create and implement a Niagara-wide addictions screening strategy. The NHS Addictions Service should also help other hospital programs that encounter people facing negative and physical consequences of addictions to include screening for addictions as part of their core activities.

12.2.2 Assessment and Referral

During the stakeholder engagement part of the program review, a number of NHS staff and external stakeholders expressed concern about wait times for assessments carried out by Community Addiction Services of Niagara (CAS-N). Some stakeholders ascribe this to the way CAS-N organizes its assessment work. Others ascribe it to a shortage of resources for CAS-N to carry out timely assessments and referrals.[17]

Several other addictions organizations in Niagara indicate, via the DART data base, that they provide assessments:

- Three organizations have assessment programs that are considered distinct programs in the DART database:
  - NHS provides a French language assessment program, a methadone assessment program and an assessment program for its early childhood development program (its ABC program)
  - Arid Group Homes provides assessment programs at both its sites
  - The Indian Friendship Centre (Fort Erie) provides an assessment program.
- Although not listed as separate assessment programs, both the Men's and Women's Withdrawal Management Services operated by the NHS Addictions Service indicate they carry out assessments.

[17] In addition to scheduled assessments, CAS-N offers walk-in assessments on Mondays, Wednesdays and Fridays from 8:30 a.m. to 11:00 a.m., but this is limited to four people each morning on a first come-first served basis. Several stakeholders voiced concerns about the frustration and demoralization faced by people who turn up for assessments on these days and are not seen.

By way of context, in the 1980s Ontario's Ministry of Health created a group of service agencies called assessment and referral centres as an outgrowth of the "core-shell model" for addiction services developed by the Addiction Research Foundation. Assessment and referral centres were meant to be part of the core, providing a specialized function for the addictions service system.

Over time, two things happened in many places in Ontario that affected the assessment and referral function:

- Some addictions programs continued to perform their own assessments, because they did not trust the assessments done by assessment and referral centres, or because the wait times for assessments done by assessment and referral centres were too long.
- Assessment and referral centres began operating treatment programs as well as assessment and referral programs. This left some assessment and referral centres open to the concern that they either steered clients toward, or away from, their own treatment programs, rather than referring clients to the "best fit" resource.

Some stakeholders in Niagara indicate that agencies other than CAS-N provide assessments because they can do them in a more timely way than CAS-N.

Broadly speaking, there are three ways to address the issue of specialized assessment and referral programs that do not meet the expectations of other service providers:

- By ensuring that specialized assessment and referral resources organize their work in an appropriate way, and/or receive enough resources to perform high quality timely assessments
- By acknowledging that assessments should often best be done by individual provider agencies, who should be held accountable for the quality of assessments to be done within acceptable practice standards, and who should be provided with enough resources to achieve this accountability
- Through a combination of both these strategies.

Assessment and referral are not one-shot processes. As clients progress in a treatment and recovery system, as more information about them becomes available and as new treatment and recovery options become known or available, re-assessment or continuous assessment is as important as initial assessment. It is crucial to know who does what, and who informs whom, when re-assessments are carried out.

Recommendation #11: The NHS Addictions Service should work with other addictions service partners to develop a strategy for timely high quality assessments, re-assessments and referrals of people living with addictions. This strategy should be informed by knowledge about how mental health assessments and referrals are conducted (and should be conducted) in Niagara Region, so that opportunities for integrated assessments and referrals can be maintained or enhanced.

12.3 Cohesion/Integration via Staff Orientation to Service Systems

Several times during this program review, NHS Addictions Service front-line service providers expressed concerns related to knowledge levels about addictions services in Niagara. They indicated that:

- They do not know, in sufficient detail, what NHS addictions programs (other than their own program) do and how they do it.
- They do not know, in sufficient detail, what addictions services outside the NHS addictions program portfolio do and how they do it.
- Some staff of NHS non-addictions programs do not know that NHS addictions programs such as New Port Centre are part of the NHS program portfolio.
- Some staff of NHS non-addictions programs treat NHS Addictions Service personnel with condescension or hostility.

Several stakeholders suggested that the issue goes beyond lack of knowledge about what NHS programs do, and also reflects a belief, even on the part of other NHS departments, that addictions are low status and low importance within health care (perhaps reflecting outmoded views of the complexities faced by people with addictions).

Stakeholders suggested several solutions to these problems:

- A more useful inventory of addictions services and related services in Niagara, perhaps with two versions – one for providers and one for potential consumers and their families
- Orientation sessions for NHS Addictions Service staff to give them more information on other addictions programs and related programs within and beyond NHS
- Opportunities for NHS Addictions Service staff to spend time in other programs within and beyond NHS, so they can experience alternate service settings. NHS should reciprocate by encouraging return visits from other programs and agencies
- Promotional material containing practical information that can be distributed to other NHS programs to make them more aware of NHS addictions programs and their competencies, augmented by opportunities to make presentations to other departments.

It would be tempting to simply suggest that NHS Addictions Service managers develop more promotional material and opportunities. However it makes more sense to engage front-line staff in helping to develop and shape the material and opportunities, so they are “owned” by the people who say these resources are needed.

Recommendation #12: The NHS Addictions Service should engage staff in developing and shaping opportunities and material to promote greater understanding of addictions programs by people within the addictions service system and by people beyond the system.

12.4 Cohesion/Integration of Addictions Services and Mental Health Services

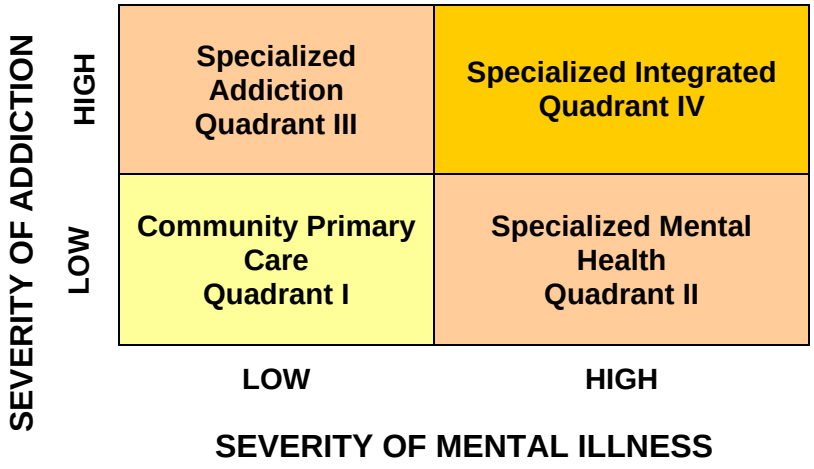
Several stakeholders suggested that a more formal relationship between NHS addictions programs and NHS mental health programs is needed, as a way to address the needs of people with concurrent disorders in particular.

There is evidence that both NHS addictions programs and mental health programs are interested in developing an integrated approach to meeting the needs of people with concurrent disorders. There is also evidence of cross-boundary initiatives, most notably the presence of NHS addictions program counsellors on NHS psychiatric units on a visiting basis, to assist in identifying and serving patients who have a concurrent disorder. But this has not progressed yet to a shared plan, with shared protocols based on this plan, to address the needs of people with concurrent disorders.

Before developing a plan, NHS addictions and mental health programs – working with community partners who may also have a role in meeting the needs of people with concurrent disorders – should develop or adopt a shared understanding of how to categorize concurrent disorders. Without this, addictions and mental health providers may not be able to use common concepts and terms that help them to address concurrent disorders.

Best practice literature may be of some help in developing this common language.

For some time now, the most common way of viewing concurrent disorders has been to see it through the lens of severity. This approach is characterized by the four quadrant model developed by Rosenthal and Westreich[18]. The model proposes four quadrants based on the severity of the addictions problem and of the mental health problem. Quadrant !V is considered the quadrant that most needs an integrated approach to serving people with concurrent disorders.



[18] Rosenthal, R, Westreich, L. (1999). *Treatment of persons with dual disorders of substance use disorder and other psychological problems*. In B.S. McCrady & E.E. Epstein (Eds.), *Addictions: A Comprehensive Guidebook*. New York: Oxford University Press

Health Canada's 2002 best practices document on concurrent disorders,[19] however, suggests a different way to categorize concurrent disorders, based on psychiatric diagnosis. This model encompasses five groups based on diagnosis:

- **Group 1:** Co-occurring substance use and mood and anxiety disorders (While bipolar affective disorders fall within the broad DSM-IV mood and anxiety category, they are typically considered as "severe and persistent" mental illness and are included in the second group)
- **Group 2:** Co-occurring substance use and severe and persistent mental disorders (including bipolar affective disorders)
- **Group 3:** Co-occurring substance use and personality disorders (the majority of people with co-occurring substance use disorders, and problems related to anger, impulsivity and/or aggression, also fall into this category)
- **Group 4:** Co-occurring substance use and eating disorders
- **Group 5:** Other co-occurring substance use and mental health disorders (including but not limited to sexual disorders and pathological gambling).

Health Canada's best practices document prefers this approach:

> "Both the severity approach and the DSM diagnostic strategies have merit and there is not a consensus among the experts as to the preferred method; although all agree some sub-categorization is necessary. For this project, the diagnostic approach, compared to the classification method adopted by Ryglewicz and Pepper… is favoured since it:
>
> - is more directly linked to a preferred course of treatment and support, including pharmacological symptom management which is highly disorder-specific;
> - still recognizes the need for comprehensive and ongoing assessment to sort out the interaction of the substance use and symptoms within each of the broad categories;
> - still retains considerable flexibility within the categories to discuss common patterns of presentation, for example, the high percentage of consumers presenting to methadone programs who are dependent on opiates, and who have a personality disorder; and the high prevalence of schizophrenia and alcohol abuse among clients of psychiatric units, community mental health centres and programs for the homeless."[19]

Drawing a distinction between these categories is not merely splitting hairs. If programs cannot agree on how to visualize and categorize concurrent disorders, they are less likely to agree on how to address the disorders.

Assuming agreement on how to categorize concurrent disorders, NHS addictions and mental health programs should work with each other and with their community partners to develop a plan for addressing the needs of people with concurrent disorders, in an integrated way, through program integration or system integration (see next page for a statement of the difference between these forms of integration).

---

[19] *Best Practices - Concurrent Mental Health and Substance Use Disorders*. Health Canada, 2002

"**Program integration** means mental health treatment and substance abuse treatment are brought together by the same clinicians/support workers, or team of clinicians/ support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.

System integration means the development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance abuse treatment are, therefore, brought together by two or more clinicians/ support workers working for different treatment units or service providers. Various coordination and collaborative arrangements are used to develop and implement an integrated treatment plan."

***Best Practices - Concurrent Mental Health and Substance Use Disorders*. Health Canada, 2002**

Ongoing information about promising and best practices in concurrent disorder treatment can be found at the Concurrent Disorders Knowledge Exchange Area web site, created by the Centre for Addiction and Mental Health. It can be accessed at http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disorders/CD_priority_projects.html.

As well, a recent comparison of models used in other jurisdictions can also provide helpful food for thought as Niagara develops its approach to serving people with concurrent disorders.[20]

Recommendation #13: The NHS Addictions Service and NHS mental health programs, working together with their community partners, should develop a common categorization of concurrent disorders, then develop a plan (also with their community partners) to produce either program integration or system integration to serve people with concurrent disorders.

[20] Puddicombe J, Rush B, Bois C. *Concurrent Disorders Treatment: Models for Treating Varied Populations*. Program Models Project 2003–04. Centre for Addiction and Mental Health, 2004

12.5 Cohesion/Integration of Addictions Services and Emergency/Urgent Care Services

Several stakeholders engaged during the program review identified problems with how people with addictions are served by NHS emergency departments, including:

- Making people with addictions feel unwelcome in the emergency department
- Assumptions (sometimes unwarranted) that people with addictions are only in the emergency department to get access to drugs. This can lead to misdiagnosis of genuine physical or emotional health issues that have brought the person to the emergency department.[21]
- Failure to refer people with addictions from the emergency department to appropriate addictions resources.

Some people who raised these concerns also pointed out that solving these problems should not lie solely on the shoulders of emergency department personnel. Addictions services should play a greater role as problem-solvers with emergency department personnel in identifying, screening and providing brief assistance to people in the emergency department with addictions problems.

Some solutions have been instituted collaboratively between NHS addictions programs and NHS emergency departments:

- Nurse-to-nurse referrals from emergency departments to NHS addictions programs
- Signage in emergency departments making people aware of the availability of addiction services elsewhere in NHS (although one stakeholder considered this to be a possible danger that might divert people inappropriately from emergency services).

Earlier, this program review cited the promising opportunity to identify, in emergency departments, people who are there because of the results of an addiction-related problem and who may be open to help when screening in the emergency department indicates they have an addictions problem. The assistance may comprise two parts:

- Brief motivational counselling in the emergency department
- Follow-up referral for more detailed assessment and a referral to an addictions resource within or beyond NHS.

> "Opportunistic screening of alcohol-related attendances by accident and emergency staff is of little use, unless it is followed by uptake of a health intervention. Anti-alcoholic interventions can be of a variety of forms, but they all aim at effectively targeting the patient to help him/her recognize his/her drinking problem and the need for help. The benefits of brief anti-alcoholic interventions in the management of people who are at the early and critical stage of alcohol misuse have been well documented both in the accident and emergency department, as well as in general practice and in hospital settings)."
>
> **Charalambous, M. *Alcohol and The Accident And Emergency Department: A Current Review.* Alcohol and Alcoholism Vol. 37, Issue 4, 2002**

[21] Some stakeholders who raised this concern also pointed out that some people with addictions do visit emergency departments to gain inappropriate access to drug prescriptions, and can be skilled at feigning conditions that warrant prescription of psychoactive drugs.

> "Researchers have documented the relationship between substance use and trauma, especially motor vehicle accidents that end in serious injury. Both emergency departments and trauma centers treat a high proportion of patients whose condition is related to alcohol misuse (Gentilello, Donovan, Dunn, & Rivara, 1995; Maio, Waller, Flow, Hill, & Singer, 1997). About 30 percent of those admitted to a trauma center have a positive heightened blood alcohol level (Soderstrom et al., 2001). Pivotal studies by Gentilello and colleagues (1995; 1999) showed significant reductions in drinking and reinjury following a brief intervention that are consistent with findings from other emergency department research… Gentilello subsequently estimated that 'The brief intervention resulted in $3.81 in health care costs saved for every $1.00 spent on screening and intervention'".
>
> ***Integrating Appropriate Services For Substance Use Conditions In Health Care Settings: An Issue Brief on Lessons Learned and Challenges Ahead.*** **Forum on Integration, July 2010**

The NHS Addictions Service can provide help in at least five ways:

1. By providing training and support to emergency department staff and urgent care department staff who are willing to conduct screening or brief motivational sessions in the emergency department or urgent care centre
2. By placing an addictions counsellor in these departments (perhaps only at peak times) to help via screening and motivational counselling. However, this may not be cost-effective if patient volumes in need of this service are too low.
3. By having addictions counsellors visit emergency/urgent care departments on an on-call basis to help via screening and motivational counselling when a client needs assistance
4. By arranging for a patient in the emergency/urgent care department to immediately visit an NHS addictions service site (if this can be done without jeopardizing patient safety) to be screened and to receive brief motivational counselling
5. By providing brief over-the-phone screening and brief motivational counselling to patients in emergency/urgent care departments.[22]

What the appropriate mix of these supports should be, for each NHS emergency department and urgent care centre site,[23] requires further joint planning between NHS addictions programs and NHS emergency departments and urgent care centres. NHS mental health services should also be involved in the planning, since many addictions-related emergency department issues may be mirrored by similar mental health issues.

.

Recommendation #14: The NHS Addictions Service, NHS mental health programs, NHS emergency departments and NHS urgent care centres should collaboratively develop a joint plan for providing addictions and mental health support in NHS emergency departments and urgent care centres. In terms of addictions service support, this should involve provision of (and/or support for) screening, brief motivational counselling services and referral.

[22] Rhode Island Hospital is conducting research to determine whether brief counseling delivered by telephone is more effective than standard ED care in reducing future alcohol related injuries/alcohol related negative consequences for injury patients treated in the ED.

[23] A solution should be tailored to each NHS emergency department (St, Catharines, Niagara Falls and Welland) and each NHS urgent care centre (St. Catharines, Fort Erie and Port Colborne) to forestall the reality or appearance of inequitable distribution of addictions services.

This collaboration may also have the side-benefit of reducing the stigmatization of emergency department visitors who have addictions problems.

> "Trauma centers can use the teachable moment generated by the injury to implement an effective prevention strategy, for example, alcohol counselling for problem drinking. Alcohol is such a significant associated factor and contributor to injury that it is vital that trauma centers have a mechanism to identify patients who are problem drinkers. Such mechanisms are essential in Level I and II trauma centers. In addition, Level I centers must have the capability to provide an intervention for patients identified as problem drinkers. These have been shown to reduce trauma recidivism by 50 percent."
>
> **Committee on Trauma, American College of Surgeons, 2006**

12.6 Cohesion/Integration with Non-Hospital Services

NHS addictions programs are only one part of the array of addictions treatment and recovery services available in Niagara Region. While this program review did not find any evidence of serious conflicts among addictions, mental health or related agencies in Niagara Region (and in fact found evidence of collaboration among these agencies), the program review also did not find evidence that services are generally linked via service agreements among these agencies. This leaves the combined service system vulnerable to one-off decisions by agencies to back out of, or change the conditions of, collaborative working relationships without consulting other parties.

Service agreements should specify the following:

- the roles and responsibilities of partner agencies
- how client referrals are made
- admission and discharge criteria
- method of conflict resolution
- scope of practice
- responsibility of partner services for ensuring continuity of care
- protocols for routine screening, integrated (joint) assessment and treatment planning and referral and/or single point of access for clients
- entering substance use and mental health service systems
- regular case conferencing
- consultation and/or supervision across systems and services
- mobile resource teams or person to provide expertise to a variety of services/locations
- cross-system secondment or placement of clinical staff
- interagency or blended service delivery teams
- co-location of services in one physical location.[24]

[24] These characteristics of service agreements were adapted from *Concurrent Disorders Policy Framework – September 2005*. Concurrent Disorders Ontario Network, 2005, but they are applicable beyond concurrent disorders.

Recommendation #15: The NHS Addictions Service should work with community partners to develop service agreements in areas where collaboration exists or is under development. These service agreements may include agreements with specialized service elsewhere in the Hamilton Niagara Haldimand Brant LHIN, and may also include service protocols between NHS Addictions Service and other NHS programs such as mental health and emergency services.

12.6.1 Primary Care and Community Health Centres

"Many health problems or mental disorders that healthcare practitioners (particularly those in primary care) encounter in their everyday practices derive from or are complicated by alcohol use disorders (AUDs). Consequently, healthcare practitioners are in key positions to manage the care of large numbers of individuals with AUDs. However, only a small percentage of these patients are actually treated for AUDs in these settings."

***TIP 49: Incorporating Alcohol Pharmacotherapies Into Medical Practice*. Substance Abuse and Mental Health Service Administration, 2009**

Most addictions service systems have difficulty engaging the primary care community in addictions services, and for understandable reasons. Primary care practitioners are often overworked, they often have trouble finding the time they would like to devote to patients with addictions problems, they often receive no financial incentive for addressing the often demanding needs of people with addictions, they receive less than thorough education in addiction medicine and they may not know how to access complex, confusing multi-agency service systems for addictions for their patients.

"According to the results of the 2007 National Physician Survey (NPS), 4.8% of family practitioners in Canada estimate that 10% or more of their practice populations have problems with substance addiction."

Kotecha J, Savage C. *Primary care and collaboration with addiction counsellors*. Canadian Family Physician, Vol. 56, No. 6, June 2010

Best practice literature on primary care and addictions suggests that primary care resources can play major roles in prevention, screening, referral for assessment, referral for treatment, case management, medication prescription and management, and treating medical conditions caused by or associated with, addictions.[25]

Addictions programs like those operated by NHS can assist primary care physicians by providing information on addictions and on addictions screening/treatment, help in understanding and navigating the addictions service system, and responding promptly to questions and requests for help from practitioners. This program review's understanding is that NHS addictions programs do their best to discharge these roles.

[25] *TIP 24: A Guide to Substance Abuse Services for Primary Care Clinicians*. Substance Abuse and Mental Health Service Administration, 1997

The NHS Addictions Service also has an opportunity to capitalize on the growth in the number of community health centres (CHCs) in Niagara in the last few years:

- **Niagara Falls Community Health Centre**, recently opened in Niagara Falls, has a counselling component under development.
- **Bridges Community Health Centre** (serving Fort Erie and Port Colborne/Wainfleet, and with service sites in both Port Colborne and Fort Erie) has a mental health program that provides the services of a mental health nurse and consulting psychiatrists for adults and children.
- **Quest Community Health Centre** (serving St. Catharines/Thorold and located in downtown St. Catharines) has, as one of its priority populations, "people with mental health/addiction issues".
- **Centre de santé communautaire Hamilton/Niagara**, established in 1992, is a Francophone CHC providing health and social services to French-speaking clients. Its Welland site serves Niagara Region and its Hamilton site serves Hamilton and Burlington. It provides mental health services for adults, youth and children**.**

During the engagement phase of this project review, officials of three of the four community health centres in Niagara Region expressed an interest in further pursuing the relationships CHCs might develop with the NHS Addictions Service and with the addictions service system as a whole.

Recommendation #16: Officials from the NHS Addictions Service and NHS mental health programs should meet with officials of Niagara Region's four community health centres to explore programmatic cooperation. A representative of Community Addiction Services of Niagara should also be invited to the meeting.

In future, the NHS Addictions Service will have an opportunity to link in a similar way with the Life Sciences Centre slated to open next year in Welland on land transferred to the Centre by NHS. This centre will include a family health team care clinic, a medical arts centre for doctors, medical student placements, and allied health professionals to improve and expand community health services and complement hospital services.

12.7 Co-Located Addictions Agency Satellite Services

This program review has suggested that NHS addictions programs would play a specific role in the broader Niagara addictions services system, providing acute care to people who have severe addictions problems that are made more complex by physical and psychological conditions caused by, or associated with, their addictions. This is where hospital-based addictions programs, well linked to other hospital programs and to community resources, can make the most difference.

