MINISTRY OF HEALTH AND LONG-TERM CARE

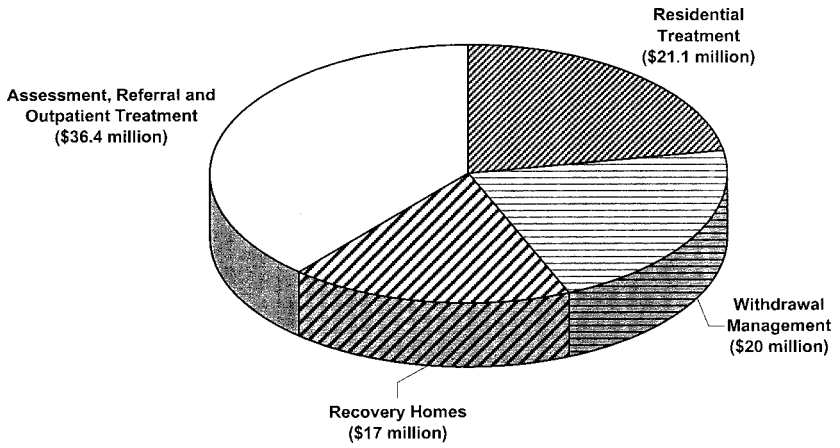
Ontario Substance Abuse Bureau

The Ontario Substance Abuse Bureau (the Bureau), which is part of the Ministry of Health and Long-Term Care's Community and Health Promotion Branch, is responsible for funding addiction treatment services in Ontario. These services are funded under the authority of the *Ministry of Health Act.* The Bureau's mandate is to reduce or eliminate substance abuse and other addictive behaviours.

The Bureau funds a range of direct treatment programs for people with substance abuse problems. During the 1998/99 fiscal year, the Bureau provided transfer payments totalling approximately $94.5 million to 158 agencies to deliver drug and alcohol addiction treatment. Services provided by these agencies included:

- assessment and referral services, which help clients assess their addiction problems, health needs and treatment options;
- community-based outpatient services, which are designed to help clients develop the skills to manage their addictions and related problems;
- withdrawal management services, which help people who are intoxicated go through withdrawal from drugs or alcohol;
- residential treatment, which provides structured short- and long-term treatment and/or rehabilitation services for clients in a residential setting; and
- treatment in recovery homes, which provide residential services to clients who need supportive housing, vocational rehabilitation and other life skill supports to regain or maintain their health and allow them to make the transition to independent living.

Funding For Drug and Alcohol Treatment Services 1998/99
(Total $94.5 Million)



Source: Ministry of Health and Long-Term Care

In the 1998/99 fiscal year, the Bureau also provided approximately $3.5 million for problem gambling initiatives.

Based on information from the new Drug and Alcohol Treatment Information System, approximately 95,000 individuals were treated for addictions during the 1998/99 fiscal year. The most recent study estimated that the economic cost of substance abuse in Ontario in 1992 was as follows:

Economic Cost of Substance Abuse in Ontario in 1992

	Alcohol ($ millions)	Illicit Drugs ($ millions)
Direct Costs		
Health Care	442	39
Law Enforcement	528	134
Other Direct Costs	285	24
Total Direct Costs	1,255	197
Indirect Costs		
Productivity losses	1,602	292
Total Costs	2,857	489

Source: Addiction Research Foundation sponsored study

This estimate does not include the costs related to the abuse of prescription and other legal drugs. While no cost/benefit evaluations have been performed on substance abuse treatment services in Ontario, studies in another jurisdiction estimated savings to the taxpayer of $5.60 for every dollar spent on treatment.

AUDIT OBJECTIVES AND SCOPE

The objectives of our audit of the Bureau were to assess whether the Ministry had adequate processes in place:

- to ensure that addiction treatment agencies were providing quality treatment and related services in an economic and efficient manner and in compliance with related policies and procedures; and
- to measure and report on the effectiveness of the Bureau in meeting its objectives.

Our audit was performed in accordance with the standards for assurance engagements, encompassing value for money and compliance, established by the Canadian Institute of Chartered Accountants and accordingly included such tests and other procedures as we considered necessary in the circumstances. Prior to the commencement of our audit, we identified the audit criteria that would be used to address our audit objectives. These were reviewed and agreed to by senior ministry management.