Within Niagara, most outpatient, community treatment and day/evening treatment for people with addictions would be provided by agencies other than NHS – most notably by Community Addiction Services of Niagara (CAS-N). CAS-N would serve clients who might never come into contact with NHS addictions programs, or whose contact is limited to withdrawal management. But CAS-N would also serve clients who have completed residential treatment at NHS and who require less intensive post-residential treatment, aftercare and relapse prevention.

IF CAS-N carried out this role for all post-discharge NHS clients, there would be no need for satellite NHS offices to provide these services. But there may be compelling reasons for NHS to provide the follow-up services to at least some of the clients NHS served in its residential treatment program. For instance, a particularly powerful therapeutic bond may have been created between a client and her NHS councillor – a bond that should be carried forward into the post-residential phase.

> "Appropriate therapy by competent counsellors with strong interpersonal skills, such as empathy and the ability to forge a therapeutic alliance with the client, is associated with an increase in positive treatment outcomes."
>
> ***Best Practices - Concurrent Mental Health and Substance Use Disorders*. Health Canada, 2002**

Rather than creating satellite offices for the provision of non-residential follow-up services that NHS should provide in smaller communities, NHS should work with CAS-N to develop an integrated outreach capacity in communities beyond St. Catharines in which CAS-N has a presence – Fort Erie, Niagara Falls, Welland, Port Colborne and Grimsby.[26] NHS contributions to this integrated office would be provided by visiting NHS staff, since it unlikely that the combined NHS/CAS-N presence in these communities would be on a full time basis. NHS mental health programs may also benefit from doing combined concurrent disorder work in these smaller communities via an affiliation with a combined NHS/CAS-N office in smaller communities.

These integrated outreach offices could provide more than service co-location. They might also provide joint programming such as co-led treatment groups in these communities. And since CAS-N outreach offices in smaller communities are located in or adjacent to NHS hospital sites with emergency departments or urgent care centres, there are opportunities for synergies among addiction services, mental health services and emergency services in these communities.

Recommendation #17: The NHS Addictions Service should work with Community Addiction Services of Niagara, with NHS mental health programs and with any other potential partners (including NHS emergency departments and urgent care centres) to develop integrated service outreach sites in Fort Erie, Niagara Falls, Welland, Port Colborne and Grimsby.

[26] The relationship between NHS addiction services and Grimsby and environs is not fully clear. While NHS addictions programs would accept any eligible client from Grimsby and environs, that part of Niagara Region is not considered part of the NHS service area for many other NHS services, since residents of this area gravitate toward Hamilton for services or receive service from West Lincoln Memorial Hospital in Grimsby, the only hospital in Niagara Region that was not amalgamated into NHS.

12.8 A Multi-Agency Addictions System of Excellence

The *Revised Addendum to the Niagara Health System Hospital Improvement Plan* proposed the creation of nine NHS centres of excellence, including a mental health centre of excellence and an addictions centre of excellence.

Neither the *Addendum* nor the *Niagara Health System Hospital Improvement Plan* defined a centre of excellence. However, Dr. Jack Kitts, author of the *Review of The Niagara Health System Hospital Improvement Plan* (October 2008), provided the following definition in his review:

> "A centre of excellence is a program seeking the highest standards of achievement. The centre of excellence brings together a critical mass of patients, providers and infrastructure to enable leading quality care. The centre of excellence may be virtual, supported by information communication technologies, or may be consolidated to a single site. The centre of excellence, as a program hub, shares its expertise with other sites, ensuring that all sites receive excellent quality care"

A review of literature on centres of excellence produces very little information that adds to an understanding of what the term "centre of excellence" means in health care or other settings. However, the definition cited by Kitts provides at least part of the basis for defining a centre of excellence in a way that NHS addictions programs can use, based on the premise that any excellent organization meets three benchmarks:

- **It puts in place excellent[27] inputs** — As per the Kitts definition, "a critical mass of patients, providers and infrastructure to enable leading quality care"
- **It applies these inputs by organizing them into excellent processes**
- **It achieves excellent outcomes through the application of these excellent processes** — As per the Kitts definition, "highest standards of achievement…. excellent quality care"

Accordingly, if the NHS Addictions Service becomes a centre of excellence in addiction service, it must:

- Define the kinds and quality of **inputs** it requires in order to call its inputs "excellent"
- Define the kinds and quality of **processes** it requires in order to call its processes "excellent"
- Define the kinds and quality of **outcomes** it requires in order to call its outcomes "excellent"
- Achieve or exceed the levels of excellence it has defined
- Demonstrate it has achieved these levels of excellence, through evaluation.

However, the NHS Addictions Service may want to re-think whether NHS has adopted the right level of scale in pursuing a role as a centre of excellence in addictions service.

[27] "Excellence" can be defined to mean:
- Above average
- Meeting or exceeding standards in ways that can be measured.

Given current emphasis on the creation of effective systems, it may make more sense for NHS to contribute toward creating a ***system*** of excellence in addictions – or in addictions and mental health – rather than an NHS ***centre*** of excellence in addictions services in Niagara. This would not impede the achievement of excellence at NHS. Rather, it would help raise everybody to excellence. This reframed vision of excellence may attract the attention and support of enabling bodies such as the Hamilton Niagara Haldimand Brant LHIN and the Ministry of Health and Long-Term Care.

Recommendation #18: The NHS Addictions Service should initiate a change process in pursuit of excellence, starting with a specification of what it needs in order to achieve excellent inputs, processes and outcomes.

Recommendation #19: The NHS Addictions Service should consider reframing the "**centre** of excellence" model so it becomes a "**system** of excellence" model for addictions, or for addictions and mental health, in Niagara Region.

13. EFFICIENCY WITHIN NHS ADDICTIONS PROGRAMS

13.1 Co-Location of Programs

During the engagement phase of this program review, several stakeholders said that co-locating NHS addictions programs would produce efficiencies. For example, at present each of three residential facilities located in separate buildings (the Women's Withdrawal Management Service, the Men's Withdrawal Management Service and New Port Centre)[28] must provide a minimum night shift complement of two staff. Co-location of these facilities in one building could require fewer night staff, generating savings.

As well, co-location would generate savings per unit of space because of more efficient operation of the physical plant – heating costs as well as maintenance costs (the current buildings are old, require extensive maintenance, and were not designed to meet current standards of energy efficiency).

More efficient use of space can also be achieved, including reduction of duplicated kitchen, food preparation and storage areas, a single entrance area rather than three, and meeting/activity rooms that serve all three programs (less room duplication).

Stakeholders also pointed out that co-location in a new purpose-designed building would produce service quality improvements as well as efficiencies. In terms of the access dimension of quality, for example, the new building would be built to meet accessibility standards for people with disabilities as well as up-to-date design standards to meet the programmatic needs of withdrawal management centres and treatment facilities.

As well, cross-program staff meetings and educational sessions would be easier to hold, thereby increasing staff competence and cohesion (important dimensions of quality).

[28] A fourth residential facility affiliated with NHS – Branscombe House – is a women's residence, it would not become part of the new site, and as per an earlier recommendation in this program review report, would be divested from NHS as soon as this is feasible.

The preferred site for co-located programs is St. Catharines because it is the largest community in Niagara Region and therefore generates the largest number of clients who use NHS programs. Within St. Catharines, two options for location of the new facility are programmatically feasible:

- A location on the site of the new hospital in St, Catharines, in a building adjacent to the main hospital physical plant
- A location in downtown St. Catharines.

Both sites have advantages, shown below.

Site Adjacent to New St. Catharines Hospital	Site in Downtown St. Catharines
ADVANTAGES	**ADVANTAGES**
• Proximity to the emergency department, so joint/ complementary programming between addictions and emergency services is easier to achieve • Proximity to NHS psychiatric/mental health services, so joint/complementary programming between addictions and mental health services is easier to achieve • Proximity to NHS physical health programs for to physical conditions faced by people with complex addictions, making joint/ complementary programming between addictions and physical health services is easier to achieve • Some support services provided in the main hospital building could be shared/extended to serve the addictions facility (food services, maintenance services, meeting rooms, audiovisual equipment bank, computer system maintenance resources) • Greater visibility for addiction programming in the eyes of hospital staff and physicians • Ease with which addictions service staff can participate in educational sessions held in the main hospital building • May send a signal to some clients, staff and visitors that addictions services are equal in value to physical health services • Proximity to doctors' offices in a medical building adjacent to the hospital • Will be on a major municipal bus route • Further from locations where alcohol and drugs are more readily available.	• Proximity to a range of health and social support services that are located downtown (including Quest Community Health Centre), making it easier to develop and operate joint/ complementary programming that is accessible to clients • May be located close to where many St. Catharines clients live • May be easier to attract other organizations to co-locate there if these organizations prefer to be located downtown for ease of access by clients • Closer to the transit hub in downtown St. Catharines • While a downtown location may face a "not in my back yard" reaction, it may also fit well with the Provincial Growth Plan that designates downtown St. Catharines as an Urban Growth Centre (UGC) that is intended to be the "focal area for investment in institutional and region-wide public services"[29] and therefore may receive municipal support and assistance.

From a program point of view, this program review report recommends placing the addictions centre in a purpose-designed building on the grounds of the new NHS St. Catharines hospital site, largely because of the program connections that can be

[29] *Niagara's Growth Management Strategy Backgrounder: Charting Our Shared Future.* Regional Municipality of Niagara, September/November, 2006

developed between addictions programs and other NHS programs for both mental health and physical health – connections that will require virtually day-to-day contact among many of these programs.

On the other hand, if this preferred option is considered unfeasible or unacceptable to NHS, the option of locating the addictions centre in a purpose-designed building in downtown St. Catharines is also an acceptable option. If this is chosen as the option, NHS should make provisions so that liaison and joint programming between addictions programs at the downtown site, and other NHS programs at the St. Catharines hospital site, can be as effective and efficient as possible. This may include, for instance, providing space at each site that can be used by visiting clinicians from the other site.

Recommendation #20: NHS addictions programs should be located in a purpose-designed building on the grounds of the new NHS St. Catharines hospital. If this is not feasible or acceptable, NHS addictions programs should be located in a purpose-designed building in downtown St. Catharines. The following programs (along with NHS Addictions Service administrative offices and centralized building/program support services) would be located in the addictions centre:

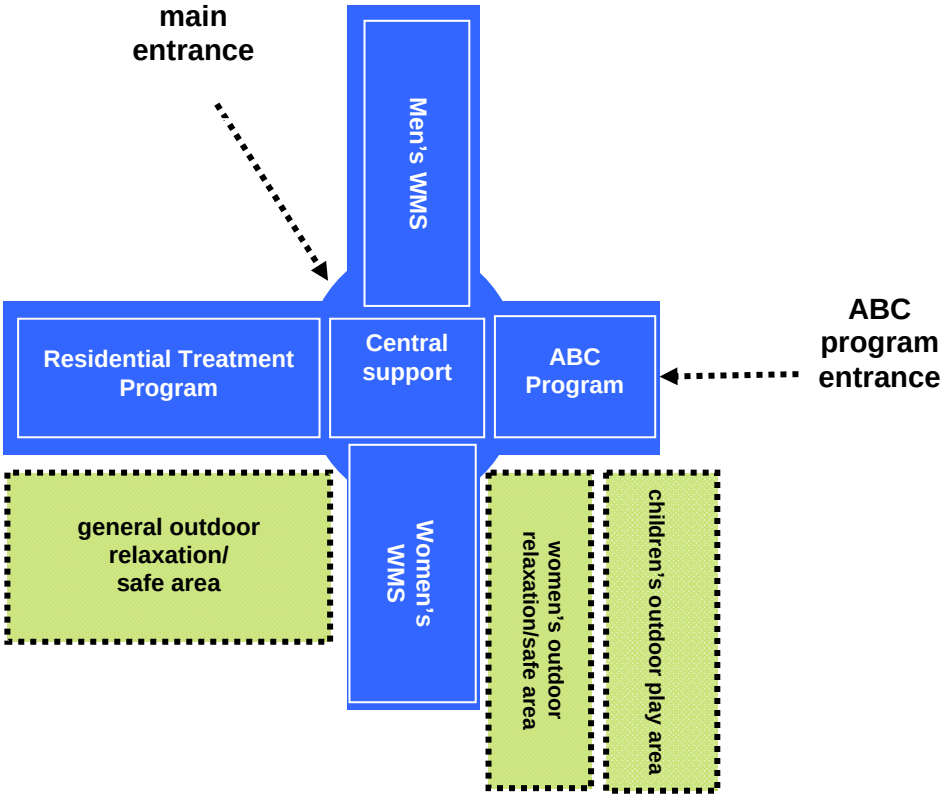
- The Women's Withdrawal Management Service
- The Men's Withdrawal Management Service
- The short-term residential treatment program (New Port Centre)
- The ABC Women's/Early Childhood Development program
- The Nurse Practitioner Primary Care Program
- The Out and About Methadone Program
- Any other specialized addictions-related programs added to the NHS Addictions Service portfolio (for example, a hepatitis C clinic).

13.1.1 Design Considerations for the Addictions Centre

- Each of the three residential programs, as well as the ABC Program, should have its own distinct part of the building. However, the withdrawal management components should be designed to allow for use of some beds for people of either gender without compromising the sense of safety that clients derive from gender-specific areas.
- The building should have with maximum window space to bring light into the building (although some WMS areas may need light restrictions to avoid sensory over-stimulation of people who are detoxifying).
- All four of these program spaces should connect to a central support area that should also include administrative offices, the Out and About Methadone Program, the Nurse Practitioner Primary Care Program, any other specialized addictions-related programs added to the NHS Addictions Service portfolio, and space to be rented to any other co-locating agencies.
- If the centre is located in downtown St. Catharines it should also include space for clinicians and clinical programs visiting from the main NHS site.
- The number of entry/exit points should be limited to ensure safety and building control.

- It should include both indoor space and outdoor space, including safe outdoor spaces for children and for women.
- Since land is at a premium at both possible sites, the size of the building footprint may need to be as small as possible, On the other hand, the building may not function well as a residential and child/mother service centre if it is a square high-rise building. A compromise might be to limit the residential treatment, withdrawal management and ABC Program areas to two stories, while allowing the central core of support services and non-residential programs to exceed two stories.
- The centre should provide space for current and future co-location of other agencies, and should be built in a way that allows for easy building expansion in the longer term to accommodate NHS addictions program expansion or additional co-locating agencies (including outreach service from other NHS programs that would benefit from a downtown St. Catharines location).
- It should be fully accessible to people living with sensory or mobility disabilities.
- Accessibility design features should be reviewed by a committee of people living with disabilities, to be sure that "on paper" accessibility features are actual accessibility features.[30]

The following building schematic represents the broad relationships among program spaces and other spaces within the addictions centre.



[30] For instance, in Ontario it is possible for a building to include "accessible washrooms" that conform to the building code but that are still inaccessible to many people using wheelchairs.

14. A PROJECTION OF NHS ADDICTIONS PROGRAM SERVICE DEMAND

14.1 Population Trends Affecting the Projection

Between 2009 and 2019, the Hamilton Niagara Haldimand Brant LHIN's population is projected to grow by about 9.6% to over 1.5 million people.[31] This growth rate is slower than the Ontario rate of 12.1%. Growth within the LHIN varies by community. Burlington is projected to grow the fastest and Niagara Region is projected to grow the slowest.

Projected population counts for Niagara Region[31], 2009 to 2019, are:

- 2009 = 436,053
- 2019 = 455,566 (growth rate of 4.47 % over the 10 year period).

The largest communities in Niagara are St. Catharines, Niagara Falls and Welland. According to *Region of Niagara – A Strategy for a Healthy Sustainable Niagara 2031*, which recommended a medium growth strategy for the region, Niagara Falls will grow at the highest rate, reaching a population of 98,000 by 2026.

The Hamilton Niagara Haldimand Brant LHIN's population is aging. The highest rate of population growth in LHIN as a whole, and in Niagara Region, over the ten year period from 2009 to 2019 will be in the 65 to 74 years of age range.[31]

Over 200,000 seniors live in the Hamilton Niagara Haldimand Brant LHIN – the largest number of seniors of all Ontario LHINs.[31] As of 2009, seniors 65 years of age and older comprised 15.7% of the total Hamilton Niagara Haldimand Brant LHIN population, compared to 13.6% for all of Ontario. Based on projections for 2019, seniors will comprise 18.7% of the LHIN's population compared to 16.7% for the province as a whole. Seniors 65 years of age and older, in Niagara Region, comprise 17.7% of the total Niagara population.

The projected rates for population growth from 2009 to 2019 by age in Niagara are:[31]

- **age group 65 to 74**: 38.7% growth rate
- **age group 85 and older**: 19.2% growth rate
- **age group 74 to 85**:11.1% growth rate
- **age group 45 to 64**: 5.3% growth rate
- **Younger groups** as percentage of overall population will decline, and the population aged less than 15 years is projected to actually decline by 2.8%.

The Hamilton Niagara Haldimand Brant LHIN has lower percentages of immigrants and visible minorities than Ontario as a whole.[31] Within the LHIN the highest percentage of immigrants and visible minorities are located within the Hamilton area. Niagara region has the second highest rates.

Compared to the province the Hamilton Niagara Haldimand Brant LHIN has a lower percentage of the population living below the low income cutoff.[31] Socio-economic characteristics vary across the LHIN. For example, Hamilton has 18.1% of its population

[31] Hamilton Niagara Haldimand Brant LHIN. *HNHB Health Atlas.* December 2009

living in low income which is considerably higher than the 8.0% for Haldimand. In Niagara Region the rate is 12 % (and over 13 % for women). Compared to the Ontario average, the Hamilton Niagara Haldimand Brant LHIN has higher percentages of lone parent families and seniors living alone and a lower percent of adults with postsecondary education.

14.2 Population Risk Factors Affecting the Projection

Health disorders often develop as a result of one or more modifiable factors, called risk factors. Reducing or eliminating the occurrence of a specific risk factor could significantly reduce the occurrence of a disorder. Two notable risk factors are alcohol consumption and smoking. The Hamilton Niagara Haldimand Brant LHIN's *Health Atlas* (2009) provides useful information on behavioural risk factors. Statistics cited in the section below are drawn from the *Health Atlas* as well as from Canadian Community Health Survey, 2009 (Stats Can).

14.2.1 Behavioural Risk Factors

Potential Years of Life Lost (PYLL) are useful for measuring the number of years of life lost from deaths that occur prematurely (i.e., before age 75). In 2005, there were over 66,000 potential years of life lost among residents of the Hamilton Niagara Haldimand Brant LHIN. Heart disease, lung cancer, suicide, and motor vehicle collisions account for the most potential years of life lost. The rate of potential years of life lost is higher in this LHIN compared to the province and variation is seen within the LHIN.

Relative to the province, more people in the Hamilton Niagara Haldimand Brant LHIN smoke daily or occasionally, drink heavily, and are obese. In 2007, 25.1% of residents of the LHIN were daily or occasional smokers, 27.0% consumed five or more drinks on one occasion, at least once a month within the last year, and 52.8% were active or moderately active. In addition, 32.2% of adults within the LHIN's population were considered overweight and 19.3% were obese.

Differences in lifestyle behaviours are seen for men and women. Compared to Ontario, the Hamilton Niagara Haldimand Brant LHIN has a significantly higher percent of:

- Women who are daily or occasional smokers
- Both men and women who drink heavily
- Men who are physically active
- Women who are obese.

The LHIN trends were reflected in the Niagara specific information. The following Niagara specific information was extracted from the Canadian Community Health Survey, 2009 (Stats Can) as provided on the Niagara Region Health Unit web site.

Niagara: Alcohol Consumption

Niagara has a significantly high percentage of its population who consumed 5 or more drinks on one occasion (42.1%), which is considered high risk drinking. The percentage for Ontario as a whole is 34.5%.

Niagara reports a significantly higher number of youth who participate in high risk drinking than Ontario. 38.9% of Niagara youth aged 12-19 reported consuming 5 or more drinks on one occasion in comparison to 33.1% of Ontario youth.

Likewise, Niagara has a much higher adult population that participates in high risk drinking. About 44.8% of Niagara adults over the age of 20 report having consumed 5 or more drinks on at least one occasion in the past year; whereas, 36.4% of Ontarians over the age of 20 have reported the same.

Niagara: Youth Smoking

Niagara has a high number of youth smokers. 17.6% of Niagara youth aged 12-19 reported smoking daily or occasionally, which is much higher than that of Ontario (9.5%).

In regards to passive smoking, 20.1% of Niagara youth aged 12-19 are exposed to passive smoke in the home everyday or almost everyday, which is much higher than that reported for Ontario as a whole (15.6%).

Niagara: Adult Smoking

30.9% of Niagara adults over the age of 20 reported smoking daily or occasionally.

Niagara: Well-Being Measure

Percentage of persons who identify their health as very good or excellent:

- Niagara = 58.6%
- Ontario = 61.2%.

This perception of good health was slightly lower than the provincial average, and notably lower for women in Niagara versus the rest of the province:

- Women in Niagara = 54.9%
- Women in Ontario = 60.9%.

Increases in service demand in the future may reflect a broader and longer-term societal move toward more substance use (particularly heavy substance use) if that broad pattern continues. As the above analysis of risk factors shows, Niagara is already at higher risk than most of the Hamilton Niagara Haldimand Brant LHIN population, and the population of Ontario as a whole.

"Since 1994 the proportion of women and men who reported drinking in the 12 months prior to the survey has increased as has the proportion who reported drinking heavily… There has been an increase in moderate drinking (one to three times a month) and a decrease in patterns of more frequent use (one to three times a week) for women. For men there has been a decrease in light drinking (less than once a month) and an increase in patterns of moderate use (one to three times a month). For both women and men lifetime illicit drug use especially use of cannabis was higher in 2004 than 10 years previously. More specifically the prevalence of lifetime use of most illicit drugs has doubled or more than doubled since the CADS survey in 1994…

- The proportion of heavy drinking (five or more drinks) also increased from 1994 to 2004. Among women, heavy drinking increased in Alberta (6.0% to 12.5%), and among men in B.C. (15.2% to 24.2%), Manitoba (19.2% to 28.8%) and Ontario (14.6% to 22.7%).
- In 2004 compared to 1994, more women were drinking moderately and less often (light infrequent), whereas more men reported drinking heavily and infrequently and heavily and frequently."

***Focus on Gender - A National Survey of Canadians' Use of Alcohol and Other Drugs. Canadian Addiction Survey (CAS),* 2004**

14.2.2 Economic Risk Factors

Increased demand for addiction services in Niagara Region will likely be driven modestly by population growth, except for the growth rate of older populations. Growth in demand for services may be driven in part by Niagara's socio-economic health. The relationship between economic downturns and increased addictions service demand is inconclusive but there is evidence that economic conditions that lead to unemployment, under-employment and occupational, family and personal distress can lead to increased demand for addictions services, perhaps largely because of stress-induced relapses.[32, 33]

"The relationships between macroeconomic changes and overall health, drug and alcohol use are complex and, in some cases, counterintuitive. Further research… is urgently needed. Nevertheless, there is international evidence to indicate that illicit drug use is likely to increase during an economic downturn. While the evidence relating to alcohol consumptions and harm is mixed, there are concerns that binge drinking may increase during a recession. When taken together with the observations by service providers who consistently report an increased demand during an economic downturn, this evidence review should be used as the basis for policy recommendations that seek to protect and expand drug and alcohol services during a period when they are likely to come under sustained fiscal pressures."

***The relationship between the economic downturn and alcohol and other drug use and harm: New Zealand Drug Foundation evidence review.* May 2009**

[32] Franklin K. *The Impact of the Economy on Individuals with Mental Health and Addiction Challenges: Tangible and Intangible Effects.* North Carolina Medical Journal July/August 2009
[33] Catalano R. et al. *Job Loss and Alcohol Abuse: A Test Using Data from the Epidemiological Catchment Area Project*. Journal of Health and Social Behavior Vol. 34 September 1993

Indicators suggest that Niagara Region's economic conditions have been less promising than the province as a whole, and will remain less promising.

> "There are relatively lower economic growth and employment levels in the Region (compared to other GTA west municipalities), with a significant portion of the labour force commuting out of the Region for work in Hamilton and other areas (.81 employment/labour force ratio)….Gross domestic product growth in Niagara has been adversely impacted by negative growth in the manufacturing sector. The real gross domestic product (GDP) in the St. Catharines-Niagara CMA has declined over the past few years. It declined by 0.2% in 2006. This may be compared to a real GDP growth of 1.7% at the provincial level. Real GDP in the St. Catharines-Niagara CMA is forecasted to increase slightly in 2007 and then increase by 2.5% in 2008, dropping down to an increase of 2.0% by 2011. Forecasted GDP growth rates are lower for the Niagara-St. Catharines CMA compared to the province"
>
> ***The Regional Municipality Of Niagara: Growth Management Strategy: Understanding Niagara Report*. Dillon Consulting**

If unpromising economic conditions are (and will remain) a fact of life in much of Niagara Region, a relatively high level of associated addiction problems is even more likely, since current research suggests a link between long-term adverse economic conditions and the prevalence of addictions (at least in terms of heavy drinking).

> "Longer durations of poverty and involuntary unemployment across a span of 13 years significantly predict being a heavy drinker and more frequent heavy drinking at ages 27–35 years. These effects are independent of gender, age, race/ethnicity, marital status, prior heavy drinking, and present socioeconomic status. Overall, this study contributes to the literature that histories of poverty and involuntary unemployment have lasting effects on heavy drinking."
>
> **Mossakowski K. *Is the duration of poverty and unemployment a risk factor for heavy drinking?* Social Sciences and Medicine Vol. 67 Issue 6, September 2008**

14.3 Estimating Desirable Capacity Requirements

Continuum of services and NHS Roles

Descriptions of a continuum of services for addictions are usually linked with the broader approach to both mental health and addictions issues. Continuums typically include the range of activities from health promotion to assessment, counselling, residential treatment, medical intervention as required, and a range of options for ongoing community supports.

The Ontario Federation of Ontario Federation of Community Mental Health and Addictions Programs has stated that:

> "Addiction services are sidelined in a system where the impact of substance abuse continues to divert much needed resources. Inclusion of Addiction services in a National Home and Community Care Basket of Services will strengthen the entire health sector. Approximately, half of individuals who suffer with serious mental illness also struggle with substance abuse and addiction issues. This extremely high rate of concurrent disorders represents a significant strain on the existing institutional sectors such as hospitals and the criminal justice system. Therefore, it is essential to include addiction services to ensure the effectiveness of a complete health care delivery system. In addition key addiction components would include:
>
> - medical withdrawal management
> - withdrawal management for special needs populations: opiate dependent, youth, older adults, young adults, women, HIV
> - addiction assessment services
> - day treatment
> - home withdrawal services."[34]

In his paper on projecting service needs for alcohol addictions, Dr. Brian Rush noted the following as key components of the service continuum:

- Detox
- Assessment
- Out patient
- Day treatment
- Short term residential
- Long term residential
- Aftercare
- Case management.

[34] *Establishing the Basket of Services for a National Home Care Program for Mental Health and Addiction Clients: A Perspective from the Ontario Federation of Community Mental Health and Addiction Programs.* Ontario Federation of Community Mental Health and Addiction Programs.(undated)

For the purposes of this program review for NHS services, the focus is on four services along the addictions service continuum, because they are provided by NHS – assessment, withdrawal management services, short term residential treatment and aftercare. Projections for services provided by other addictions and related agencies in and for Niagara should be developed as part of a Niagara-wide addictions and mental health services planning process.

14.3.1 Projecting Future Capacity

An important part of any program review is to assess capacity, how it is meeting current needs and how it will meet future needs. There is an absence of any definitive formulae for setting service level targets for addictions services. Attempts have been made to provide a population based methodology to project the need for services related to alcohol addictions, and this is discussed below.

In the absence of a methodology based on population, the default approach is to adapt current capacity numbers by growth, or utilization based planning. While not optimal it does provide some baseline level of what might be reasonably expected in the future. Shortcomings of this approach include the fact that utilization is not necessarily a valid proxy for need and does not take into account trends or other actions that might significantly increase or decrease service demand. For example, deteriorating social determinants of health in an area might result in higher levels of drinking, and proactive programs of education and/or other investments in community programs might reduce the demand for addiction services.

It is important to note that in Niagara, while the primary substance abuse reported is to alcohol, a significant percentage of the clients in NHS addictions programs present with addictions to more than one substance, and are considered poly-substance abuse clients. The chart below illustrates the break down of substance abuse, by top 10 substances, presenting at time of admission to NHS's withdrawal management services.

Substance	Fiscal Year 2007/08 % of Clients Presenting	Fiscal Year 2009/10 % of Clients Presenting	Percentage point increase/ decrease
Alcohol	64.4	70.3	+ 5.9
Tobacco	30.1	65.3	+ 35.2
Cocaine	46.5	38.5	- 8.0
Cannabis	25.9	28.5	+ 2.6
Crack Cocaine	32.7	27.8	- 4.9
Prescription Opioids	21.9	31.4	+ 9.5
Benzodiazepines	7.3	11.6	+ 4.3
Heroin/Opium	6.8	8.4	+ 1.6
Over-the-counter substances	2.7	5.6	+ 2.9
Ecstasy	4.2	6.0	+ 1.8

Admissions to the withdrawal management centres at NHS for every substance except cocaine and crack cocaine has increased between 2007/08 and 2009/10.

For alcohol treatment a capacity-predicting methodology involving four steps was developed by Dr. Brian Rush two decades ago that garnered international attention:[35]

- **First step:** defining the planning area to be served,
- **Second step**: determine the population in need of addiction services with the area
- **Third step:** determine the demand for services
- **Fourth step**: determine how much of each type of service is required to meet demand.

The Rush model was based on former district health council planning areas and it used per capita alcohol as one key indicator to determine the in-need population. Based on this formula, the percentage used for Niagara Region was 7.4%. This same number was used to apply to the current (2009) and future population projection for Niagara (2019) to identify baseline of need for addiction treatment services related to alcohol.

As noted in the risk factors section above, the population of Niagara and the Hamilton Niagara Haldimand Brant LHIN as a whole have a significantly higher number of heavy drinkers than the rest of Ontario. Although the same metrics used in the application of the Rush model to Niagara are not available, this report assumes that the percentage for Niagara (7.4%) is higher than when the original formula was developed. For this reason there may be an underestimate of population-in-need and thus an underestimate of each level of service capacity. However it provides a baseline to compare to utilization based projections.

The higher percentage of demand (20% of the in-need population) was used for this report. This will help to account for the potential underestimate of in-need population as noted above and also, to some degree, for the non-alcohol related addiction admissions.

A calculation for long term residential treatment was done because this program review revealed a common theme around the urgent need for this capacity within Niagara. The projected need for this service is 350 places by 2019, but at present it is not clear what proportion of this need would relate to long-term treatment and what proportion to long-term recovery home service (the Rush model does not differentiate between these two kinds of longer-term service).

Implications of demand projections include the following:

1) Current service capacity for short term residential care at New Port Centre seems adequate to meet Niagara demand, based on the assumption that local needs will continue to be met via New Port Centre even if it is relocated and even if a higher percentage of its residents will be from Niagara region. Other factors such as provincial needs overall, bed occupancy rates at New Port Centre and future planning for specialized programs at New Port Centre should be incorporated into longer term capacity planning.
2) Current service capacity for withdrawal management seems adequate and no additional beds are required in the near term. While projections would infer additional beds will be needed in the future, NHS is considering introduction of day withdrawal management programs which would impact the projections, and other forms of non-residential withdrawal management are discussed later in this

[35] Rush B. *A systems approach to estimating the required capacity of alcohol treatment services.* British Journal of Addictions, 1990, Volume 85.

review. Non-residential withdrawal programs will require additional benchmarking.

3) Planning with other Niagara region providers, as well as with the LHIN, will be required to appropriately identify current capacity, confirm future capacity estimates and identify roles in meeting these capacity requirements. This is particularly true for non-residential services such as aftercare, out patient services and for long term residential services including recovery homes. Branscombe House currently helps fill a gap in long term residential treatment for women, but does not operate as a recovery home.

4) The models for projecting capacity do not address quality of service. To some degree they are a measure of access. Other issues related to education and training, adherence to provincial standards and referral processes are not addressed through this projections exercise. However those other factors may impact the projections. For example enhanced education about program options may increase demand for residential treatment or day/community withdrawal management programming. As well, improved community-wide assessment and referral processes may reduce the need for assessments by NHS.

To attempt to estimate future demand, two approaches were taken – one based on the Rush formula, and one based on population growth (please see the table on the next page).

	2009	2019	Current NHS service volume	Comments
Population 14 yrs & older	358,436	374,475 (4.47% increase)		
In-need population (7.4% of pop'n 14 yrs & older as per Rush model)	26,524	27,711 (4.47% increase)		
Demand (20% of in-need population)	5,305	5,542		
Withdrawal Management				
Rush formula	2,122	2,217	1,666 (all clients for all presenting substances)	NHS capacity seems to be close to adequate because only slight wait times are noted by referral agencies; thus theestimates based on the Rush model may be high.
Utilization based projection (current capacity X growth rate)		**1,748**	1,666 (all clients for all presenting substances)	NHS plans to establish aday detox program; seek service targets appropriate for mix of treatment options
Assessment				
	3,183	3,325	276 at WMS (# at New Port Centre not known)	CAS-N is Niagara's designated assessment centre; Assessments done by NHS as part of WMS and New Port Centre admission
Utilization based projection (current capacity X growth rate)		Not projected		Pending clarification of assessment role of NHS
Short Term Residential				
Rush formula	244	254	239 + (all clients for all presenting substances)	Capacity is adequate assuming current access for Niagara residents to New Port Centre program
Utilization based projection (current capacity X growth rate)		**251**	239 + (all clients for all presenting substances)	Currently New Port Centre clients – 65% men and 45% women from Niagara
Aftercare				
Rush formula	2,015	2,105		NHS role includes daily support groups at WMS; discharge planning from New Port Centre. There is a key role for other providers including CAS-N
Utilization based projection (current capacity X growth rate)		Not projected		NHS role requires further clarity through planning with other region providers

This program review report's assessment of need for future capacity, coupled with other review findings, indicate the following:

- Demand for withdrew management services as they are currently configured (residential withdrawal management only) is close to adequate at present. Future growth in demand should be accommodated not by a growth in the number of withdrawal management beds, but by an increase in the kinds of withdrawal management that should be offered (as described in Section 15.1 of this report).
- If demand for short-term residential treatment beds increases in future, it can be accommodated within the current complement of beds operated at New Port Centre. However, increased Niagara/LHIN area demand may lead to an increase in the number of short-term residential treatment clients who are from Niagara Region or from other areas in the Hamilton Niagara Haldimand Brant LHIN area, and a decrease in the number from other parts of Ontario.
- An increase in space and staff in the ABC Program is warranted, given wait times for service from this program (the current initial intake wait is approximately one month).
- The workload of the Nurse Practitioner Primary Care Program has exceeded original expectations and it should be expanded.
- Based on wait times for assessments and referrals conducted by Community Addiction Services of Niagara, additional resources may be needed to augment assessments done by CAS-N, or to augment resources in other programs such as NHS addictions programs (in its withdrawal management services for example) to assure timely assessments.
- Future aftercare demand be met by NHS addictions programs will depend on the degree to which NHS addictions programs meet this demand, and the degree to which NHS clients are transferred to CAS-N for aftercare/community treatment.
- While demand for longer-term forms of residential service (long-term treatment as well as recovery home service) cannot at this point be broken down by type of longer-term service, stakeholders indicate that there is:
    - A need for more long-term treatment beds within the Hamilton Niagara Haldimand Brant LHIN
    - An absence of designated women's recovery home spaces in Niagara Region.[36]

Recommendation #21: The NHS Addictions Service should not increase the number of residential service beds it provides between now and 2019. However, alternative forms of withdrawal management should be added to its service portfolio, and expansion of the capacity of the ABC Program is warranted. As well, the workload of the Nurse Practitioner Primary Care Program has exceeded original expectations and it should be expanded.

[36] Provision of recovery home services in an area that comprises a number of communities poses challenges. Recovery homes operate best when they encourage and help residents to re-integrate into their community. This is hard to do when the client is in a recovery home that is not located in the client's community.

Our Planning Assumptions

For the purposes of this review and its recommendations the following assumptions related to future services were used:

- Need for addictions services will continue at current rates and are likely increase with population growth and in response to some socio-demographic trends.
- Addictions services are essential within the health care system and need to be addressed on par other health issues; recent evidence shows the importance of addictions for longer term health.
- Estimating future demand and how to best provide it requires additional work, initially through planning by all Niagara Region addiction providers, and secondly, by providers of mental health and addictions services within the Hamilton Niagara Haldimand Brant LHIN.
- The current range of addictions services in Niagara Region needs to be reviewed to ensure it provides the basic core services (for example, recovery home capacity) and to enable it to meet the changing face of addictions (aging population with unknown addiction patterns, increased addiction to substances like oxycontins and a decreasing youth population).
- The Niagara Health System has a strong history of service provision in Niagara and will remain a provider, focusing more on residential services like withdrawal management and short term residential.
- The Niagara Health System has been a leader in introducing new program approaches to its addictions programs, including the no smoking policy and current project with the Diabetes Education Centre and potential future pilot with the Canadian Hearing Society.
- The Niagara Health System, as the local provider of gender specific programs is well positioned to continue to provide the ABC program, a program fully funded by the Early Years Program; the potential exists to link this program further with other hospital women's programs; this program may need to be expanded if funding becomes available through the Early Years Initiative.
- The Niagara Health System should continue its approach to providing primary care across its programs through nurse practitioners, a service which enhances the programs being delivered, and improves access to more comprehensive health care and support for clients in the system who may otherwise not have regular primary care options.
- While current visits to emergency rooms by persons with a primary diagnosis of addiction is less than 1%, there is a potential to further decrease this number by collaborative planning internally within the NHS, and with the external community partners in addictions services provision.

15. RECOMMENDED PROGRAM DEVELOPMENT AREAS

15.1 Additional Withdrawal Management Options

As in many other communities in Ontario, NHS withdrawal management services are limited to residential non-medical withdrawal management. Personnel in NHS addictions programs are, however, interested in exploring other forms of withdrawal management that will complement current WMS services. These other forms are described below.

15.1.1 Community Withdrawal Management

The Ministry of Health and Long-Term Care defines three categories of community withdrawal management:[37]

Community withdrawal management Level 1:

Assistance with voluntary withdrawal from alcohol and/or other drugs to clients who are under the influence of these substances and/or in withdrawal or otherwise in crisis directly related to these substances. Clients may be simultaneously accessing residential support services, or they may be residing in their home, the home of a significant other or in another community setting, supervised or unsupervised. Care may be provided with or without the aid of drug therapy and/or other medical interventions. Additional support such as discharge planning and early recovery education is provided. Level 1 Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Client/staff ratios do not permit high intensity symptom monitoring. In consultation with a physician, if necessary, consider/assess individuals for admission who are taking the following types of medication: medications for medical problems; medications for diagnosed psychiatric problems; and pain medications only for acute injuries or recent surgery.

Community withdrawal management Level 2:

Client symptoms can be safely monitored by staff who are not medically trained. Intensity/severity of symptoms can be managed, as required, with medical consultation being provided by a physician/after hours clinic/health centre/hospital emergency department. Routine medical consultation and sufficient staff resources are available to consider management of the following medications/ situations: all medications as listed in Level I; clients on methadone; clients being tapered from benzodiazepines or narcotics.

Community withdrawal management Level 3:

Client symptoms require monitoring by medically trained staff. Medical consultation and staff are available on a constant basis to monitor and manage the following medications/situations: all medications as listed in Level 1; circumstances as listed in Level 2; medically-assisted withdrawal.

[37] Source: DART database service definitions found at http://www.dart.on.ca/DART/owalive/dart_dir_multi_v2.service_categories

Several years ago the Ministry awarded funds to a number of organizations (usually existing withdrawal management services) to develop Level 1 community withdrawal services. Niagara was not one of the areas chosen to receive this funding.

Thirteen organizations provide community withdrawal management in Ontario:
- Four organizations provide Level 1 community withdrawal management
- Nine organizations provide Level 2 community withdrawal management
- No organizations provide Level 3 community withdrawal management.

None of them are located in the Hamilton Niagara Haldimand Brant LHIN.

Community withdrawal management has the advantage of allowing the provision of withdrawal support to people in their own homes, but it is relatively expensive per unit of service because of staff travel times to outlying communities to provide this service.

15.1.2 Telephone-Based Withdrawal Management Support

This form of withdrawal management does not exist as a service category in Ontario, nor do there appear to be best practice guidelines for its use.

However, this form of withdrawal management may be helpful for people in stable living arrangements who want to withdraw, but do not feel they need to attend (or are otherwise unwilling or unable to attend) a day/evening or residential withdrawal management service and who do not require (or are unwilling to receive) home visits.

It is possible that through a mix of telephone support provided by a withdrawal management counsellor as well as mailed, faxed or e-mailed written support material (and augmented by an accessible web site), some people can receive effective withdrawal management support without the need for residential or home visit-based withdrawal management support.

This would be an innovation if it were introduced into Niagara, and could perhaps be funded on a pilot project basis. It would not replace other forms of withdrawal management, but might reach out to a population that would not otherwise use withdrawal management services. It might also be considered a form of early intervention, providing help before an addictions problem has escalated to a level requiring more intensive forms of withdrawal management. It would also be a way to make further use of an existing body of withdrawal management expertise within NHS withdrawal management programming.

It should be possible to incorporate a telephone withdrawal management capacity into the telephone outreach component of NHS addictions programming that is proposed in Section 15.2 of this report.

15.1.3 Day/Evening Withdrawal Management

The Ministry does not recognize day/evening withdrawal management as a distinct service category, although at least one day/evening withdrawal management program in Ontario is listed under “community day/evening treatment” in the DART database.

Day/evening withdrawal management typically runs for several hours per day, and clients attend for several weeks. This can prove less disruptive to some people who want to withdraw. As well, it can sometimes be grafted onto residential withdrawal management daily programming, potentially reducing the cost of the day/evening program. It could potentially operate in communities other than St. Catharines in Niagara Region without incurring the cost that decentralized residential withdrawal management would incur.

Day/evening withdrawal management would be a useful extension of current withdrawal management services in Niagara Region. However, it would be important to determine whether the demand for day withdrawal management or evening withdrawal management is greater if both cannot reasonably be offered.

15.1.4 Medical Withdrawal Management

This form of withdrawal management is called "Residential Withdrawal Management Level 3" within the Ministry's categorization of services. The Ministry defines it as:

> "Client symptoms require monitoring by medically trained staff. Medical consultation and staff are available on a constant basis to monitor and manage the following medications/ situations: all medications as listed in Level I; circumstances as listed in Level II; medically assisted withdrawal."[38]

This kind of withdrawal management is only available at the Centre for Addiction and Mental Health (Toronto), Royal Ottawa Mental Health Centre (Ottawa) and Humber River Regional Hospital, Keele Street Site (Toronto).

Medical withdrawal management fits well with the mission for NHS addictions programming proposed in this program review report. It would serve people with the most complex and severe withdrawal problems.

However, it requires:

- Designated beds within a hospital setting or in some other setting consistent with medical monitoring or management
- Specialized medical, nursing and addictions expertise
- Sufficient patient volume to maintain the competence of personnel working in the program.

The withdrawal management classification used by the American Society of Addiction Medicine recognizes two kinds of medical withdrawal management (using the same "monitor/manage" terms found in the Ontario definition) at the top of the intensity scale:

- **Level III.7-D: Medically Monitored Inpatient Detoxification**. This level provides 24-hour medically supervised detoxification services. In describing this level, SAMHSA best practice guidelines say:

  > "Since this level of care is relatively more restrictive and more costly than a residential treatment option, the treatment mission in this setting should be clearly focused and limited in scope. Primary emphasis should be placed on

[38] Source: DART database service definitions found at http://www.dart.on.ca/DART/owalive/dart_dir_multi_v2.service_categories

ensuring that the patient is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal); assessing for adequate biopsychosocial stability, quickly intervening to establish this adequately; and facilitating effective linkage to and engagement in other appropriate inpatient and outpatient services."