In conducting our audit, we reviewed and analyzed program policies and procedures; interviewed ministry staff and outside experts in the substance abuse field, visited a number of agencies funded by the Bureau, reviewed relevant literature and researched the delivery of substance abuse programs in other jurisdictions. We also reviewed the work performed by the Ministry's Audit Branch. However, because the Branch had not issued any relevant reports on the program since 1995, we did not reduce the extent of our audit work. Our audit was substantially completed in April 1999.

OVERALL AUDIT CONCLUSIONS

The Ministry did not have adequate processes in place to ensure that addiction treatment agencies were providing quality treatment services in an economic and efficient manner. The delivery of addiction treatment services in Ontario has been the subject of a number of studies, yet action on recommendations has been slow. While the Ministry had initiated a process to provide a more coordinated and efficient system of treatment services, much still needed to be done.

- The Ministry needed to monitor whether its initiatives were increasing capacity to treat substance abuse.
- The Ministry was not adequately ensuring that services were provided economically and efficiently.

While the Ministry has developed a draft operating manual to ensure compliance with its policies and procedures, in a number of areas policies were not being followed. In particular:

- The Ministry did not have an appropriate transfer payment accountability framework in place.
- The Ministry did not approve treatment agencies' funding on a timely basis.
- The Ministry needed to ensure that addiction treatment agencies submit budgets for approval that more accurately reflect agency spending.

The Ministry also did not have adequate procedures in place to measure and report on its effectiveness in reducing or eliminating substance abuse and other addictive behaviours. Our major concerns were as follows:

- The Ministry had not developed performance expectations or benchmarks for treatment agencies.
- The management information system did not provide adequate information to enable the Ministry to monitor the performance of treatment agencies regarding costs and outcomes of services provided.
- The Ministry had not sufficiently reviewed the accessibility of treatment services or monitored waiting times to ensure all clients were receiving treatment that met their needs on a timely basis.
- The Ministry had not developed program standards relating to quality of service or complaint procedures of treatment agencies.

DETAILED AUDIT OBSERVATIONS

ECONOMY AND EFFICIENCY

RESTRUCTURING ADDICTION TREATMENT SERVICES

According to the Bureau, Ontario's addiction treatment services did not develop as part of an integrated system. Instead, the programs grew individually over the last 30 years, as communities tried to respond to people's health needs. A number of ministry-initiated studies have dealt with the structure of addiction treatment services. The studies often had similar recommendations for restructuring the delivery of treatment services. Although the Ministry had agreed with many of the recommendations, implementation has been slow.

For example, in a 1990 report produced by the Provincial Advisory Committee on Drug Treatment, *Treating Alcohol and Drug Problems in Ontario, A Vision for the 90's,* recommendations included a substantial shift in emphasis toward more cost-effective outpatient approaches and developing more multi-functional treatment agencies. A multi-functional agency has the potential to enhance the continuity of care and improve efficiency, for example, by reducing administrative costs and duplication of services. However, only one multi-functional agency has been created since 1990.

In 1996, the Bureau initiated a *Rationalization Project* to ensure that the highest quality services were being delivered at the best price and more expenditures were directed to frontline services. A major component of this project was restructuring service delivery systems across the province. Consultants were hired in October 1996 to work with six regional planning committees to prepare regional restructuring plans. In April 1997, the consultants made recommendations relating to the mergers of treatment agencies, the creation of multi-functional agencies, reductions in residential beds, reinvesting savings in additional services and timeframes for implementation. However, these recommendations had not yet been acted upon.

In January 1999, the Bureau published *Setting the Course, A Framework for Integrating Addiction Treatment Services in Ontario* "to lay out the steps Ontario can take to improve the quality of addiction services, increase the capacity of the system, coordinate services and make more effective use of addiction resources." This was the next step resulting from the consultants' reports. Again, the Ministry intends to use a multi-functional approach to achieve the vision stated in *Setting the Course,* which is that:

> *All people in Ontario with an addiction problem will have access to an integrated, client-focused system of evidence-based, cost-effective services to meet their diverse needs as well as the needs of family members and others affected by someone's addiction.*

All ministry-funded addiction treatment agencies are expected to participate with district health councils (DHCs) in developing integrated addiction treatment service plans that demonstrate how each district intends to improve the delivery, monitoring and evaluating of services and identify opportunities to merge or amalgamate services.