- **Level IV-D: Medically Managed Intensive Inpatient Detoxification**. This level provides 24-hour care in an acute care inpatient setting. In describing this level, SAMHSA best practice guidelines say:

  "At this level of care, physicians are available 24 hours per day by telephone. A physician should be available to assess the patient within 24 hours of admission (or sooner, if medically necessary) and should be available to provide onsite monitoring of care and further evaluation on a daily basis. An RN or other qualified nursing specialist should be present to administer an initial assessment. A nurse will be responsible for overseeing the monitoring of the patient's progress and medication administration on an hourly basis, if needed. Appropriately licensed and credentialed staff should be available to administer medications in accordance with physician orders."

As poly-substance abuse becomes more prevalent there will likely be an increased need for medical withdrawal management units across Ontario. However, it is not anticipated that this will happen overnight. It would be prudent for the NHS Addictions Service to develop a process of moving in carefully chosen and resourced stages toward a full medical withdrawal management capacity – first through medically **monitored** withdrawal management, then through medically **managed** withdrawal management.

The NHS Addictions Service could shorten the developmental process by seeking approval to operate medical withdrawal management services for the entire LHIN area. But NHS would need to demonstrate that it can maintain specialized resources better than Hamilton can, and that it can overcome the disadvantage of being less centrally located than Hamilton if it were the LHIN's only medical withdrawal management facility.

Assuming there will someday be a need for medical withdrawal management in more than one community in the LHIN, NHS should initiate a process of phased augmentation of medical withdrawal management resources and capabilities, possibly culminating some day in the creation of a full medically managed withdrawal management program.

Recommendation #22: The NHS Addictions Service should develop a day/evening withdrawal management program, it should explore the creation of telephone-based withdrawal management, and it should develop a phased plan for developing medical withdrawal management services.

15.2 Telephone-Based Outreach and Support

The previous section of this report suggested that the NHS Addictions Service consider including telephone-based withdrawal management as part of its complement of withdrawal management resources. This might become part of a set of telephone-based services that could be created or expanded to help NHS serve its clients by providing:

- Telephone-based withdrawal management
- Phone-based pre-treatment support
- Phone-based post-treatment support for individuals for whom the NHS Addictions Service, rather than another agency such as Community Addiction Services of Niagara, should provide post-treatment support.

In each of the activity areas cited above, telephone assistance would be only one of an array of techniques NHS addictions programs would use. Telephone support might help to provide services to clients, particularly from smaller communities, when they have difficulty travelling to larger centres for support, when it is not feasible for the NHS Addictions Service to provide travelling or satellite service, or when the client opts for telephone support rather than other forms of support.

While there does not seem to be a body of best practice information in the area of telephone-delivered addictions service, some research suggests promising ways to use the phone as a service adjunct.

A recent U.S. study proposal categorized telephone counselling interventions in the following way:

- Unstructured/non-directive
- Structured/non-directive
- Unstructured/directive
- Structured/directive.[39]

Telephone support can be provided as a scheduled series of phone calls to clients, or on an as-needed basis, initiated either by a client or a counsellor.

Other U.S. studies suggests that phone-based continuing care is effective with all but the most severely disadvantaged graduates of residential programs[40, 41] (which suggests that even though NHS should serve complex populations and that some clients would not likely benefit from phone support, it may be appropriate at the lower end of the NHS client severity gradient).

---

[39] *Four Models of Telephone Support for Stimulant Recovery* (clinical trial announcement). U.S. National Institutes of Health, Aug. 2008. Described on Web at http://clinicaltrials.gov/ct2/show/NCT00744068

[40] McKay, J.R.; Lynch, K.G.; Shepard, D.S.; and Pettinati, H.M. *The effectiveness of telephone-based continuing care for alcohol and cocaine dependence*. Archives of General Psychiatry 62(2):199-207, 2005.

[41] McKay, J.R., et al. *Do patient characteristics and initial progress in treatment moderate the effectiveness of telephone-based continuing care for substance use disorders?* Addiction 100(2):216-226, 2005.

One recent study suggested that staff in addictions programs may see proactive telephone interventions as a valid part of a package of post-treatment support options characterized by maintenance of established client/clinician relationships.[42]

There is also evidence that trained volunteers can play a role in a telephone-based recovery support program.[43]

If NHS expands its use of telephone-based adjuncts to current interventions, then its exploratory/planning phase should involve consultation with bodies of expertise in telephone-based methodologies, including distress centres in and beyond Niagara, and The Centre for Addiction and Mental Health help line, to build a body of knowledge on the use of telephone technology in the helping field. Telephone support may also help in providing support to families (please see the next section for a discussion of family programming).

An enhanced telephone support function could be a separate NHS addictions program, or a community of practice whose members are drawn from existing NHS programs and who share and build on their experiences providing telephone support (a community of practice that may also draw in staff from other provider agencies).

Recommendation #23: The NHS Addictions Service should expand the use of telephone-based methods of providing pre-treatment and post treatment support as well as family support, should develop staff and/or volunteer competence in using telephone-based techniques, and should help to create a body of knowledge in telephone-based techniques.

[42] Pulford J, Black S, Wheeler A, Sheridan J, Adams P. *Providing Post-Treatment Support in an Outpatient Alcohol and Other Drug Treatment Context: A Qualitative Study of Staff Opinion.* International Journal of Mental Health and Addiction, Vol. 8 No. 3 471-481, DOI: 10.1007/s11469-009-9218-0

[43] Broffman T, Fisher R, Gilbert B, Valentine P. Telephone Recovery Support & the Recovery Model. Connecticut Department of Mental Health and Addiction Services (undated) http://www.facesandvoicesofrecovery.org/pdf/Publications/Addiction_%20Professional_Article.pdf

15.3 Family Programming

Several stakeholders suggested that family programming is a need in NHS and in Niagara. Community Addiction Services of Niagara already provides three family-related programs: couples counselling, a spousal support group and family counselling.

Family programming can be considered as assistance to families of people with addictions that comprises three streams:

- **Education:** the provision of information that will help families understand addictions, how they affect family relationships, and what resources can be accessed for people with addictions and their families. This information is provided in some communities through web based information or over-the-phone services, and information and referral are provided province-wide via the Drug and Alcohol Treatment Infoline component of the Drug and Alcohol Registry of Treatment (DART) and by the Ontario Problem Gambling Helpline (a similar service for mental health needs is provided by Mental Health Service Information Ontario).
- **Support:** This involves support tailored to specific families struggling with addictions within the family. It may, for instance, involve helping a family to encourage a family member to enter treatment, support a family member during treatment, or continue to maintain recovery, or it may involve helping the family to know how to adjust to the ”new person” in the family when he graduates from treatment.
- **Treatment:** This is the most intense form of assistance. It may involve assistance with dysfunction within the dynamics of the family or it may involve engaging a family member (other than the family member already receiving help) in mental health counselling, addictions counselling, or some other forum of counselling.

Family assistance programs may target particular kinds of family members. For instance, a program might target spouses/significant others, or youth and children in families, or only the adults in families, or all family members. And family assistance may be offered in several treatment settings. It may be provided to a single family member through one-on-one contact, or through a group of spouses or children from several families, or several members of a single family, or several members of several families.

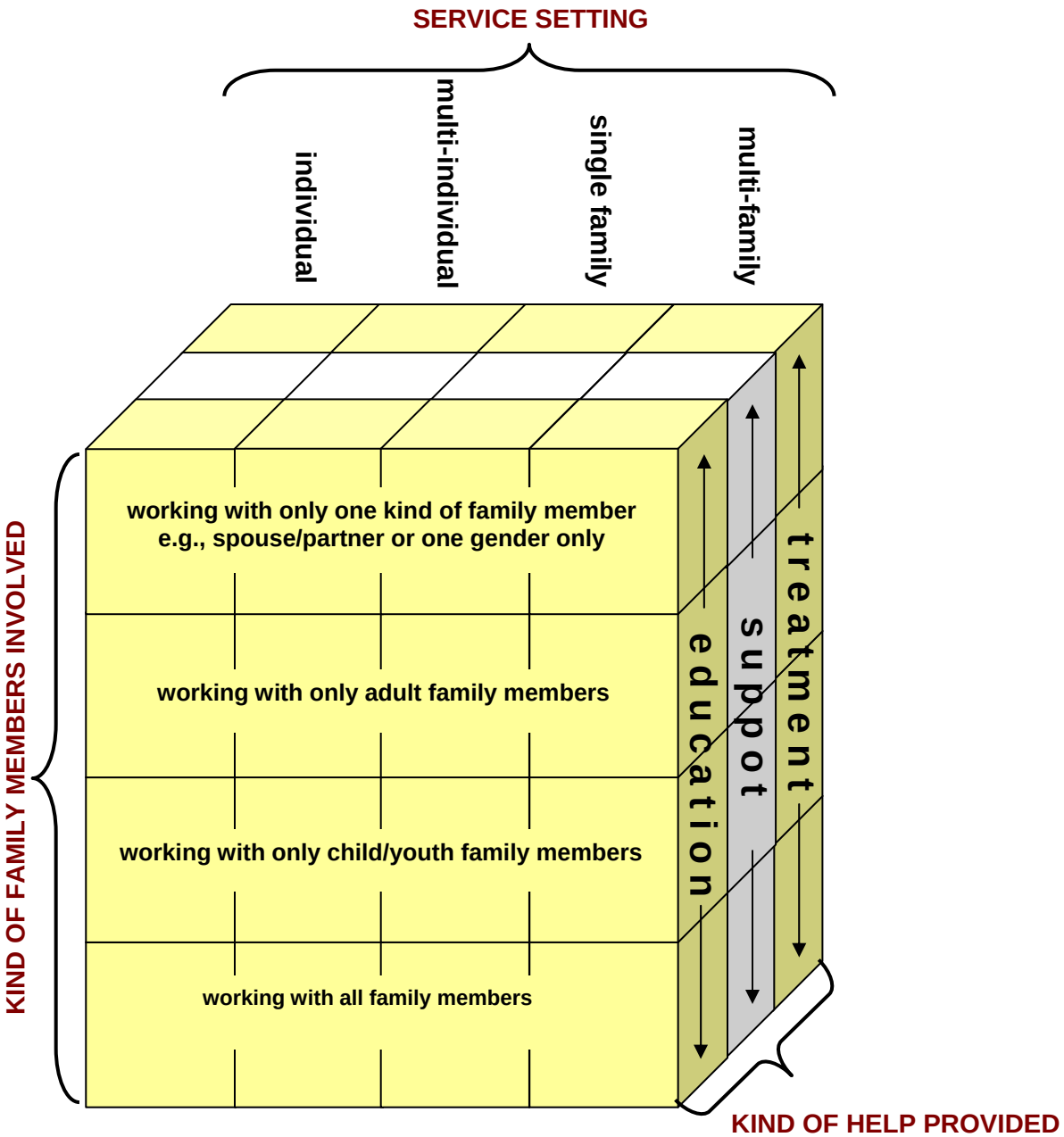
These dimensions are shown in the graphic on the next page.

Addictions clients are often transferred from one treatment agency to another during their course of treatment and recovery. However, family members may need consistent continued involvement with other families and counsellors with whom they have established a bond: just because a person with an addiction has moved from agency “A” to agency “B”, this does not necessarily mean that her family needs to move from family resource “A” to family resource ”B”.

Given the number of kinds, settings and target groups for family assistance and given the possibility that family assistance that spans several agencies may be desirable, it makes sense to plan for family assistance resources on a system-wide basis, not on the basis of each agency developing its own family assistance programs without reference to a broader family assistance plan (a plan that should also engage assistance sectors like the distress centre sector and the child and family services sector).

Recommendation #24: The NHS Addictions Service should work with other addictions agencies in Niagara and with other Niagara service sectors such as mental health services, distress lines and child and family services to develop a family assistance plan focusing on families who have members living with addictions. Within the context of this plan, The NHS Addictions Service should then develop family programming that is consistent with the family assistance plan.

SERVICE DIMENSIONS THAT MAY BE INVOLVED IN HELPING FAMILIES OF PEOPLE WITH ADDICTIONS



15.4 Nicotine Addiction Programming

NHS addictions programs already have in place policies that discourage the use of nicotine while in treatment, it provides nicotine addiction treatment at New Port Centre, and NHS will shortly be able to pay for nicotine replacement aids for clients under treatment, as a result of registering New Port clients in the Centre for Addiction and Mental Health's STOP study. The NHS Addictions Service is interested in going a step further by creating a nicotine addiction component to serve all NHS addictions programs.

This is a logical extension of the interest NHS addictions programs have already shown in addressing nicotine addiction. Initially, this could be an adjunct to other NHS addictions programs, but thereafter:

- The NHS Addictions Service might open this program to people who are not under NHS treatment for other addictions, or
- The NHS Addictions Service might work with other addictions agencies to help create an additional nicotine addiction program that could be provided in/for other agencies.

Recommendation #25: The NHS Addictions Service should create a nicotine addiction treatment program, to be provided initially to NHS clients under treatment for other addictions, but with the later possibility of:

- Opening this program to people who are not under NHS treatment for other addictions, or
- Working with other addictions agencies to help create an additional nicotine addiction treatment program that could be provided in/for other agencies.

15.5 Specialized Clinics and Resources

As NHS addictions programs continue to evolve, opportunities may arise for NHS to operate programs that provide service at the interface between an addictions problem and a physical or mental health problem. NHS should examine these on a case-by-case basis to see whether such programs would fit under the NHS addictions portfolio.

One such program, related to Hepatitis C, is described below.

15.5.1 Hepatitis C Virus Program

"Niagara has the largest population of people infected with Hepatitis C Virus, (HCV) within the Central West Region; 1.23% according to epidemiology reports completed in 2007 by R.S. Remis. In the Niagara Region, this accounts for 5,300 people infected with Hepatitis C.

***Request for Funding for 2 HCV (Hepatitis C Virus) Nurses in the Niagara Region*, Niagara Health System**

NHS has applied for funding from the Ministry of Health and Long-Term Care's Hepatitis C Secretariat for funding for a Hepatitis C Virus (HCV) Team comprising 1.0 FTE HCV nurse practitioner, 1.0 FTE social worker, 1.0 FTE peer support outreach worker and 1.0 FTE coordinator/clerical support for the Niagara community in order to improve access to care and treatment for patients with Hepatitis C. This team, to be affiliated with NHS methadone programming, will collaborate with interested physicians as well as with other addictions service providers in Niagara Region.

Since at least 80% of those living with HCV are current or former injection or intranasal drug users who have HCV as a major medical complexity,[44] a Hepatitis C team seems to fit with the NHS Addictions Service mandate.

Recommendation #26: The NHS Addictions Service should create a Hepatitis C Virus (HCV) Team, to improve access to care and treatment for patients with Hepatitis C.

[44] *Request for Funding for 2 HCV (Hepatitis C Virus) Nurses in the Niagara Region*, Niagara Health System

15.6 Serving People with Hearing Impairments

"135,000 Ontarians or 2% of the provincial adult population age 16-65 are Deaf or hard of hearing: of this number, 36% have difficulty hearing a group; 39% have also difficulty hearing a person; and 25% are completely unable to hear.

Loss of hearing is often accompanied by various disabilities: 40% of Deaf and hard of hearing individuals age 16 to 65 reported eye trouble, a speech disability, or a learning disability (compared to 13% among all Ontarians). The incidence of a learning disability was highest among ages 16 to 45 (36%)."

***Literacy Profile of Ontario's Deaf and Hard of Hearing Adults*.**
Ontario Ministry of Education and Training, 1998

Recently, a representative of the NHS Addictions Service and a representative of the Canadian Hearing Society's CONNECT Counselling program held preliminary discussions about the possibility of collaboration between the two organizations to improve addictions services for people in Ontario who are Deaf, deafened and hard of hearing. Such services are virtually non-existent at present.

"ASL [American Sign Language] is a visually and spatially grounded language that does not provide a direct 'translation' of English forms and the concepts represented by English vocabulary and syntax. Thus, knowledge about chemical dependency is not communicated very well in the Deaf community. For example, some key concepts and terms in chemical dependency treatment simply do not exist in the Deaf culture. In treatment settings designed for the mainstream, language and communication are both barriers to participation among Deaf and hard of hearing individuals."

Guthmann, D. *Is There a Substance Abuse Problem Among Deaf and Hard of Hearing Individuals?* Web document found at http://www.mncddeaf.org/articles/problem_ad.htm

CONNECT Counselling provides community-based mental health services for people who are Deaf, deafened and hard of hearing in 25 communities in Ontario, including an office in St. Catharines. CONNECT Counselling is interested in exploring the creation of addiction services affiliated with its mental health services in these communities, but has been searching (so far unsuccessfully) for a partner who could provide:

- Guidance on how to create and structure addiction services for people who are Deaf, deafened and hard of hearing
- A residential treatment resource willing and able to provide service to people who are Deaf, deafened and hard of hearing, and to integrate this service with the non-residential services that CONNECT Counselling is interested in providing.

This presents an opportunity for the NHS Addictions Service to use part of its residential treatment capacity to provide a provincial-level resource that would be closely tied to both community addictions and mental health resources for people who are Deaf, deafened and hard of hearing in communities across Ontario.

If NHS explores this further, it has two enablers that put it in a good position to make use of this opportunity:

- It is likely to establish a purpose-built facility for its programs (as described earlier in this report). This building's residential components could be built with adaptations necessary to serve people who are Deaf, deafened and hard of hearing.
- The NHS Regional Director responsible for addictions programs has had extensive involvement in issues of culture, language and service access for people who are Deaf, deafened and hard of hearing.

While it is not possible at this time to predict the "draw" that a residential treatment program would make on the total residential resources NHS provides, an examination of similar services in New York State may be instructive. New York, with a much larger population than Ontario, has a single 7-bed residential addictions program serving the entire state (as well as people from other states), operated by the John L. Norris Addiction Treatment Center in Rochester.

Recommendation #27: The NHS Addictions Service should explore, with the Canadian Hearing Society's CONNECT Counselling service, the development of a sub-program within NHS's residential addictions treatment program to serve people who people who are Deaf, deafened and hard of hearing. This sub-program would be linked to community addictions programming to be provided by CONNECT Counselling in communities across Ontario.

15.7 Serving Elderly People

Earlier, this program review report pointed out that Niagara's elderly population is growing faster than any other age cohort. As a result, NHS can anticipate that Niagara Region will need a plan for serving its elderly population with age-appropriate addictions services in future.

Most of these services will likely be non-residential and operated by organizations other than NHS, but NHS may act in support of these services by lending its expertise in geriatric care and chronic disease management to the planning and service delivery processes. As well, NHS may be in a unique position to conduct case-spotting among elderly hospital patients who enter hospital because of physical or mental health problems, but who have underlying addictions issues that cause or exacerbate their physical or mental health conditions.

Recommendation #28: The NHS Addictions Service should be an active and supportive partner in planning for future addictions services for elderly people in Niagara Region, and should enhance, if necessary, its case-spotting activities within the hospital to identify elderly people who enter hospital because of physical or mental health problems, but who have underlying addictions issues that cause or exacerbate their physical or mental health conditions.

15.8 Prevention and Early Intervention in Other NHS Program Sites

Several recent reports on addictions and mental health system reform in Ontario point out the importance of prevention and early intervention as key functions within a reformed service system.

NHS addictions programs are not heavily involved in primary prevention, since there are a number of other agencies in Niagara Region whose mandates are a better fit with primary prevention.

However, the NHS Addictions Service can play a role in early intervention by working with other hospital departments and programs that encounter people who are at risk of developing addictions problems, or who are in the earlier stages of exhibiting these problems. The role of the NHS Addictions Service could be to raise other hospital departments' awareness of addictions problems, provide these departments with tools to identify early-stage addictions, and help these departments to inform patients of options available to them to deal with their addictions.

This recommendation is made with the knowledge that it may be a continuation and enhancement of work that the NHS Addictions Service already does in the area of promoting early intervention within NHS.

Recommendation #29: The NHS Addictions Service should work with other NHS departments and programs to raise their awareness of addictions problems, provide these departments with tools to identify patients with early addictions, and help these departments to inform patients of options available to them to deal with their addictions.

16. ENABLERS OF CHANGE

The Hamilton Niagara Haldimand Brant LHIN's Program Advisory Group on Mental Health and Addiction has identified six key enablers of change to help create an integrated addictions and mental health system within the LHIN:

1. Cross-ministry agreement on flexible use of funding to support logical and agreed-upon client outcomes
2. LHIN support and policy re accountability to meet system-wide expectations
3. Equitable funding throughout the region including Six Nations
4. Integrated data systems for monitoring outcomes and assessing progress
5. Improved region-wide access to programs and services
6. Transportation to improve and equalize access to programs and services and improve outcomes.

The NHS Addictions Service cannot do much to promote the first three enablers. However, it can contribute to the last three enablers in the following ways:

- **Integrated data systems for monitoring outcomes and assessing progress:** The NHS Addictions Service can maximize its use of available data, share its analysis with service partners in Niagara Region, use these data to constantly monitor and periodically evaluate its programs, and share evaluation results with community partners as an aid in ongoing service planning in Niagara. It can also continue to seek and use research resources available in and beyond Niagara to conduct addictions research in which NHS can participate.

- **Improved region-wide access to programs and services:** NHS can ensure, in ways outlined in this program review report, that it provides accessible centrally located services in St. Catharines while also partnering with other agencies (particularly Community Addiction Services of Niagara) to ensure that non-residential services can be provided in other communities in Niagara Region. It can also make maximum use of telephone technology to enhance access to withdrawal management services, pre-treatment support services and post-treatment support.

- **Transportation to improve and equalize access to programs and services and improve outcomes:** While the NHS Addictions Service cannot solve transportation problems directly, it can ensure that its services are placed in locations that are as accessible as possible to help overcome transportation problems, it can continue to subsidize taxi fares as a way to help clients get to NHS services, and (as noted above) it can use telephone technology to help overcome some of the barriers posed by the current transportation system.

17. CONCLUSION

This program review is timely, as the Niagara Health System implements its Hospital Improvement Plan and strengthens programs both geographically and clinically. The NHS is working closely with its many partners and funders to meet its mandate in Niagara Region.

Throughout this program review – through the review of reports, in conversations with key informants and in focus group dialogues – there has been a continuous message about the ***need for strong addiction programs in Niagara***. This report highlights issues relevant to the delivery of addiction services by NHS, and makes recommendations to advance an accessible, evidence based and sustainable continuum of addiction services.

For this reason it is appropriate to review the report through the lens provided by the Ontario Health Quality Council, in its *2010 Health Monitor Report*, for what people expect from their health system. In this report the Ontario Health Quality Council describes the attributes people seek in health systems, described below.

Integration

As part of the fact finding for this review, inquiries were made about how the addiction program could be more integrated/aligned with other programs. People expressed ideas for change and complimented current services and people providing those services. As well, participants noted that some good activities to improve alignment were already underway to benefit clients and providers alike.

For example, it was noted that while the component programs of addictions seem committed to integration with each other and with other providers, the consolidation of all NHS Addictions Service residential programs on one site will aid in program consistency, cross program referrals, education, resource management and innovation.

Participants in the consultation process remarked on the need to develop more formalized concurrent disorder programs, both inside the hospital system and with its community partners. Opportunities for the NHS to integrate knowledge and protocols between emergency and other programs like addictions were noted, and some integration with emergency departments is already underway.

A Population Health Focus

For this report, population trends and population risk factors have been reviewed. There is an abundance of information available through the LHIN and through Niagara Public Health that support and inform a population-based focus.

Based on the population trends, there may not be a significant need for new beds for residential services, at least in the short term. However, given the growing percentage of seniors and the unknowns about the addictions presenting from that group, flexibility in service design will be important. Introduction of programs like telephone-based

withdrawal management, in-home withdrawal management and day withdrawal management will be important additions to the care continuum.

Niagara Region has significantly higher risk factors than other areas of the province related to heavy drinking and smoking, which support the case for an array of addiction programming, including secondary prevention and aftercare, and prevention through education and early intervention. Given the recommended hospital focus on residential clients and clients with complex needs, its role in responding to population health needs, will include early intervention and appropriate assessment and referral. The risk factor information also supports the NHS approach to nicotine-free residential services.

Appropriate Resources

The review highlighted gaps in the current addictions service continuum, including access to specialized psychiatric care, recovery home capacity and transitional resources. NHS should work with its other partners in the region and with the LHIN to address these gaps. NHS may be best positioned to work within the LHIN on the psychiatry access issues.

Equity

People expect health care to be equitable and that has different meanings for people. Within Niagara, with its mix of smaller and larger communities and its limited public transportation options, equity is tied to access and location of service, as well as to a full range of services. As part of its Hospital Improvement Plan, NHS has stated its intention to look at options for satellite service provision. This should be done in concert with NHS mental health programs and with other providers such as Community Addiction Services of Niagara and community health centres, as noted in the review. CHCs, with their focus on primary care and on serving marginalized or hard to serve populations, are key community partners for the NHS Addictions Service.

Patient-Centred Service

As noted in this report, addictions is an area with a broad range of presenting issues and health challenges. People with addictions may have chronic health problems, poor coping skills, lack of social supports, income challenges and other issues which make their care and support challenging to the health system, which often focuses on short term fixes rather than long term recovery. For this reason, people with addictions who go to hospital emergency rooms present staff with significant challenges.

There is evidence and examples from other jurisdictions about the ideal continuum of addiction services required to better serve the client and their families. That continuum includes prevention through to hospitalization. System “touch down” points such as withdrawal management services, emergency departments and urgent care centres are key opportunities for intervention and case management. Recovery homes and community aftercare are key elements to support recovery. While each client brings his or her own needs, a baseline of well coordinated care and supports for addictions will provide the best opportunities for health improvement and both long and short term client satisfaction**.**

Safety

As noted in the review, clients need to be supported through crisis and recovery. There is a need for well trained staff, delivering evidence-based care, through a coordinated service system, to ensure client safety and recovery. Residential care is an important component of the addiction service system and should be located in a purpose-designed facility that fosters both the physical and emotional safety of people who are vulnerable and who have experienced significant trauma in their lives. Similarly post-care supports ranging from counselling to peer support to family education are all enablers for recovery. Education of health care providers – for example, clinicians in emergency rooms or in community practice settings – will enhance the local system's ability to respond, to assess and to refer, appropriately.

Efficiency

The consolidation of addictions programs in St Catharines offers an opportunity to create efficiencies both within the programs and within the hospital. By centralizing residential addictions programs, staff can be used more effectively through integrated night shifts and sharing of clinical supervisory staff. By consolidating addictions programs in St Catharines, opportunities to build and maintain more comprehensive service models – for example establishing a concurrent disorder program with NHS mental health programs – are enabled.

As part of the new location, designs for space and infrastructure can incorporate rooms suitable for day withdrawal management, shared life skills programming and shared staffing. Savings then may be reinvested in the development of new programming.

Effectiveness

An examination of quality was part of the methodology of the program review. The programs currently receive high satisfaction from client surveys, and the referrals to the programs remain fairly constant. That being said, ideas arose about certification of staff, increased access to clinical supervisors, and other resources. Recommendations addressing these are included in this report.

Accessibility

A goal of health system transformation is increased access to services. As part of planning within the Hamilton Niagara Haldimand Brant LHIN, priority areas have been identified, including mental health and addictions. NHS contributes to a stronger local health system by enhancing its own programs and linking them with other services. The creation of shared service models in other communities in Niagara, as recommended in the report, will improve geographic access. Access to a broader continuum of care will emerge from shared planning by providers, and approval of a system model by the LHIN.

Given its strong history of services in addictions in Niagara, NHS will be a major participant in planning with other providers of addictions services, and with mental health services in the region, to achieve a more integrated system of care and support for people with addictions.

17.1 Final Thoughts

This review was created from the ideas and aspirations of many people – within NHS, within Niagara, and beyond Niagara. These ideas and aspirations suggest that while every door should be the right door, the services to be found when a person or family opens each door should be integrated services.

The passion and heartfelt comments of clients of NHS addictions programs add greatly to a shared understanding of how programs should be structured and what is valued most by clients. This review provides a framework for consolidating and strengthening NHS addictions programs. But it is also a living document, one that will be enhanced by continuing engagement and dialogue among consumers and providers of service in Niagara Region and across the Hamilton Niagara Haldimand Brant LHIN.

Many of the changes and service augmentations suggested in this report will require new funding. This report believes this funding is justified, based on the personal, family and societal impact of addictions, and based on the savings and service improvements that would accrue to other hospital services, other health services, and broader community services that foster the well-being of people who live in Niagara Region.

APPENDIX ONE: SOCIODEMOGRAPHIC DATA ON NIAGARA REGION'S POPULATION

The following data are derived from Statistics Canada, 2006 Census of Population. The data do not include a factor for census undercounting.

Total Populations

Communities (least populous to most populous)	Population, 2006 census	Population aged 0-14 (%)	Population aged 65+ (%)	Median earnings, persons aged 15+ ($)	2001 to 2006 population change (%)
Township of Wainfleet	6,601	17.4%	13.9%	$26,384	5.5%
Township of West Lincoln	13,167	22.9%	10.0%	$27,865	7.3%
Town of Niagara-on-the-Lake	14,587	13.8%	24.1%	$22,440	5.4%
Town of Pelham	16,155	17.0%	16.6%	$31,056	5.8%
City of Thorold	18,224	17.6%	14.4%	$27,670	1.0%
Town of Port Colborne	18,599	15.1%	21.3%	$23,460	0.8%
Town of Lincoln	21,722	19.3%	17.4%	$26,350	5.4%
Town of Grimsby	23,937	18.0%	15.4%	$33,412	12.4%
Town of Fort Erie	29,925	16.6%	17.9%	$23,430	6.3%
City of Welland	50,330	16.7%	16.8%	$26,015	4.0%
City of Niagara Falls	82,184	16.7%	17.1%	$24,614	4.3%
City of St. Catharines	131,989	16.2%	18.0%	$24,345	2.2%
Total, Regional Municipality of Niagara	**427,421**	**16.8%**	**17.4%**	**$25,108**	**4.1%**

Source: Statistics Canada, 2006 Census of Population

Growth Rates

Communities, lowest growth to highest growth	2001 to 2006 population change (%)
Town of Port Colborne	0.8%
City of Thorold	1.0%
City of St. Catharines	2.2%
City of Welland	4.0%
Total, Regional Municipality of Niagara	4.1%
City of Niagara Falls	4.3%
Town of Niagara-on-the-Lake	5.4%
Town of Lincoln	5.4%
Township of Wainfleet	5.5%
Town of Pelham	5.8%
Town of Fort Erie	6.3%
Township of West Lincoln	7.3%
Town of Grimsby	12.4%

Source: Statistics Canada, 2006 Census of Population

Child/Youth Populations

Communities, lowest, % child/youth to highest % child/youth	Population aged 0-14 (%)
Town of Niagara-on-the-Lake	13.8%
Town of Port Colborne	15.1%
City of St. Catharines	16.2%
Town of Fort Erie	16.6%
City of Welland	16.7%
City of Niagara Falls	16.7%
Total, Regional Municipality of Niagara	16.8%
Town of Pelham	17.0%
Township of Wainfleet	17.4%
City of Thorold	17.6%
Town of Grimsby	18.0%
Town of Lincoln	19.3%
Township of West Lincoln	22.9%

Source: Statistics Canada, 2006 Census of Population

Elderly Populations

Communities, lowest % 65+ to highest % 65+	Population aged 65+ (%)
Township of West Lincoln	10.0%
Township of Wainfleet	13.9%
City of Thorold	14.4%
Town of Grimsby	15.4%
Town of Pelham	16.6%
City of Welland	16.8%
City of Niagara Falls	17.1%
Town of Lincoln	17.4%
Total, Regional Municipality of Niagara	17.4%
Town of Fort Erie	17.9%
City of St. Catharines	18.0%
Town of Port Colborne	21.3%
Town of Niagara-on-the-Lake	24.1%

Source: Statistics Canada, 2006 Census of Population

Median Earnings, Niagara Communities

Communities, lowest median earnings to highest median earnings	Median earnings, persons aged 15+ ($)
Town of Niagara-on-the-Lake	$22,440
Town of Fort Erie	$23,430
Town of Port Colborne	$23,460
City of St. Catharines	$24,345
City of Niagara Falls	$24,614
Total, Regional Municipality of Niagara	$25,108
City of Welland	$26,015
Town of Lincoln	$26,350
Township of Wainfleet	$26,384
City of Thorold	$27,670
Township of West Lincoln	$27,865
Town of Pelham	$31,056
Town of Grimsby	$33,412

Source: Statistics Canada, 2006 Census of Population

Median Earnings, Unemployment Rates, Low Income Levels and % of Income from Government Transfers, and Youth and Elderly Populations, Niagara's Three Largest Communities Compared to Ten Other Ontario Non-GTA Large Communities

Median earnings, 13 selected non-GTA cities, lowest to highest	Median earnings, persons aged 15+ ($)
St. Catharines	**$24,345**
Niagara Falls	**$24,614**
Kingston	$25,357
Welland	**$26,015**
Sudbury	$26,815
Windsor	$27,543
Brantford (in the same LHIN as Niagara Region)	$27,977
London	$28,169
Hamilton (in the same LHIN as Niagara Region)	$28,933
Barrie	$29,876
Kitchener	$30,078
Cambridge	$31,191
Ottawa	$34,343

St. Catharines, Niagara Falls and Welland combined comprise 62% of the population of Niagara

Source: Statistics Canada, 2006 Census of Population

Median earnings for those working full year full time, 13 selected non-GTA cities, lowest to highest	Median earnings, persons aged 15+ ($)
Niagara Falls	**$37,866**
St. Catharines	**$40,179**
Brantford (in the same LHIN as Niagara Region)	$40,479
Welland	**$40,890**
Kitchener	$42,218
London	$42,226
Kingston	$43,744
Cambridge	$43,839
Hamilton (in the same LHIN as Niagara Region)	$43,970
Windsor	$44,863
Barrie	$45,123
Sudbury	$45,128
Ottawa	$52,635

Source: Statistics Canada, 2006 Census of Population

Unemployment rates, 13 selected non-GTA cities, highest to lowest	Unemployment rate[45]
Windsor	9.7%
Sudbury	7.8%
Welland	**7.3%**
Kingston	7.0%
Brantford (in the same LHIN as Niagara Region)	6.7%
St. Catharines	**6.6%**
London	6.5%
Hamilton (in the same LHIN as Niagara Region)	6.5%
Niagara Falls	**6.2%**
Barrie	6.0%
Ottawa	5.9%
Cambridge	5.9%
Kitchener	5.7%

Source: Statistics Canada, 2006 Census of Population

% low income, after tax	% low income
Windsor	14.2
Hamilton (in the same LHIN as Niagara Region)	14.0
Ottawa	12.3
London	11.8
Kingston	11.1
St. Catharines	**10.5**
Welland	**10.2**
Brantford (in the same LHIN as Niagara Region)	10.1
Niagara Falls	**9.6**
Sudbury	9.4
Kitchener	8.7
Barrie	8.4
Cambridge	7.1

Source: Statistics Canada, 2006 Census of Population

[45] Refers to the unemployed expressed as a percentage of the labour force in the week (Sunday to Saturday) prior to Census Day (May 16, 2006).

Government transfers as % of total income, 13 selected non-GTA cities, highest to lowest	Government transfers as % of total income
Welland	**15.8%**
Niagara Falls	**14.4%**
St. Catharines	**13.7%**
Brantford (in the same LHIN as Niagara Region)	13.6%
Windsor	13.0%
Sudbury	12.6%
Hamilton (in the same LHIN as Niagara Region)	12.0%
Kingston	11.4%
London	10.8%
Kitchener	9.9%
Cambridge	9.6%
Barrie	9.4%
Ottawa	7.3%

Source: Statistics Canada, 2006 Census of Population

Population 65+, 13 selected non-GTA cities, highest to lowest	Population 65+
St. Catharines	**18.0%**
Niagara Falls	**17.1%**
Welland	**16.8%**
Sudbury	14.9%
Hamilton (in the same LHIN as Niagara Region)	14.9%
Brantford (in the same LHIN as Niagara Region)	14.6%
Windsor	14.3%
London	13.7%
Kingston	13.4%
Ottawa	12.4%
Kitchener	11.7%
Cambridge	11.3%
Barrie	10.9%

Source: Statistics Canada, 2006 Census of Population

Population aged 0-14, 13 selected non-GTA cities, highest to lowest	Population aged 0-14
Barrie	21.3%
Cambridge	20.4%
Brantford (in the same LHIN as Niagara Region)	18.7%
Windsor	18.7%
Kitchener	18.5%
Hamilton (in the same LHIN as Niagara Region)	17.8%
Ottawa	17.6%
London	17.3%
Sudbury	16.8%
Welland	**16.7%**
Niagara Falls	**16.7%**
St. Catharines	**16.2%**
Kingston	15.8%

Source: Statistics Canada, 2006 Census of Population

Mother tongue

% of population for which French is the sole mother tongue (highest to lowest)	French only
Welland	11.4%
Town of Port Colborne	5.3%
Niagara Region	**3.3%**
City of Niagara Falls	2.5%
Township of Wainfleet	2.5%
St. Catharines	2.3%
Town of Pelham	2.1%
City of Thorold	2.0%
Town of Fort Erie	1.8%
Town of Niagara-on-the-Lake	1.6%
Town of Grimsby	1.4%
Town of Lincoln	1.1%
Township of West Lincoln	0.8%

Source: Statistics Canada, 2006 Census of Population

% of population for which mother tongue is a language other than English or French (highest to lowest)	Other languages
Town of Niagara-on-the-Lake	23.6%
City of Niagara Falls	19.0%
St. Catharines	18.9%
Niagara Region	**16.1%**
Town of Lincoln	15.5%
City of Thorold	15.0%
Town of Pelham	12.8%
Town of Grimsby	12.7%
Welland	12.4%
Township of West Lincoln	11.6%
Town of Port Colborne	10.5%
Town of Fort Erie	10.5%
Township of Wainfleet	8.4%

Source: Statistics Canada, 2006 Census of Population

Visible Minorities

Visible minorities as % of total population (highest to lowest)	% visible minorities	Top visible minority as % of total population	Second visible minority as % of total population
City of St. Catharines	10.0%	Black (2.0%)	Latin American (1.8%)
City of Niagara Falls	7.8%	Chinese (1.5%)	Black (1.3%)
Niagara Region	**6.3%**	**Black (1.2%)**	**Latin American (1.0%)**
Town of Niagara-on-the-Lake	5.9%	Chinese (1.0%)	Latin American (0.9%)
Town of Fort Erie	5.5%	Latin American (1.4%)	Chinese (1.2%)
City of Welland	3.7%	Black (1.3%)	Latin American (0.7%)
Town of Lincoln	3.2%	Latin American (1.0%)	South Asian (0.6%)
Town of Grimsby	3.2%	South Asian (0.7%)	Black (0.6%)
Town of Pelham	2.2%	South Asian (0.9%)	Chinese (0.3%)
City of Thorold	2.1%	Black (0.7%)	Latin American (0.4%)
Township of Wainfleet	1.8%	South Asian (0.7%)	Latin American(0.5%)
Town of Port Colborne	1.5%	South Asian (0.4%)	Black & Filipino (0.2% each)
Township of West Lincoln	1.4%	Chinese (0.4%)	Black & South Asian (0.3% each)

Source: Statistics Canada, 2006 Census of Population

Immigrants

Immigrants as % of total population (highest to lowest)	Immigrants as % of total population	Recent immigrants (2001-2006) as % of total immigrant population
Town of Niagara-on-the-Lake	28.1%	7.2%
City of St. Catharines	21.1%	12.9%
City of Niagara Falls	20.0%	12.4%
Niagara Region	**18.0%**	**10.4%**
Town of Fort Erie	17.5%	12.7%
Town of Lincoln	16.5%	5.3%
Town of Grimsby	16.4%	5.2%
Town of Pelham	15.6%	3.4%
City of Thorold	14.2%	4.5%
Township of West Lincoln	12.6%	4.2%
City of Welland	12.3%	9.1%
Town of Port Colborne	12.2%	7.2%
Township of Wainfleet	8.6%	1.8%

Source: Statistics Canada, 2006 Census of Population

APPENDIX TWO: SUMMARY OF KEY DOCUMENTS SHAPING ADDICTIONS SERVICES

Key documents at three levels will shape the future of addictions services operated by the Niagara Health System:

1. Documents at the level of the Province of Ontario
2. Documents at the level of the Hamilton Niagara Haldimand Brant LHIN
3. Documents at the level of the Niagara Health System or the Region of Niagara.

This section of the review describes these documents and their implications for the program review

Ontario Documents

Every Door is the Right Door

Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy: A discussion paper (July 2009) is an interim report from an Advisory Group to Ontario's Minister of Health and Long-Term Care. The Advisory Group is helping develop a 10-year strategy to transform Ontario's mental health and addiction services. It adopts the premise that mental health, problematic substance use and problem gambling services will be integrated into the same strategy, not in separate silos. The strategy will focus on people with serious mental illnesses but will also include services for people with mild to moderate symptoms of mental illness.

The strategy will look beyond specialized mental health and addiction services funded by the Ministry of Health and Long-Term Care and the Ministry of Children and Youth Services, to the other *health* services that people with mental illnesses and addiction use, such as family health care services, home care and long-term care. The province's strategy will also look beyond health to include all other services used by people with mental illnesses and addictions and which are funded by other ministries. *Every Door is the Right Door* proposes ten transformational strategies**:**

Where We Are Now	Where We Want to Be
Prevention is overlooked	Prevention and early identification are priorities
The system helps only people who reach services	The system reaches out to the whole population and all who need help
Services focus on treatment	Services focus on healthy development, recovery and harm reduction
Care is disease or provider-centred	Care is person-driven and family-centred
People with mental illness and/or addiction have limited support to manage their own care	People with mental illnesses and/or addictions are empowered/supported to manage their own care
Care is reactive and episodic	Care is proactive and ongoing
Providers and programs work in isolation	Providers and programs work collaboratively
Services plan and operate in separate silos	Services are integrated and coordinated
There is a sense of isolation and frustration	There is a culture of improvement and innovation
The system uses data and measurement for reporting	The system uses data and measurement to improve services

Every Door is the Right Door proposes seven directions:

1. Act Early: Identify mental health and addiction problems early and intervene appropriately.

.**2. Meet People on their Terms:** Develop a range of evidence-based, person-directed services.

3. Transform the System: Provide access to a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports by revaluating current resources. The system will provide a range of evidence-based services that are coordinated with other health services, and with other services that people with lived experience use, such as education, social services, housing and employment programs.

4. Strengthen the Mental Health and Addictions Workforce: Ensure we have the right people with the right skills in the right places, sharing knowledge and promoting respectful, evidence-based services for people with mental illnesses and addictions. Life experience as well as academic training help build a stronger, more efficient workforce.

5. Stop Stigma: Bring mental illness and addiction out from behind closed doors. Ontario should eradicate stigma in the health system, public services, and society. We should create healthy, supportive communities.

6. Create Healthy Communities: Fostering supportive communities is a shared responsibility requiring commitment of all segments of society and cooperation of all ministries.

7. Build Community Resilience: Take a strengths-based approach to protect people from mental illness and addictions – strengths such as family and friends, problem-solving skills, coping style, social skills and being connected to the community.

Implications for the NHS Addictions Services Program Review:

- The review should be evidence-based.
- It should foster integration with mental health and other relevant services, both within and beyond the NHS service portfolio.
- It should identify what role NHS addictions services can play in prevention and early intervention.

Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians

Issued in August 2010, this is the final report of the Ontario Legislature's Select Committee on Mental Health and Addictions. It is based in part on public hearings held across Ontario. The report recommends that:

- An umbrella organization—Mental Health and Addictions Ontario (MHAO), responsible to the Ministry of Health and Long-Term Care—should be created to ensure that a single body is responsible for designing, managing, and coordinating the mental health and addictions system, and that programs and services are delivered consistently and comprehensively across Ontario.
- All mental health and addictions programs/services for all regions and ages including children/youth should be consolidated in the Ministry of Health and Long-Term Care.
- MHAO should ensure that a basket of core institutional, residential and community services is available in every region for clients of all ages. MHAO should also identify gaps and eliminate duplication. Referral patterns must be put in place for the

provision of specialized services only available outside a region. Each region must also have the capacity to serve clients with concurrent disorders.