In *Setting the Course,* the Ministry established June 30, 1999 as the deadline for the submission of DHC-prepared integrated service plans. However, *Setting the Course* contains no information on implementation or timelines for achieving its vision. While the Ministry acknowledged that mergers of treatment agencies could support and facilitate the integration of services which would better serve clients, *Setting the Course* does not address how the mergers of treatment agencies will be accomplished. We understand that while the DHC-prepared integrated service plans may include opportunities for mergers, the Ministry is not requiring mergers of addiction agencies as was originally intended.

For residential services, which include recovery homes and withdrawal management services and account for approximately 60% of the funding, the Bureau is undertaking a parallel planning exercise. Over the next few years, the Bureau intends to examine the services being offered and develop benchmarks to be used in the long-term restructuring of those services.

Because residential restructuring may be the source of a significant amount of funds for reinvestment, the Ministry needs an action plan, including a timetable for implementation.

Recommendation

To ensure that the treatment services funded by the Ministry are cost effective and meet the needs of their clients, the Ministry should:

- **act on those recommendations that it has acknowledged will improve service delivery; and**
- **develop a timetable for restructuring treatment services.**

Ministry Response

We agree that the Ministry should act on recommendations we have acknowledged will improve service delivery. As part of the rationalization process for addiction treatment services in Ontario, district health councils (DHCs) have been asked to take the lead in a planning process and are expected to submit plans for district-wide integrated addiction services by November 30, 1999.

DHCs are expected to base these plans on the principles outlined in the document* Setting the Course *which describe the steps to take to improve the quality of addiction services, increase the capacity of the system, coordinate services and make more effective use of addiction resources. In addition, the* Guidelines for the Development of Integrated Service Plans*, which were distributed in January 1999 to DHCs and participating agencies, clearly indicate how the DHCs should proceed in order to develop plans which reflect the principles outlined above.

We agree that there should be a timetable for restructuring treatment services. In the* Guidelines*, DHCs are expected to submit projected time lines for the implementation of integration. The Ministry will review these plans by December 1999.

3.10

The Ministry is committed to the three key roles set out by the Deputy Minister which include direction setting, accountability and enabling providers in the system. The principles set out in the document* Setting the Course *support these key directions.

TREATMENT EFFICIENCY

The 1996 *Rationalization Project* identified a number of strategies to increase treatment capacity and reduce waiting times, including:

- reducing the standard length of stay in short-term residential services from 28 to 21 days;
- implementing standardized admission and discharge criteria in all components of the treatment system in order to ensure that residential treatment services and recovery home services are admitting clients who require the level of care they provide;
- streamlining treatment assessment procedures;
- where appropriate, increasing group counselling in community services; and
- promoting greater innovation in the delivery of withdrawal management services.

In April 1997, the standard length of stay in short-term residential services was reduced to 21 days. In *Setting the Course,* the Ministry states that monitoring by the Bureau indicated that this had reduced the waiting times for these services. The Bureau intends to work with treatment providers and the Centre for Addiction and Mental Health to develop flexible lengths of stay for all residential programs, whereby individuals stay only as long as they need to rather than a specific number of days.

At the time of our audit, the Bureau had developed draft admission, discharge and referral criteria, and service definitions for use province-wide by treatment agencies. These criteria and definitions are important both for standardizing referrals and for clarifying the roles of different types of treatment agencies.

In the past, assessment referral agencies usually performed comprehensive client assessments. Clients referred for another treatment service were assessed again. At the time of our audit, the Bureau was developing an assessment protocol and tools to reduce the number of assessments performed.

In certain circumstances, group counselling may be as effective as individual counselling and is also less expensive. According to *Setting the Course,* the Centre for Addiction and Mental Health will provide training and support to help agency staff make the transition from individual to group work.

At the time of our audit, almost all withdrawal management services in Ontario were provided in a residential setting. Experience in other jurisdictions has shown that, with the proper support, many individuals can successfully withdraw (detoxify) at home. This approach can be less intrusive for clients and more cost effective than admission to a withdrawal management facility. The Bureau has recently completed a pilot study on the potential role of in-home withdrawal management that it intends to use in developing policy directions.

Recommendation

To help ensure that its initiatives to increase treatment efficiency are successful, the Ministry should assess the impact of these initiatives on service capacity and take corrective action where necessary.