- Clients and families should have access to system navigators to connect them with treatment and community support services. People with continuing, complex needs should be supported by a plan that leads them to recovery and wellness, particularly on discharge from institutional or residential treatment.
- MHAO should ensure that all primary care providers and staff in the education and long-term care systems can access common, age-appropriate, evidence-based assessment and screening tools.
- MHAO should facilitate the creation of more 24/7 mobile crisis intervention teams.
- The Ministry should expand and do more to publicize Telehealth Ontario's ability to help callers with mental health and addictions issues.
- MHAO should work with the Ministry review emergency department protocols, to increase their capacity to serve people with mental health and addictions issues and when appropriate, to connect them to community based services and supports.
- Primary care providers should be given the proper tools and support to enable them to develop greater sensitivity to their patients' mental health and addictions needs.
- Interdisciplinary primary care models should include a mental health/addictions care component (e.g., social worker, psychiatrist, psychologist, mental health worker).
- The Ministry should immediately address addiction to prescription painkillers.
- The Ministry should change the family physician remuneration model to focus on improving primary care for people with mental illnesses and addictions.
- MHAO should ensure, coordinate and advocate for more affordable safe housing units, with levels of support to meet the long-term and transitional needs of people with serious mental illnesses and addictions.
- MHAO should ensure that institutional and community-based service providers seek to involve peer support workers in all aspects of service delivery.
- MHAO should work with employers and service providers on strategies to increase employment opportunities and supports for people with mental illnesses/addictions.
- MHAO should provide for the increased respite care so family members can pursue endeavours to maintain their own mental health. It should also monitor the progress of the Mental Health Commission of Canada's Mental Health Family Link program's peer support project for family caregivers, and adopt best practices.
- Court mental health workers should be widely available, to divert more people with a mental illness or addiction into mental health/addictions services and supports.
- More Mental Health, Drug Treatment, and Youth Mental Health Courts should be created to serve for people with a mental illness or addiction.
- The Ministry of Community Safety and Correctional Services should direct police forces to train officers who encounter people with mental illnesses and addictions.
- The core basket of mental health and addictions services should be available to incarcerated people. Discharge plans for people with a mental illness or addiction should be expanded to include a system navigator, and community services.

- The Ministry should create a task force to propose changes to mental health legislation and policy on involuntary admission and treatment. Changes should ensure that involuntary admission criteria include serious harms that are not merely physical, and that involuntary admission entails treatment.
- This task force should propose changes to the *Personal Health Information Protection Act, 2004,* so family members and caregivers supporting a person with a mental illness or addiction have access to the personal health information necessary to provide that support, prevent deterioration and minimize risk of serious harm.

Implications for the NHS Addictions Services Program Review:

- The review should foster integration with mental health and other relevant services, both within and beyond the NHS service portfolio.
- It should contribute to defining a basket of services for Niagara.

Ontario Health Quality Council Report, Monitor 2010

The Ontario Health Quality Council (OHQC) is an independent agency, created under the *Commitment to the Future of Medicare Act* on September 12, 2005. The Council's role is to advance the delivery of health care in Ontario with a focus on identifying and recommending quality improvements.

As part of its role, the Council releases an annual report on the health system.

In June 8, 2010, *The Excellent Care for All Act* was passed in the legislature expanding the Council's role and mandate. The functions of the Council are:

- To monitor and report to the people of Ontario on quality issues
- To support continuous quality improvement
- To promote health care that is supported by the best available scientific evidence.

Implications for the NHS Addictions Services Program Review:

- In its 2010 Report, the OHQC articulated preferred attributes for the health system. These provide a useful framework for looking at program design.
- The report – in its section on healthy behaviours – notes that cocaine use is a significant unhealthy behaviour.
- The report – in its maternal/child section – notes that special attention should be directed to high risk mothers (thus supporting the goals of the ABC program).
- The report – in its section on deaths that could be avoided through prevention – notes that suicides are linked to depression and substance abuse (as well as other factors), thus supporting proactive treatment and follow up programs for persons with addictions.

.

Hamilton Niagara Haldimand Brant LHIN Documents

Integrated Health Service Plan, 2010 – 2013

The LHIN's Integrated Health Service Plan (IHSP) is a core planning document for LHIN, since it is the roadmap for local heath system change over the next three years. It is built on significant consultation and represents a melding of Ministry and local priorities. It sets priorities for action and it is a framework document against which business plans and integration will be assessed.

Included in LHIN priorities is mental health and addictions (a provincial priority as well as a local priority).

The LHIN's IHSP puts forward, as its mental health and addictions goal for the IHSP's three-year period:

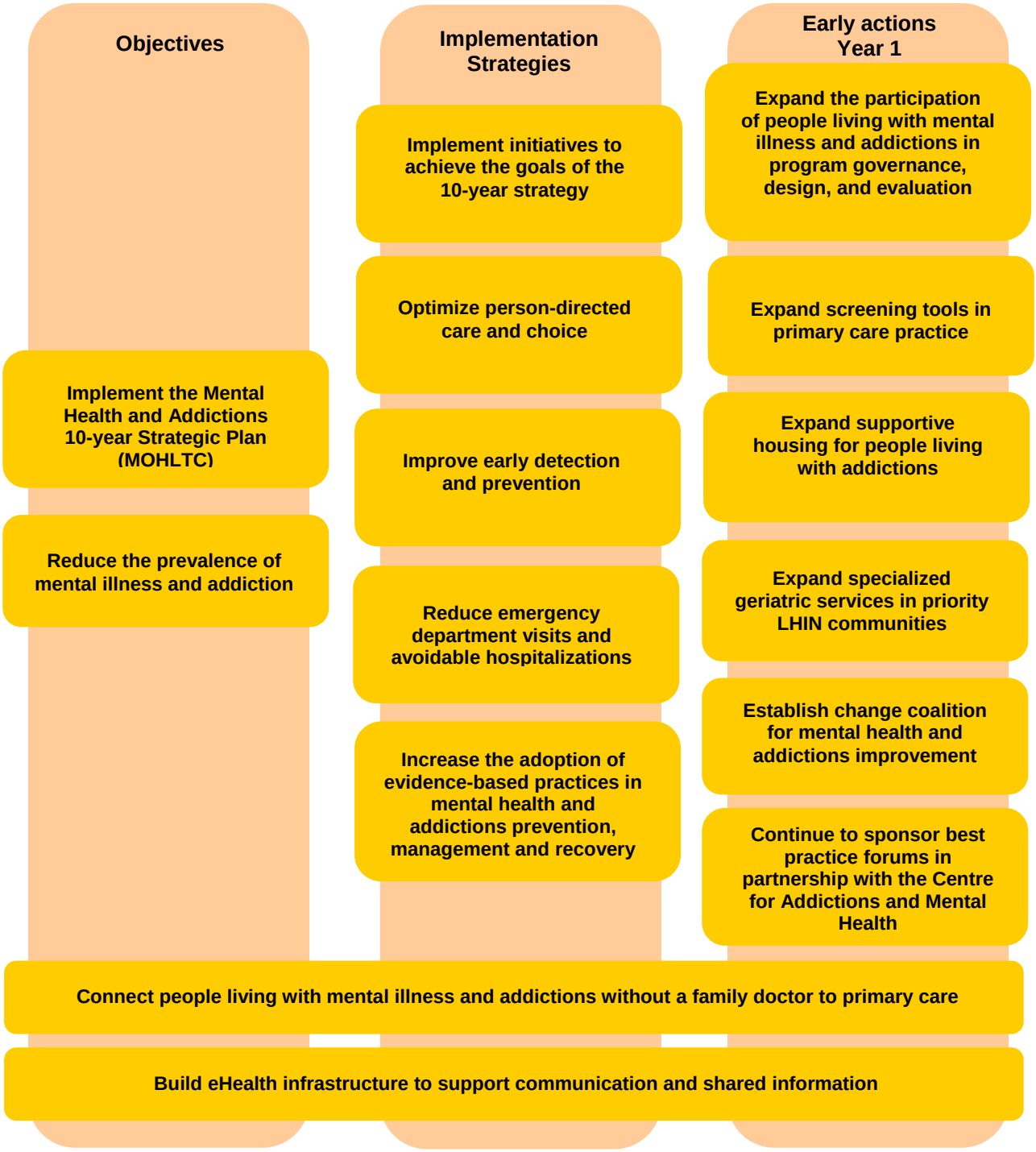
"Integrated and Linked Services for Prevention, Management and Recovery"

The IHSP then presents performance goals, objectives, implementation strategies and early actions (Year 1) to address the goals and objectives (shown on the next page).

Implications for the NHS Addictions Services Program Review:

- The review should foster integration with mental health and other relevant services, both within and beyond the NHS service portfolio.
- It should identify LHIN-wide issues and opportunities.
- It should indicate how NHS addictions services can improve early detection and prevention.
- It should indicate how NHS addictions services can help reduce avoidable emergency department visits and hospitalizations.

- **Goal: Integrated and Linked Services for Prevention, Management and Recovery**



Performance Goals

- **Improve client/patient experience**
- **Increase inclusion rates of people living with mental illness and addictions in program governance, design and evaluation**
- **Increase screening rates in primary care practice**
- **Reduce avoidable ED visits and hospitalizations**
- **Increase local access to specialized geriatric services**

Clinical Service Plan

All LHINs were required to develop clinical service plans to try to reduce duplication and demand, and increase efficiency and quality in hospital services

Produced in November 2009, the Hamilton Niagara Haldimand Brant LHIN's Clinical Service Plan is based on three key strategies for change:

1. Interprofessional Care

Health service providers (HSPs) will work collaboratively to provide comprehensive, quality health services within and across settings, with a strong focus on health promotion, disease prevention, screening and self-management. Interprofessional care "teams" may include social workers, nurse practitioners, family physicians, pharmacists, traditional healers, optometrists and other health care providers (HCPs) as appropriate. Care teams can be either co-located in one setting or function as a virtual team in multiple sites. Interprofessional care will enable all health professionals to work to their full scope of practice or expertise. This will optimize work place satisfaction for primary care providers and assist with training, education and recruitment of new primary care providers.

2. Community-Based Health Service Capacity

Most people will continue to get most of their health care, most of the time, in the community. Community services for health, wellness and recovery will be aligned with population health goals, such as reduced diabetes and chronic lung disease, and improved mental health. Decision support tools and improved client matching processes will link people with the appropriate level of care in the right setting. Robust and linked community services will improve patient/client flow, and reduce inappropriate demand for hospital care.

3. Clinical Program Integration

Health care programs will be reorganized and distributed to improve access, quality, and efficiency. This will eliminate, for instance, unnecessary duplication of low volume, high complexity services and ensure appropriate use of human and equipment resources. Integrated programs will be led by one or more organizations, and guided by clear roles and shared accountabilities, best practice standards and guidelines, and common protocols for client transitions along the care path.

The Clinical Services Plan provides specific program integration attributes including:

- Clear roles, responsibilities and accountability
- Common admission, discharge and referral guidelines
- Elimination of unnecessary duplication of low volume, high complexity services
- Commitment to best practices and implementation of clinical standards/guidelines
- LHIN wide population based planning, evaluation and performance monitoring.

The Plan notes that each LHIN wide clinical program will have as its goal an equitable and evidence based continuum of services – and the Plan talks about communication and partnerships across the LHIN.

The Plan projects and increase in demand (2007 – 2022) for hospital services of 30% and the Plan establishes the goal of reducing this to 10% or less.

The following page shows the Clinical Services Plan's Priorities for Action and Early Starts – Using Existing Resources. This priorities schedule indicates that realignment of mental health and addictions across the continuum of care is scheduled to take place in Year 2 (2011-12).

Implications for the NHS Addictions Services Program Review:

- The review should foster integration with mental health, emergency health services and other relevant services, both within and beyond the NHS service portfolio. As per the LHIN's Clinical Services Plan, mental health and addictions services and emergency services are slated for realignment across the continuum of care in the same year – 2011-12. This suggests the possibility of synergies between the two realignments.
- It should indicate how the NHS Addictions Service can help reduce avoidable emergency department visits and hospitalizations.
- It should suggest how the NHS Addictions Service can help reduce hospital inpatient admissions.

Priorities for Action and Early Starts – Using Existing Resources

Year 1: 2010-11	Year 2: 2011-12	Years 3+: 2012 and beyond
Implementation of interprofessional model of care: □ implement and evaluate a 'virtual' interprofessional care model □ develop interprofessional care toolkit to support interprofessional care model dissemination in the LHIN □ maximize health professionals' scope of practice. **Implementation of clinical program integration:** □ LHIN-wide charter for clinical program integration endorsed by hospital leadership □ realignment of the following program areas across the continuum of care: o cancer care o complex continuing care and rehabilitation o hepatobiliary o maternal/newborn o vascular and thoracic. □ development of a functional plan for a LHIN-wide integrated laboratory medicine program, to support clinical program integration - for capital approval □ establish LHIN-wide hospital common credentialing to support clinical program integration for physicians, dentists, midwives, and nurses. **Realignment of community-based health service capacity:** □ establish peritoneal dialysis units in three long-term care homes □ enhance organizational capacity in the community sector through process improvements (e.g. pilot common tools and processes to link clients/patients to appropriate community based services) □ implement 'demand modeling tool' to identify service gaps in community sector □ implement strategies and fund initiatives (e.g. through Aging at Home) to address service gaps in community sector □ expansion of diabetes education centres □ expansion of foot care services for high risk diabetics – starting in Niagara and Hamilton □ implement falls prevention strategies across the LHIN □ implement common client eligibility criteria for LHIN-funded transportation programs. **Implementation of e-Health activities:** □ implementation of regional Diagnostic Imaging Repository (DI-r) at St. Joseph's Healthcare Hamilton, Hamilton Health Sciences Corporation, West Lincoln Memorial Hospital, Niagara Health System □ expand access to ClinicalConnect to all HNHB LHIN hospitals and HNHB CCAC to enable HCPs to obtain patient/client health information, diagnostic imaging and medical/lab test results in 'real' time □ implement CCAC 'resource matching' tool to connect clients to services.	**Implementation of interprofessional model of care:** □ expand interprofessional care models into a minimum of two additional communities □ formalize linkages with academic sector to support ongoing performance measurement, evaluation and quality improvement processes □ establish a process and implement two best practice or quality projects LHIN-wide every year. **Implementation of clinical program integration:** □ realignment of the following program areas across the continuum of care: o cardiac o chronic kidney disease o diabetes o emergency/trauma o mental health and addictions o paediatrics. **Implementation of community-based health service capacity:** □ ongoing 'demand modeling' for continuous improvement □ ongoing implementation of strategies and funding of initiatives (e.g. through Aging at Home) to address service gaps in community sector □ LHIN-wide application of common tools and processes to link clients/patients to appropriate community-based services. **Implementation of e-Health activities:** □ connect remaining LHIN hospitals to DI-r	**Implementation of interprofessional model of care:** □ expand interprofessional care models LHIN-wide □ establish screening/health promotion targets LHIN-wide. **Implementation of clinical program integration:** □ realignment of the following program areas across the continuum of care: o ear, nose, and throat o chronic pain o gastroenterology o neurosciences o ophthalmology o orthopedics o respiratory o specialized geriatrics o urology. **Implementation of community-based health service capacity:** □ continue to address gaps in community capacity based on estimates of unmet need for services. **Implementation of e-Health activities:** □ HNHB LHIN HSPs fully connected electronically □ establish patient portals to provide access to health care information and support self management of chronic health conditions.

Niagara Health System Documents

NHS Hospital Improvement Plan and Related Documents

The NHS Hospital Improvement Plan is the hospital's strategy to address issues of quality and sustainability. This plan was approved by the LHIN in December 2009. NHS is now in phase II of the implementation of the plan.

The importance of the NHS addictions programs is cited in the plan. Integrating NHS addictions programs, as well as consolidation of NHS mental health beds, were seen as a potential early gains emerging from the plan.

Once this plan was completed and submitted to the Hamilton Niagara Haldimand Brant LHIN, the LHIN commissioned a review of the plan by a team headed by Dr, Jack Kitts. His team's report was entitled *Review of The Niagara Health System Hospital Improvement Plan* and was completed in October 2008.

The Niagara Health System subsequently re-examined its plan in light of the findings of the Kitts report, and in December 2008, NHS issued a *Revised Addendum to the Niagara Health System Hospital Improvement Plan*. The Revised Addendum proposed the creation of nine NHS centres of excellence, including a mental health centre of excellence and an addictions centre of excellence. The Revised Addendum was subsequently approved by the LHIN.

In reference to the addictions centre of excellence, the Revised Addendum described the addictions centre of excellence as:

> ***"an integrated in-patient/residential and outpatient addictions services in a new, special purpose built location in the community of St. Catharines, with satellite programs at the Greater Niagara, Welland, Port Colborne, and Fort Erie sites."***

Implications for the NHS Addictions Services Program Review:

- The program review should speak to the centre of excellence concept relative to the NHS program and future goals
- It should indicate what a "new, special purpose built location" for NHS addictions services in St. Catharines should look like.
- It should indicate what the satellite programs at the Greater Niagara, Welland, Port Colborne, and Fort Erie sites should look like, in programmatic terms.

Niagara Health System Addictions Services Functional Program (2006)

The 2008 NHS Hospital Improvement Plan (HIP) articulated a vision for the consolidation of all NHS Addictions Services into a centre of excellence in St. Catharines. This consolidation would allow for strengthened integration of care across the treatment continuum as well as achievement of operating efficiencies to be reinvested in the program. To support the consolidation, NHS initiated the development

of a comprehensive *Functional Program* identifying the future state program parameters and associated space requirements.

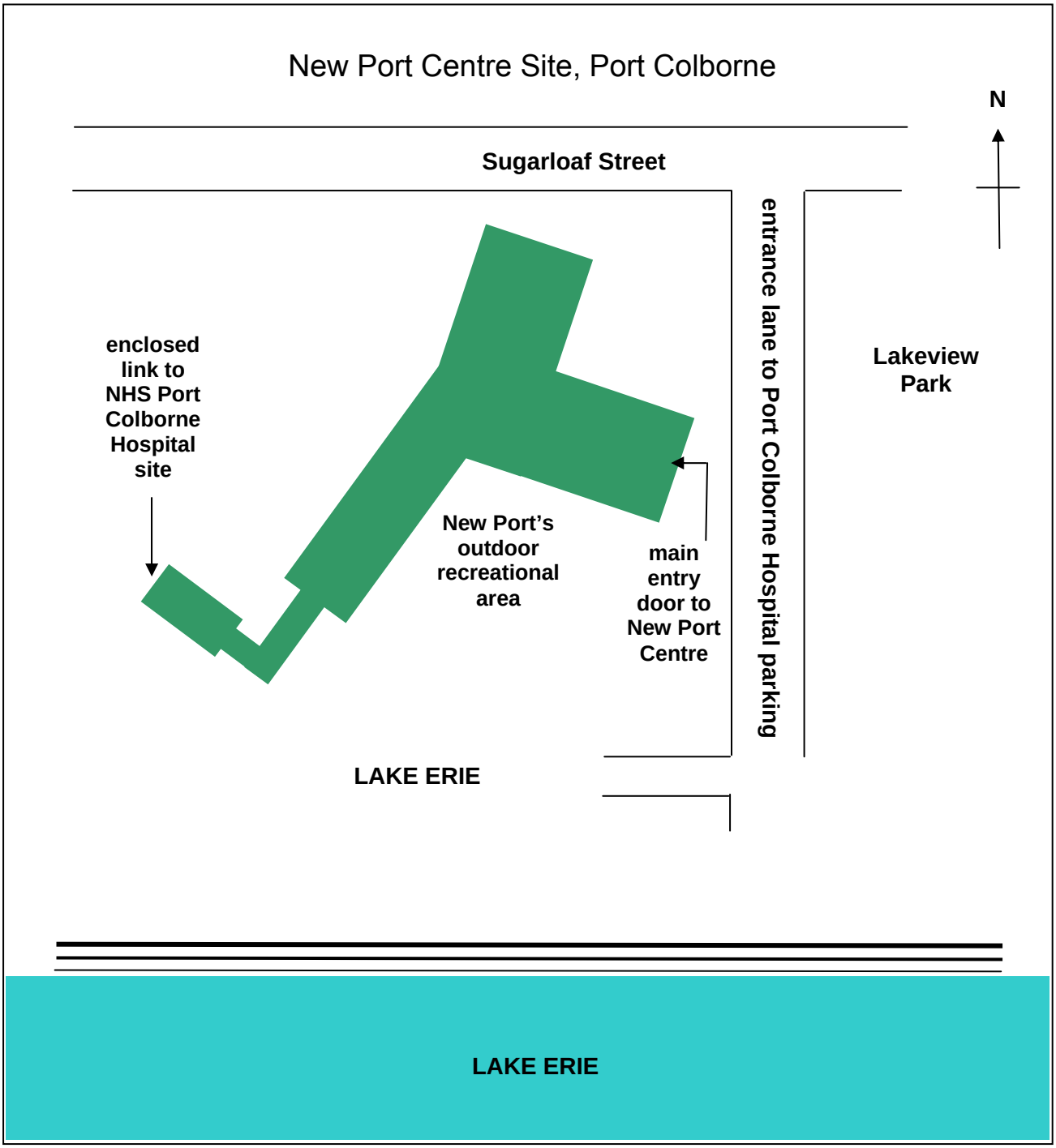
The functional program report provides an overview of NHS addictions programs (as well as those of their key partners), as these were envisioned at the time of that report (2006). It provided descriptions of how the programs would operate in the future and identified the related infrastructure requirements. This functional program document supports the request for capital funding for the new site and new building.

The functional program document used data to 2006/07. For this program review more recent utilization information was available and used – specifically to 2009/10.

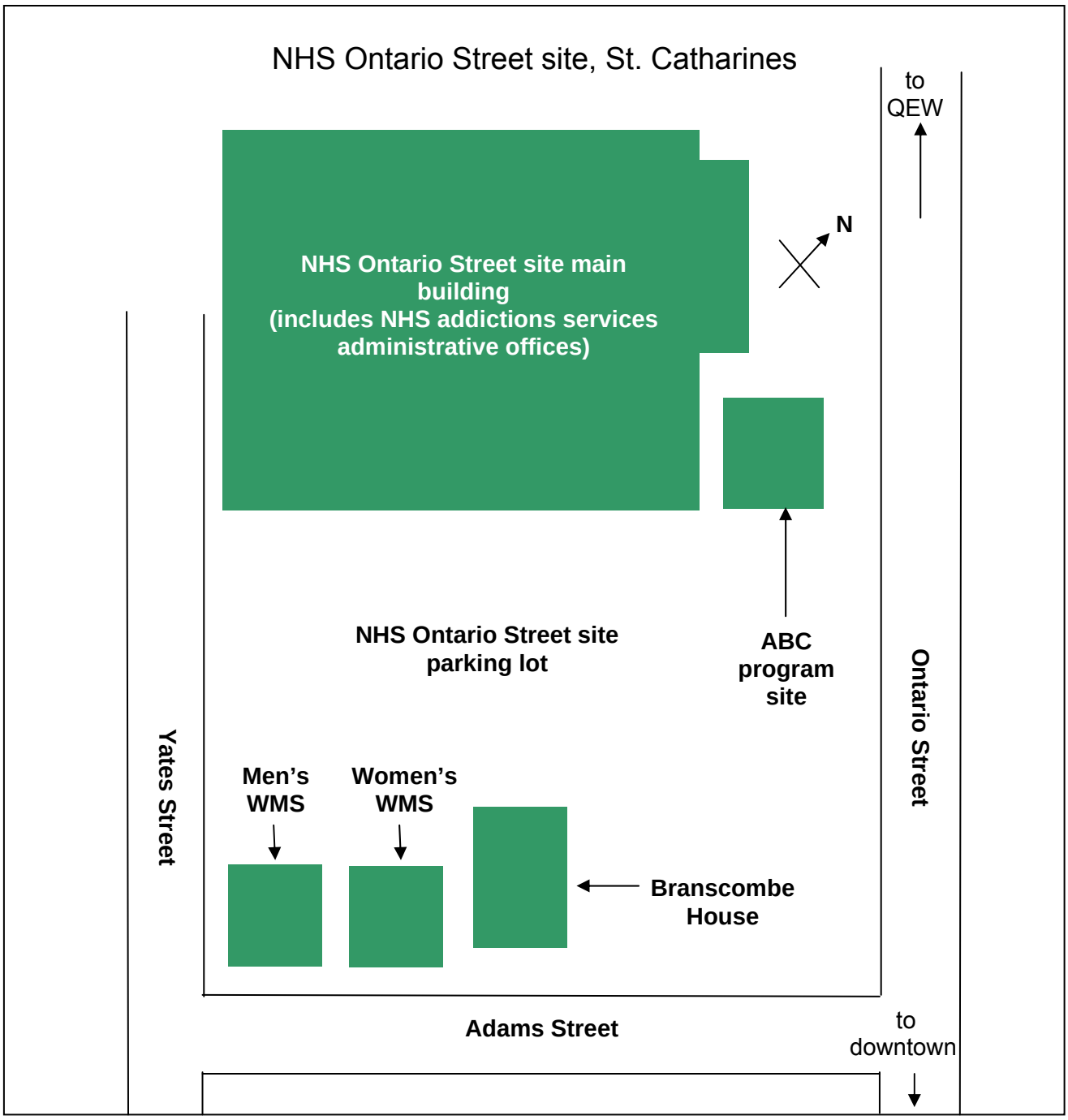
Implications for the NHS Addictions Services Program Review:

- The *Functional Program* provided a comprehensive overview of NHS addictions programs and the work of their partner agencies. It provides useful baseline information about future program operational needs.
- The program review includes perspectives and options not mentioned in the functional program plan - for example the implementation of a day withdrawal management program; assuming these new directions are approved, the functional program plan will have to be updated to include these program requirements
- This review has been able to use more updated service data figures than those available at the time of the functional program plan development. The following has been observed:
    - although service volume trends have remained generally consistent, the projections built into the functional program plan for WMS and New Port Centre are slightly higher than the reality for 2009/10 or expected for 2010/11.
    - Length of stay projections were very close to the current state.
    - The Primary Care program in the St. Catharines at the Ontario Street site seems to significantly exceed the numbers of visits projected in the functional program plan, and will need to be examined in the light of future space requirements.
    - The ABC program shows a client roster of 122 versus the 40 projected in the functional plan (a 200% + increase over expected capacity) so this will have to be revisited as part of any future site development.
- The functional plan includes a program not currently in operation – family programming – which is emerging as well through the program review as an unmet need in the community.
- The functional program plan notes that Branscombe House is being converted to a recovery home, which is not reflective of the current status.

APPENDIX THREE: SCHEMATICS, NHS ADDICTIONS SERVICE SITES



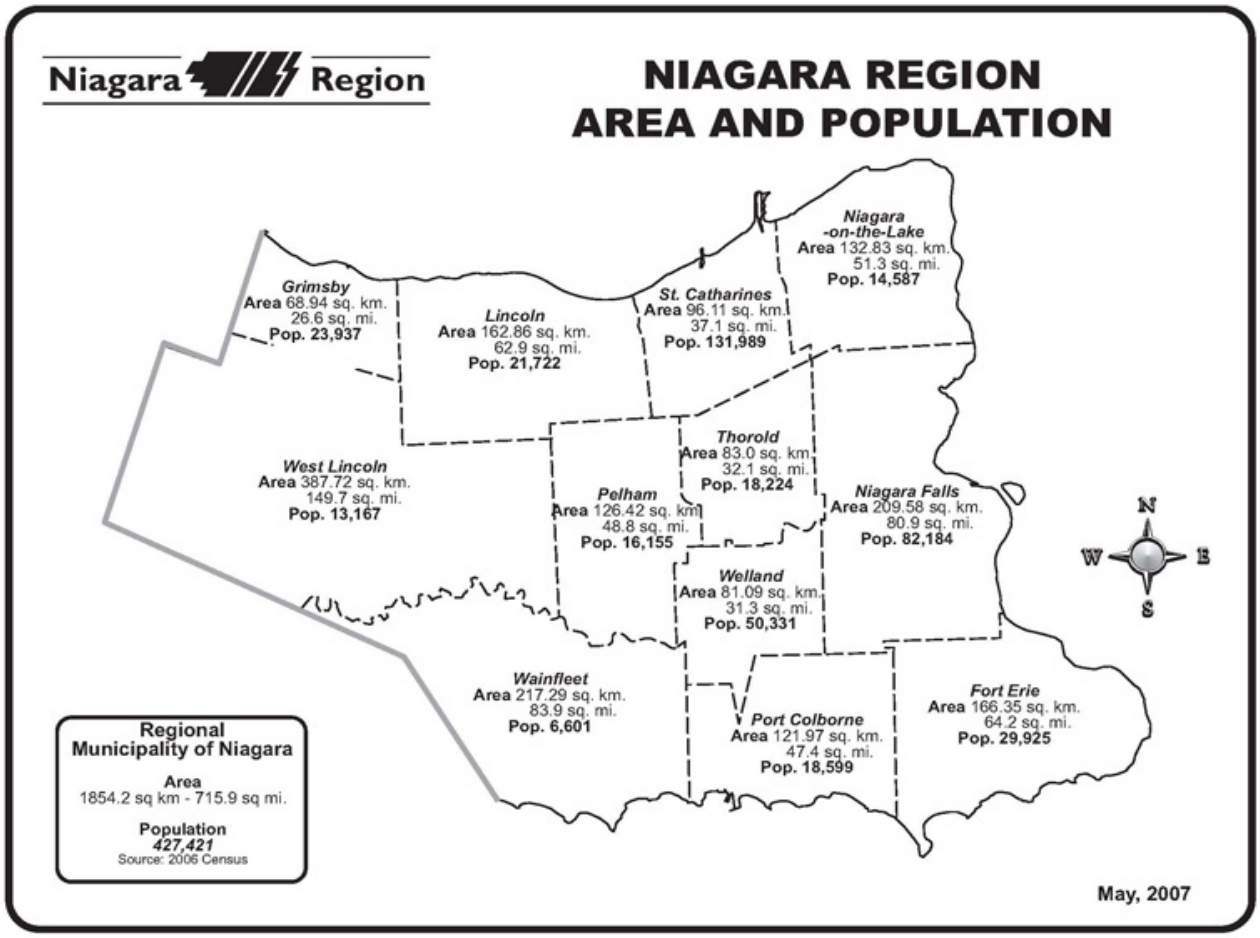
New Port Centre in southeast Port Colborne comprises a single two-story building with three wings and an enclosed connection to the Niagara Health System's Port Colborne Hospital site. New Port Centre was originally built in the 1960s as a residence for student nurses affiliated with the Port Colborne Hospital. It is located 37 kilometres (45 minutes travel time) from the NHS addictions services site (the Ontario Street site) in St. Catharines.



The Ontario Street site of NHS addictions services comprise four buildings. The main building (formerly the Hotel Dieu Hospital) houses NHS addictions services administrative offices on its fourth floor. The ABC program site is an early 20th century 2½ story freestanding building that was built as the residence for the sisters whose religious order owned and operated Hotel Dieu. The Women's Withdrawal Management Service, Men's Withdrawal Management Service and Branscombe House are 2½ story converted former houses fronting on Adams Street and not physically connected to each other. The Ontario Street site in St. Catharines is located 37 kilometres (45 minutes travel time) from the NHS New Port Centre site in Port Colborne.

APPENDIX FOUR: ADDICTIONS SERVICES IN NIAGARA REGION

Information in this inventory is drawn from the Drug and Alcohol Registry of Treatment (DART).



ADDICTIONS SERVICE PROVIDERS IN EACH NIAGARA COMMUNITY

Grimsby

1. Community Addiction Services of Niagara

St. Catharines

1. Niagara Health System
2. Community Addiction Services of Niagara
3. Wayside House of St. Catharines
4. Segue Clinic

Thorold

1. ARID Group Homes (Niagara)

Niagara Falls

1. Community Addiction Services of Niagara

Welland

1. Community Addiction Services of Niagara
2. Segue Clinic

Fort Erie

1. Niagara Health System
2. Community Addiction Services of Niagara
3. ARID Group Homes (Niagara)
4. Ontario Federation of Indian Friendship Centres

Port Colborne

1. Niagara Health System

Summary of Programs

St. Catharines

ORGANIZATION: Niagara Health System		
		Men's Withdrawal / Crisis
		Women's Withdrawal / Crisis
		Assessment Program *ECD
		Community Treatment *ECD
		Out and About Clinic
		Primary Health Care by Nurse Practitioner
		Branscombe House
ORGANIZATION: Community Addiction Services of Niagara		
		Adult Substance Abuse Assessment/Treatment Planning
		Assessment for Day Treatment
		Youth Substance Abuse Assessment/Treatment Planning
		Women's Aftercare Group
		Men's Aftercare Group
		Co-ed Aftercare Group
		Smoking Cessation Counselling
		Youth Substance Abuse Counselling
		Early Treatment Group
		Spousal Support Group
		Family Counselling
		Adult Substance Abuse Counselling
		Couples Counselling
		Panic Anxiety Group
		Day Treatment
ORGANIZATION: Wayside House of St. Catharines		
		Phase 1 - 15-Day Restriction / Phase 2 - Core Groups / Phase 3 - Discharge
ORGANIZATION: Segue Clinic		
		Methadone Maintenance Treatment Program
		Buprenorphine Maintenance Treatment Program

Port Colborne

ORGANIZATION: Niagara Health System		
		Women's Residential
		Men's Residential
		French Assessment/Treatment Planning
		French Language 1-1 Counselling
		Assessment for Methadone Services
		Methadone Clinic
		Primary Health Care by Nurse Practitioner
		Smoking Cessation Program
		Hepatitis C Clinic

Niagara Falls

ORGANIZATION: Community Addiction Services of Niagara		
		Adult Substance Abuse Assessment/Treatment Planning
		Youth Substance Abuse Assessment/Treatment Planning
		Adult Substance Abuse Counselling
		PROGRAM: Youth Substance Abuse Counselling

Welland

ORGANIZATION: Community Addiction Services of Niagara		
		Adult Substance Abuse Assessment/Treatment Planning
		Youth Substance Abuse Assessment/Treatment Planning
		Adult Substance Abuse Counselling
		Youth Substance Abuse Counselling

ORGANIZATION: Segue Clinic			
			Methadone Maintenance Treatment Program
			Buprenorphine Maintenance Treatment Program

Fort Erie

ORGANIZATION: Niagara Health System		
		Assessment for Methadone Services
		Fort Erie Methadone Services

ORGANIZATION: Community Addiction Services of Niagara		
		Adult Substance Abuse Assessment/Treatment Planning
		Youth Substance Abuse Assessment/Treatment Planning
		Adult Substance Abuse Counselling
		Youth Substance Abuse Counselling
		StreetWorks

ORGANIZATION: ARID Group Homes (Niagara)		
		Assessment
		Residential
		Big Book Study

ORGANIZATION: Ontario Federation of Indian Friendship Centres		
		Intake / Assessment
		Community Treatment Programs

Thorold

ORGANIZATION: ARID Group Homes (Niagara)		
		Assessment
		Residential
		Big Book Study

Grimsby

ORGANIZATION: Community Addiction Services of Niagara		
		Adult Substance Abuse Assessment/Treatment Planning
		Youth Substance Abuse Assessment/Treatment Planning
		Adult Substance Abuse Counselling
		Youth Substance Abuse Counselling

Detailed Program Listings

St. Catharines

ORGANIZATION: Niagara Health System
SITE: Niagara Regional Men's Withdrawal Management Service 10 Adams Street, St. Catharines, ON L2R2V8
PROGRAM: Men's Withdrawal / Crisis
Provincial Service Category: Residential Withdrawal Management Level 2
Program Description: The centre provides crisis intervention, withdrawal management, rest, nutrition and hygiene restarts, assessments, supportive counselling and self help groups, consultation, treatment referrals and discharge planning in a supportive, supervised setting for alcohol and other drug issues. Inpatient and outpatient support is available.
Phone: (905) 378-4647 ext. 63383 **Contact e-mail:** none provided **Web site:** www.niagarahealth.on.ca
Gender served: Male
Ages served: 16 to 99 years of age.
Catchment: Niagara Region
Hours: 24/7
Language of service: English

ORGANIZATION: Niagara Health System
SITE: Niagara Regional Women's Withdrawal Management Service 6 Adams Street, St. Catharines, ON L2R2V8
PROGRAM: Women's Withdrawal / Crisis
Provincial Service Category: Residential Withdrawal Management Level 2
Program Description: The centre provides crisis intervention, withdrawal management, rest, nutrition and hygiene restarts, assessments, supportive counselling and self help groups, consultation, treatment referrals and discharge planning in a supportive, supervised setting for alcohol and other drug issues. Inpatient and outpatient support is available.
Phone: (905) 378-4647 ext. 63383 **Contact e-mail:** none provided **Web site:** www.niagarahealth.on.ca
Gender served: Female
Ages served: 16 to 99 years of age.
Catchment: Niagara Region
Hours: 24/7
Language of service: English, French

ORGANIZATION: Niagara Health System
SITE: ABC Program (Early Years Initiative) 151 Ontario Street St. Catharines, ON L2R5K2
PROGRAM: Assessment Program *ECD
Provincial Service Category: Initial Assessment / Treatment Planning
Program Description: The MOHLTC-approved standardized assessment tools are administered through this program in person through this organization. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Treatment planning. Clients are offered an addiction prenatal psychological needs assessment (ALPHA). Post-partum depression assessment tools are also used. This program is restricted to Early Childhood Development clients and women.
Phone: (905)378-4647 ext. 63854 **Contact e-mail:** shirleyanne.ogilvie@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
Gender served: Female
Ages served: 0 to 99 years of age.
Catchment: Niagara Region
Hours: Monday to Friday, 8:30 AM to 4:30 PM
Language of service: English

		PROGRAM: Community Treatment *ECD
		Provincial Service Category: Community Treatment
		Program Description: ABC is a community-based harm reduction program. Treatment philosophy is based on the principles of women-centered care (empowerment, participatory, safe, holistic, comprehensive, individualized, and respectful of diversity, social justice focussed). Treatment modalities rely on stages of change model primarily but not exclusively. Individual and group counselling support, education (includes children and/or child supervision), and life skill development. Case management includes screening and intake, psychosocial needs assessment, individual treatment, goal planning and review, outreach, education, and referrals. There are no mandatory or exclusionary aspects. Outreach/home visits as needed. This program is restricted to Early Childhood Development clients and women.
		Phone: (905)378-4647 ext. 63854 **Contact e-mail:** shirleyanne.ogilvie@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
		Gender served: Female
		Ages served: 0 to 99 years of age.
		Catchment: Niagara Region
		Hours: Monday to Friday, 8:30 AM to 4:30 PM
		Language of service: English

ORGANIZATION: Niagara Health System		
SITE: Out and About Clinic 151 Ontario Street, St. Catharines, ON L2R5K2		
		PROGRAM: Out and About Clinic
		Provincial Service Category: Community Treatment
		Program Description: Methadone maintenance treatment. Accepting new clients with intake complete and same day transfers.
		Phone: (905) 378-4647 ext. 63850 **Contact e-mail:** rhianon.burkholder@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
		Gender served: Male and female
		Ages served: 0 to 99 years of age.
		Catchment: Niagara Region
		Hours: Tuesdays 8:00 AM to 4:00 PM, Thursdays 1:00 PM to 7:00 PM
		Language of service: English
		PROGRAM: Primary Health Care by Nurse Practitioner
		Provincial Service Category: Community Treatment
		Program Description: Primary health care is provided by two nurse practitioners for people with substance abuse issues at two sites: New Port Centre and the Out and About Clinic.
		Phone: (905) 378-4647 ext. 32516 **Contact e-mail:** none listed **Web site:** www.niagarahealth.on.ca
		Gender served: Male and female
		Ages served: 16 to 99 years of age.
		Catchment: Niagara Region
		Hours: Monday to Wednesday, 9:00 AM to 4:00 PM Thursday, 9:00 AM to 11:30 AM
		Language of service: English, French (French offered where individual/family services required. French services available as arranged)

ORGANIZATION: Niagara Health System
SITE: Branscombe House 4 Adams Street, St. Catharines, ON L2R2V8
PROGRAM: Branscombe House
Provincial Service Category: Residential Supportive Treatment Level 2
Program Description: Branscombe House provides a home-like environment for women in early recovery from alcohol and drug dependency. Residents must have an active recovery plan and be engaged in educational or employment pursuits and pay rent.
Phone: (905) 378-4647 ext. 63383 **Contact e-mail:** none listed **Web site:** www.niagarahealth.on.ca
Gender served: Female
Ages served: 16 to 99 years of age.
Catchment: Niagara Region
Hours: 24/7
Language of service: English

ORGANIZATION: Community Addiction Services of Niagara
SITE: 401-60 James Street St. Catharines, ON L2R7E7
PROGRAM: Adult Substance Abuse Assessment/Treatment Planning
Provincial Service Category: Initial Assessment / Treatment Planning
Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
Phone: (905) 684-1183 **Web site:** www.cas-n.ca
Gender served: Male & female
Ages served: 21 to 99 years of age.
Catchment: Niagara Region
Hours: Monday to Friday, 8:30 AM to 4:30 PM
Language of service: English (interpretation services available)
PROGRAM: Assessment for Day Treatment
Provincial Service Category: Initial Assessment / Treatment Planning
Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program does not follow the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate.
Phone: (905) 685-5425 **Web site:** www.cas-n.ca
Gender served: Male & female
Ages served: 16 to 99 years of age
Catchment: Niagara Region
Hours: Monday to Friday, 8:00 AM to 4:00 PM
Language of service: English
PROGRAM: Youth Substance Abuse Assessment/Treatment Planning
Provincial Service Category: Initial Assessment / Treatment Planning
Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines. Principal youth clients are aged 25 or under, however family members (particularly parents) attend the program in family therapy sessions.
Phone: (905) 684-1183 **Web site:** www.cas-n.ca
Gender served: Male & female
Ages served: 0 to 21 years of age
Catchment: Niagara Region

			Hours: Monday to Friday, 8:30 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Women's Aftercare Group	
			Provincial Service Category: Community Treatment
			Program Description: The Women's Aftercare Group is designed to provide clients with gender-specific, ongoing support subsequent to completion of a formal treatment program. It provides an atmosphere conducive to continued growth and positive change, from a female perspective. The focus of Women's Aftercare is in assisting clients to maintain the changes made in treatment. This is achieved through further goal identification, the development of relapse prevention strategies and a more intensive focus on issues identified by individual clients necessary to sustain abstinence and life functioning activities.
			Phone: (905) 685-5425 **Contact e-mail:** susan_bonn@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Thursdays, 1:00 PM to 2:30 PM
			Language of service: English
		PROGRAM: Men's Aftercare Group	
			Provincial Service Category: Community Treatment
			Program Description: No description in DART database
			Phone: (905) 684-1183 **Contact e-mail:** lpanetta@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Co-ed Aftercare Group	
			Provincial Service Category: Community Treatment
			Program Description: The Co-ed Aftercare Group is designed to provide clients with ongoing support subsequent to completion of a formal treatment program. It provides an atmosphere conducive to continued growth and positive change, from both the male and female perspectives. The focus of Co-ed Aftercare is in assisting clients to maintain the changes made in treatment. This is achieved through further goal identification, the development of relapse prevention strategies and a more intensive focus on issues identified by individual clients necessary to sustain abstinence and life functioning activities. Aftercare is provided in the form of weekly group sessions. Issue-specific workshops may also be provided to address identified needs for this client group (e.g., Healthy Emotions, Couples Counselling, Strengthening Families, and others).
			Phone: (905) 685-5425 **Contact e-mail:** susan_bonn@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:0 0 AM to 4:00 PM
			Language of service: English
		PROGRAM: Smoking Cessation Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Smoking Cessation Counselling can be accessed for tobacco addiction alone without other substance involved. Following assessment, treatment can follow an individualized plan. The plan may include auricular acupuncture.
			Phone: (905) 684-1183 **Contact e-mail:** lpanetta@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Youth Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation. Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female