Ministry Response

We agree with the recommendation to assess the impact of the initiatives developed on service capacity and where necessary to take corrective action.

Through the information generated by the Drug and Alcohol Registry of Treatment (DART), it will be possible to monitor length of stay for all residential programs and make adjustments to service requirements.

Admission, discharge and referral criteria and service definitions have been developed and distributed to agencies for use. Training sessions for each of these initiatives are planned for the fall and winter of 1999. As modifications are made to the Drug and Alcohol Treatment Information System (DATIS) and DART, these definitions and criteria will be incorporated into the data points so that all agencies will be using a common criteria for admission, discharge and referral, and a common service definition. By using these common criteria and definitions, referrals can be standardized and the roles of different types of treatment agencies can be clarified.

As agencies are trained and begin to use the common assessment protocol, the number of assessments performed will decrease because it will not be necessary to repeat an assessment as clients move from one agency to another in the stages of their treatment (that is, from residential treatment to community-based outpatient treatment).

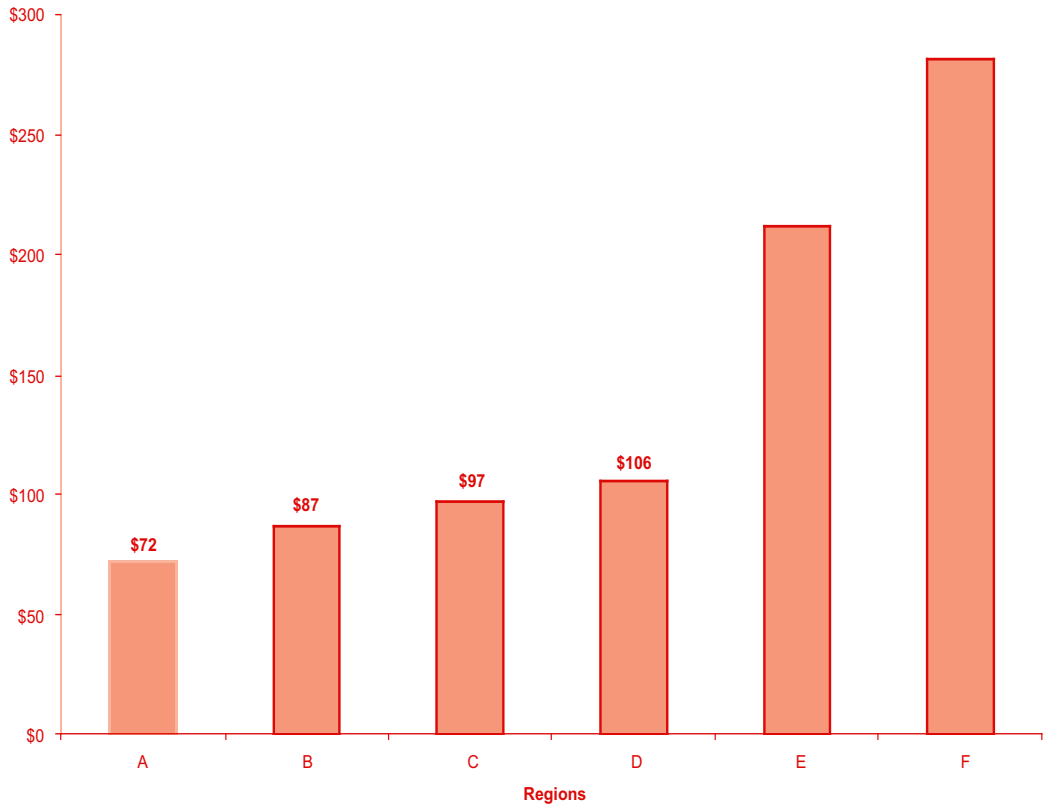
FUNDING

Making the most effective use of the resources available for addiction treatment requires that funding be allocated equitably to meet the treatment needs of clients across the province. It is also important to review how resources are used and identify opportunities to use them more effectively.

Agency funding is generally allocated based on the amount the agency requested in its first funding submission to the Ministry. Over time, this practice has resulted in funding inequities.