			Ages served: 0 to 21 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Early Treatment Group	
			Provincial Service Category: Community Treatment
			Program Description: Early Treatment Group is a group-level program designed to assist people awaiting more intensive treatment. It meets once weekly for two hours. As a preparation stage intervention, it is intended to engage clients in a treatment process, to provide an opportunity to become acquainted with a group setting, and to offer an introduction to relapse prevention strategies. In addition, it is intended to support clients as they stabilize in their own community, build a support network and to ensure that they are sufficiently detoxified to begin intensive treatment. The group also seeks to ensure that clients have realistic expectations of themselves and the treatment process before moving on to the next stage. Clients must attend at least two sessions before moving on to further programming. A weekly group oriented to assisting clients to maintain/build motivation and abstinence prior to beginning a more intensive treatment program. Three sessions. One session a week.
			Phone: (905) 685-5425 **Contact e-mail:** susan_bonn@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:00 AM to 4:00 PM
			Language of service: English
		PROGRAM: Spousal Support Group	
			Provincial Service Category: Community Treatment
			Program Description: Family support and educational services are provided for significant others.
			Phone: (905) 685-5425 **Contact e-mail:** lisa_panetta@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Wednesdays, 5:00 PM to 6:30 PM
			Language of service: English
		PROGRAM: Family Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Family support and educational services are provided for significant others.
			Phone: (905) 685-5425 **Contact e-mail:** lisa_panetta@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:00 AM to 4:00 PM
			Language of service: English
		PROGRAM: Adult Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:3 0 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Couples Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Couples Counselling is a six-session program for couples in recovery. It teaches partners to access their strengths, to develop helpful skills and techniques, and to create a framework for building more effective ways of talking, listening and resolving conflict. Participants are provided with the means of gaining a better understanding of themselves, their partner, and their relationship.
			Phone: (905) 685-5425 **Contact e-mail:** lisa_panetta@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region

			Hours: Monday to Friday, 8:0 0 AM to 4:00 PM
			Language of service: English
		PROGRAM: Panic Anxiety Group	
			Provincial Service Category: Community Treatment
			Program Description: Panic Anxiety Group is a ten week group offered twice per year. The group is offered to clients experiencing anxiety and panic with or without substance abuse issues. The group is delivered jointly with Community Addiction Services of Niagara staff and staff from Regional Niagara Public Health - Mental Health Program. A cognitive - behavioural approach is utilized.
			Phone: (905) 684-1183 **Contact e-mail:** lpanetta@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:3 0 AM to 4:30 PM
			Language of service: English (interpretation services available)
		PROGRAM: Day Treatment	
			Provincial Service Category: Community Day / Evening Treatment
			Program Description: This program is an intensive treatment intervention designed to assist individuals experiencing significant substance abuse problems. The program format is broad-based and uses a Life Skills model as a programming reference. Individuals are assisted in identifying areas of their life that are problematic and in formulating goals to systematically resolve these problems. Modalities include cognitive, educational, and experiential components. Four-week intensive non-residential day treatment program for persons addicted to alcohol and drugs. The program runs five days per week and includes group therapy, life skills training, evaluation, and individual support.
			Phone: (905) **Contact e-mail:** karen_ferruccio@adtcniagara.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:0 0 AM to 4:00 PM
			Language of service: English

ORGANIZATION: Wayside House of St. Catharines			
	SITE: Wayside House of St. Catharines 50 Queenston Street, St. Catharines, ON L2R2Y9		
		PROGRAM: Phase 1 - 15-Day Restriction / Phase 2 - Core Groups / Phase 3 - Discharge	
			Provincial Service Category: Residential Supportive Treatment Level 1
			Program Description: Morning group process/video discussion. Night workshops i.e., relapse prevention, stress management. Discharge planning, resumes, etc. Fifteen day restriction - client is restricted to property for 15 days. This program offers the following groups: A.A. Closed; A.A. Open; Addiction Impact; Anger Management; Anti Smoking; Emotional Wellness; Food Basics; Gambling; Life Skills; Money Management; One on One; Reality Therapy; Recreation; Relationships; S.T.D. Awareness; Self-Esteem; Stress Management; Video Group; Relapse Prevention and Effective Communication Group.
			Phone: (905) 684-9248 **Contact e-mail:** mstupiello@cogeco.ca **Web site:** none listed
			Gender served: Male
			Ages served: 18 to 65 years of age.
			Catchment: Niagara Region (primary) and Ontario (secondary)
			Hours: 24/7
			Language of service: English, French

ORGANIZATION: Segue Clinic			
	SITE: Segue Clinic - St. Catharines 61 James Street, St. Catharines, ON L2R5B9		
		PROGRAM: Methadone Maintenance Treatment Program	
			Provincial Service Category: Case Management
			Program Description: Segue Clinic offers Opiate Dependence Treatment for people who have an addiction to opiate-based drugs such as Heroin, Oxycontin, Morphine, Percocet and Codeine. Opiate Dependence Treatment is available with either Methadone or Buprenorphine (or Suboxone). Segue Clinic's physicians will help you determine which treatment option is best suited for your individual needs.
			Phone: 688-1827 **Contact e-mail:** none listed **Web site:** www.segueclinic.com
			Gender served: Male and female
			Ages served: 18 to 99 years of age.

			Catchment: Niagara Region and beyond if client has no problem travelling to the Clinic for treatment
			Hours: Mondays, Tuesday, Thursday, Friday 9:00 AM to 5:00 PM
			Language of service: English, Spanish
			PROGRAM: Buprenorphine Maintenance Treatment Program
			Provincial Service Category: Case Management
			Program Description: Segue Clinic offers Opiate Dependence Treatment for people who have an addiction to opiate-based drugs such as Heroin, Oxycontin, Morphine, Percocet and Codeine. Opiate Dependence Treatment is available with either Methadone or Buprenorphine (or Suboxone). Segue Clinic's physicians will help you determine which treatment option is best suited for your individual needs.
			Phone: 688-1827 **Contact e-mail:** none listed **Web site:** www.segueclinic.com
			Gender served: Male and female
			Ages served: 18 to 99 years of age.
			Catchment: Niagara Region and beyond if client has no problem travelling to the Clinic for treatment
			Hours: Mondays, Tuesday, Thursday, Friday 9:00 AM to 5:00 PM
			Language of service: English, Spanish

Port Colborne

ORGANIZATION: Niagara Health System			
SITE: New Port Centre Port Colborne General Hospital, 260 Sugarloaf Street, Port Colborne, ON L3K2N7			
			PROGRAM: Women's Residential
			Provincial Service Category: Residential Treatment
			Program Description: This is an 18-day residential program. The women's residential experience can be either a blend of the co-educational and the women's specific content or exclusively women's program content only, as determined by the client. There is a separate courtyard and separate living space for women. Program focuses on stabilization, education, skill development, health promotion, and aftercare planning. Activities include process groups, workshops, individual counselling, smoking cessation counselling and recreation. Programming relevant to women's interests is available.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: 24/7. Structured programming runs from 0830-2130
			Language of service: English
			PROGRAM: Men's Residential
			Provincial Service Category: Residential Treatment
			Program Description: This is an 18-day residential program: a 35-bed co-educational program that focuses on stabilization, education, skill development, health promotion and aftercare planning. Activities include process groups, workshops, individual counselling, smoking cessation counselling and recreation.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: 24/7. Structured programming runs from 0830-2130
			Language of service: English
			PROGRAM: French Assessment/Treatment Planning
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Assessment and treatment planning are available at the Port Colborne Hospital site.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female francophones
			Ages served: Francophones 16 to 99 years of age.
			Catchment: Niagara Region and Ontario

			Hours: Monday Tuesday and Wednesday, 8:30 to 4:30
			Language of service: French
		PROGRAM: French Language 1-1 Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Treatment models offered are biopsychosocial, cognitive behavioural, stages of change, and harm reduction. Individual counselling in French is available at Port Colborne Hospital site. Average program length is short-term.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female francophones
			Ages served: Francophones 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: Monday Tuesday and Wednesday, 8:30 to 4:30
			Language of service: French
		PROGRAM: Assessment for Methadone Services	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are not administered through this program. Assessment involves an initial telephone screening and an appointment that involves assessment for substance dependence, information gathering that includes medical history, psychiatric history, family history, alcohol and substance use history, past drug treatment programs, social history, legal status and treatment goals, and a medical assessment. This program does not follow the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Assessment treatment planning, treatment, referral and discharge follow guidelines established by the College of Physicians and Surgeons of Ontario and Centre for Addiction and Mental Health. Average program length is one to two days.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: Monday to Friday, 7:30 to 3:30
			Language of service: English and French. French offered where individual/family services required. French services available as arranged.
		PROGRAM: Methadone Clinic	
			Provincial Service Category: Community Treatment
			Program Description: Provides outpatient services, including medical assessment, methadone maintenance treatment and referral, to help people manage their opiate dependence. Average program length depends on client's needs.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: Monday, Wednesday and Friday, 8:00 to 11:30
			Language of service: English and French. French offered where individual/family services required.
		PROGRAM: Primary Health Care by Nurse Practitioner	
			Provincial Service Category: Community Treatment
			Program Description: Primary Health Care is provided by two nurse practitioners for people with substance abuse issues at two sites: New Port Centre and the Out and About Clinic.
			Phone: (905) 378-4647 ext. 32516 **Contact e-mail:** none listed **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English and French. French offered where individual/family services required. French services available as arranged.
		PROGRAM: Smoking Cessation Program	
			Provincial Service Category: Community Treatment

			Program Description: New Port Centre is a smoke-free facility. Inpatients are asked to be smoke-free for five days prior to treatment and to bring their own Nicotine Replacement Therapy (NRT) for their 18-day stay. Those clients who are tobacco users complete a smoking consult on intake day and again prior to their discharge. Educational programming specific to smoking cessation is provided daily. Auricular acupuncture and mediation sessions are offered. Clients have access to our nurse practitioner for NRT management. Post-discharge follow-up is done at one week, one month, three months, and six months.
			Phone: (905) 378-4647 ext. 32528 **Contact e-mail:** none listed **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: 24/7.
			Language of service: English and French. French offered where individual/family services required. French services available as arranged. **Note:** Program open 24/7 to residential clients attending 18-day substance abuse program.
		PROGRAM: Port Colborne General Support Group	
			Provincial Service Category: Community Treatment
			Program Description: General evening support group. Offered weekly. Provides an aftercare function for some clients.
			Phone: (905) 378-4647 ext. 32500 **Contact e-mail:** roberta.tayti@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region and Ontario
			Hours: Tuesday 7:00 PM to 9:00 PM
			Language of service: English
		PROGRAM: Hepatitis C Clinic	
			Provincial Service Category: Community Treatment
			Program Description: Comprehensive outpatient care for Niagara Region patients with Hepatitis C is provided by our physician and nurse practitioner at the Niagara Addictions Services clinic. Services included: medical assessment, treatment planning, disease management education, medical treatment and follow-up, and assistance with drug plan applications.
			Phone: (905) 378-4647 ext. 32542 **Contact e-mail:** fiona.faber@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age.
			Catchment: Niagara Region
			Hours: Monday to Friday 6:00 AM to 4:00 PM
			Language of service: English

Niagara Falls

ORGANIZATION: Community Addiction Services of Niagara			
SITE: 4632 Victoria Avenue, Niagara Falls, ON L2E4B7			
		PROGRAM: Adult Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:.21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning

			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:. 0 to 21 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Adult Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation. Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 0 to 21 years of age. Principally youth clients are aged 25 or under, however family members (particularly parents) attend the program in family therapy sessions.
			Catchment: Niagara Region
			Hours: Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Language of service: English. Interpretation services available

Welland

ORGANIZATION: Community Addiction Services of Niagara			
SITE: Community Addiction Services of Niagara – Welland site Regional Niagara Health Services Department - Welland Branch 540 King Street Welland, ON L3B3L1 (adjacent to Niagara Health System site in Welland)			
		PROGRAM: Adult Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:.21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through

			this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:. 0 to 21 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Adult Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation. Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 0 to 21 years of age. Principally youth clients are aged 25 or under, however family members (particularly parents) attend the program in family therapy sessions.
			Catchment: Niagara Region
			Hours: Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Language of service: English. Interpretation services available

ORGANIZATION: Segue Clinic			
	SITE: Segue Clinic – Welland 626 East Main Street, Welland, ON L3B3Y2		
		PROGRAM: Methadone Maintenance Treatment Program	
			Provincial Service Category: Case Management
			Program Description: Segue Clinic offers Opiate Dependence Treatment for people who have an addiction to opiate-based drugs such as Heroin, Oxycontin, Morphine, Percocet and Codeine. Opiate Dependence Treatment is available with either Methadone or Buprenorphine (or Suboxone). Segue Clinic's physicians will help you determine which treatment option is best suited for your individual needs.
			Phone: 905 688-1827 **Contact e-mail:** none listed **Web site:** www.segueclinic.com
			Gender served: Male and female
			Ages served: 18 to 99 years of age.
			Catchment: Niagara Region and beyond if client has no problem travelling to the Clinic for treatment
			Hours: Mondays, Tuesday, Thursday, Friday 9:00 AM to 5:00 PM
			Language of service: English, Spanish
		PROGRAM: Buprenorphine Maintenance Treatment Program	
			Provincial Service Category: Case Management
			Program Description: Segue Clinic offers Opiate Dependence Treatment for people who have an addiction to opiate-based drugs such as Heroin, Oxycontin, Morphine, Percocet and Codeine. Opiate Dependence Treatment is available with either Methadone or Buprenorphine (or Suboxone). Segue Clinic's physicians will help you determine which treatment option is best suited for your individual needs.
			Phone: 905 688-1827 **Contact e-mail:** none listed **Web site:** www.segueclinic.com
			Gender served: Male and female
			Ages served: 18 to 99 years of age.
			Catchment: Niagara Region and beyond if client has no problem travelling to the Clinic for treatment

			Hours: Mondays, Tuesday, Thursday, Friday 9:00 AM to 5:00 PM
			Language of service: English, Spanish

Fort Erie

ORGANIZATION: Niagara Health System			
SITE: Douglas Memorial Hospital Site - 230 Bertie Street, Fort Erie, ON L2A1Z2			
		PROGRAM: Assessment for Methadone Services	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are not administered through this program. Assessment involves an initial telephone screening and an appointment that involves assessment for substance dependence, information gathering that includes medical history, psychiatric history, family history, alcohol and substance use history, past drug treatment programs, social history, legal status and treatment goals, and a medical assessment. This program does not follow the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Assessment treatment planning, treatment, referral and discharge follow guidelines established by the College of Physicians and Surgeons of Ontario and Centre for Addiction and Mental Health. Average program length is one to two days.
			Phone: (905) 378-4647 ext. 32542 **Contact e-mail:** fiona.faber@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 7:30 to 3:30
			Language of service: English. French offered where individual/family services required. Groups are in English.
		PROGRAM: Fort Erie Methadone Services	
			Provincial Service Category: Community Treatment
			Program Description: Provides outpatient services, including medical assessment, methadone maintenance treatment and referral, to help people manage their opiate dependence. Average program length depends on client's needs.
			Phone: 905) 378-4647 ext. 32542 **Contact e-mail:** fiona.faber@niagarahealth.on.ca **Web site:** www.niagarahealth.on.ca
			Gender served: Male and female
			Ages served: 16 to 99 years of age
			Catchment: Niagara Region
			Hours: Tuesday and Tuesday, 1:00 to 3:30 PM
			Language of service: English, French. French offered where individual/family services required

ORGANIZATION: Community Addiction Services of Niagara			
SITE: Community Addiction Services of Niagara – Fort Erie site Douglas Memorial Hospital, 230 Bertie Street, Fort Erie, ON L2A1Z2			
		PROGRAM: Adult Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:.21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30 **Note:** Walk-in services 9:00-11:00 AM on Monday, Wednesday and Friday on a first come basis.
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through

			this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:. 0 to 21 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30 Note: Walk-in services 0900-1100 on Monday, Wednesday and Friday on a first come basis.
			Language of service: English. Interpretation services available
		PROGRAM: Adult Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation. Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 0 to 21 years of age. Principally youth clients are aged 25 or under, however family members (particularly parents) attend the program in family therapy sessions.
			Catchment: Niagara Region
			Hours: Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Language of service: English. Interpretation services available

		PROGRAM: StreetWorks	
			Provincial Service Category: Community Treatment
			Program Description: In partnership with StreetWorks and AIDS Niagara program, a Community Addiction Services of Niagara addictions counsellor accompanies an AIDS Niagara worker on the mobile unit (responding to calls) one evening per week. This collaboration provides health teaching, harm reduction supplies, support and counselling to the drug-using and street-involved populations in the Niagara Region.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 0 to 99 years of age.
			Catchment: Niagara Region
			Hours: one evening per week
			Language of service: English

ORGANIZATION: ARID Group Homes (Niagara)			
SITE: Alcohol Recovery in Dignity (ARID) Group Homes - Fort Erie 89 Queen Street, Fort Erie, ON L2A1T9			
		PROGRAM: Assessment	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Since assessments vary in length according to the client's residential situation, comprehensive assessments are referred to our local assessment services. Where needed, and if deemed appropriate, residents are referred to community

			treatment, residential mental health, residential support, and residential withdrawal..
			Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
			Gender served: Male
			Ages served: 21 to 75 years of age
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: Monday to Friday, 8:00 to 4:00
			Language of service: English
		PROGRAM: Residential	
			Provincial Service Category: Residential Supportive Treatment Level 2
			Program Description: Housing and accommodation provided in an alcohol and drug-free setting. Addiction services are not offered on-site or as part of the housing service.
			Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
			Gender served: Male
			Ages served: 21 to 75 years of age
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: 24/7
			Language of service: English

		PROGRAM: Big Book Study
		Provincial Service Category: Community Treatment
		Program Description: Offers guided self-change format. It is open to past residents for follow up and also to community members. Program is offered 1.5 hours weekly on Mondays, starting at 10:30.
		Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
		Gender served: Male
		Ages served: 21 to 75 years of age
		Catchment: Niagara Region (primary) and Ontario (secondary).
		Hours: Monday, !0:30 to noon
		Language of service: English

ORGANIZATION: Ontario Federation of Indian Friendship Centres		
SITE: Fort Erie Native Friendship Centre 796 Buffalo Road, Fort Erie, ON L2A5H2		
		PROGRAM: Intake / Assessment
		Provincial Service Category: Initial Assessment / Treatment Planning
		Program Description: The MOHLTC-approved standardized assessment tools are not administered through this program. This program does not follow the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate.
		Phone: (905) 871-8931 Toll free: 1-877-650-6700 **Web site:** www.ofifc.org
		Gender served: Male and female
		Ages served: 0 to 99 years
		Catchment: Niagara South (Fort Erie, Welland, Niagara Falls, Port Colborne, Dunnville, Chippewa, Thorold)
		Hours: Monday to Friday, 9-5 Note: Monday to Friday 0800-1600 July to August, and by appointment
		Language of service: English
		PROGRAM: Community Treatment Programs
		Provincial Service Category: Community Treatment
		Program Description: Provides culturally appropriate client-based services. Videos and written assignments are used. Outpatient sessions are provided on an as needed basis. Anger management group available.
		Phone: (905) 871-8931 Toll free: 1-877-650-6700 **Web site:** www.ofifc.org
		Gender served: Male and female
		Ages served: 0 to 99 years
		Catchment: Niagara South (Fort Erie, Welland, Niagara Falls, Port Colborne, Dunnville, Chippewa, and Thorold)
		Hours: Monday to Friday, 9-5 Note: Monday to Friday 0800-1600 July to August, and by appointment

			Language of service: English.

Thorold

ORGANIZATION: ARID Group Homes (Niagara)			
SITE: Alcohol Recovery in Dignity (ARID) Group Homes – Thorold 175 Pine Street South, Thorold, ON L2V3M5			
		PROGRAM: Assessment	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Since assessments vary in length according to the client's residential situation, comprehensive assessments are referred to our local assessment services. Where needed, and if deemed appropriate, residents are referred to community treatment, residential mental health, residential support, and residential withdrawal..
			Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
			Gender served: Male
			Ages served: 21 to 75 years of age
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: Monday to Friday, 8:00 to 4:00
			Language of service: English
		PROGRAM: Residential	
			Provincial Service Category: Residential Supportive Treatment Level 2
			Program Description: Housing and accommodation provided in an alcohol and drug-free setting. Addiction services are not offered on-site or as part of the housing service.
			Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
			Gender served: Male
			Ages served: 21 to 75 years of age
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: 24/7
			Language of service: English
		PROGRAM: Big Book Study	
			Provincial Service Category: Community Treatment
			Program Description: Offers guided self-change format. It is open to past residents for follow up and also to community members. Program is offered 1.5 hours weekly on Mondays, starting at 10:30.
			Phone: (905) 227-1113 **Contact e-mail:** arid@cogeco.net **Web site:** www.aridhomes.org
			Gender served: Male
			Ages served: 21 to 75 years of age
			Catchment: Niagara Region (primary) and Ontario (secondary).
			Hours: Wednesday, !0:30 to noon
			Language of service: English

Grimsby

ORGANIZATION: Community Addiction Services of Niagara			
SITE: Community Addiction Services of Niagara – Grimsby Site Alexander Globe Centre, 167 Main Street East, Grimsby, ON L3M1P2 (adjacent to West Lincoln Memorial Hospital)			
		PROGRAM: Adult Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age

			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Assessment/Treatment Planning	
			Provincial Service Category: Initial Assessment / Treatment Planning
			Program Description: The MOHLTC-approved standardized assessment tools are administered through this program. This program follows the principles of Ontario's Admission and Discharge Criteria to develop treatment plans, including referrals to other organizations where appropriate. Use Trans-Theoretical Stage of Change algorithm, DHQ, Adverse Consequences, Basis 32, Health Screening, Psychosocial Interview, Behaviour Change Summary, Socrates, Treatment Entry Questionnaire, Perceived Social Support, Gambling Screen, and SOGS if appropriate. Also fill out tracking summary and follow guidelines.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served:. 0 to 21 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Adult Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 21 to 99 years of age
			Catchment: Niagara Region
			Hours: Monday to Friday, 8:30 to 4:30
			Language of service: English. Interpretation services available
		PROGRAM: Youth Substance Abuse Counselling	
			Provincial Service Category: Community Treatment
			Program Description: Use cognitive behavioural, solution-focused, education, systems theory, stages of change, and client-directed goals. Generally 60 minute sessions. Brief duration however individualized for each client. Limited follow up for outcome evaluation. Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Phone: (905) 684-1183 **Contact e-mail:** mchudy@cas-n.ca **Web site:** www.cas-n.ca
			Gender served: Male and female
			Ages served: 0 to 21 years of age. Principally youth clients are aged 25 or under, however family members (particularly parents) attend the program in family therapy sessions.
			Catchment: Niagara Region
			Hours: Services provided bi-weekly at 16 secondary schools and one youth custody facility.
			Language of service: English. Interpretation services available