In 1993, the Bureau issued *Partners in Action, Ontario's Substance Abuse Strategy,* which recommended a review of the funding policy. However, this review was never undertaken. In 1998, an analysis by the Bureau identified funding inequities in the six health planning regions in the province. For example, regional per capita funding for addiction treatment services ranged from $10.13 to $44.74. More significantly, when taking into account estimates of the numbers of individuals who meet criteria for substance abuse or dependence (the in-need population), regional per capita funding ranged from $72 to $282 as follows:

Regional per Capita Funding Based on In-Need Population



Source: Ministry of Health and Long-Term Care data

Funding inequities translate into differing levels of services being available among and within regions. For example, using the most current estimates of the in-need population in the different regions, the available number of treatment beds per 1,000 in-need residents ranged from:

- 1.9 to 9.1 beds for withdrawal management services;
- 0.7 to 6.5 beds for short-term residential services; and
- 2.1 to 12.9 beds for recovery homes.

Comparing the costs of treatment agencies providing similar services can assist in detecting funding inequities and in identifying whether services are being provided economically and efficiently. Useful indicators may be the cost per bed or the cost per client treated at withdrawal management centres, residential services and recovery homes. We compared the cost per bed and cost per client treated for the 1996/97 and 1997/98 fiscal years and found that:

- At withdrawal management centres, annual funding provided by the Bureau ranged from $15,000 to $102,000 per bed and averaged $36,000 per bed. The cost per client treated ranged from $127 to $1,550 and averaged $560 per client.
- At short-term residential services, annual funding provided by the Bureau ranged from $25,000 to $57,000 per bed, with the average being $37,000. The cost per client treated ranged from $1,700 to $7,000 and averaged $2,430 per client.
- At long-term residential and recovery homes, annual funding provided by the Bureau ranged from $18,000 to $73,000 per bed, with an average cost of $21,000. The cost per client treated ranged from $4,000 to $18,000 and averaged $6,650 per client.

While the cost of residential services is expected to vary due to diverse client needs, the nature of the services provided and the size of the agency, the Bureau had not determined if these wide variations were justified.

Our analysis also indicated that there were apparent funding inequities for assessment, referral and outpatient agencies, which accounted for nearly 40% of the total funding by the Bureau. For example, based on estimates of the in-need population, yearly per capita funding among regions for outpatient services ranged from $23 per person to $110 per person.

Recommendation

To help ensure that services are provided economically and efficiently, the Ministry should:

- **assess whether the current distribution of funds is commensurate with the value of the services provided;**
- **compare the costs to provide services among similar treatment agencies; and**
- **develop a plan to redress any funding inequities.**

Ministry Response

We agree with the recommendations. As a first step, the Ministry is currently undertaking a review of residential services which will include an assessment of the cost of those services, the number of clients serviced and the type of programs offered. Recognizing the need to ensure that funding is used for direct services to clients, the Ministry is continuing to monitor central administration, program administration and direct service costs. The Ministry can also compare similar services using this monitoring. In addition, through the Drug and Alcohol Treatment Information System, it is now possible to confirm service utilization at individual agencies and, when linked with budget information, assess and compare the actual costs of similar services.

3.10 COMPLIANCE

AGENCY ACCOUNTABILITY

The majority of addiction treatment services are delivered by community-based organizations with volunteer boards of directors. The Bureau needs an effective means of holding treatment agencies accountable for their use of ministry funds. Management Board of Cabinet's Directive on Transfer Payment Accountability requires an effective accountability framework for provincial transfer payments. The key principle is that transfer payments should be managed wisely and prudently. The four required elements of the framework are:

- defining expectations with respect to the objectives and results that the transfer payment recipient is to achieve;
- entering into an agreement which ensures that there is an understanding about the objectives and results to be achieved and the responsibilities for reporting performance;
- timely reporting of objectives and results achieved; and
- taking necessary corrective action on a timely basis.

Treatment agencies are required to submit annual operating plans and budgets for the upcoming fiscal year, including program objectives and numerical targets. For the previous year, agencies are required to report on their progress and outcomes for each objective and to plan corrective action for objectives that were not met. When reviewing the plans, the Bureau's program consultants are to assess the outcomes and targets set by the agencies along with the treatment services being funded.

The Bureau relies on the information in the operating plans as the basis for approving funding. From our review of a sample of operating plans, we noted that:

- Many agencies set program objectives that were either too general or too vague. For example, one residential agency's main objective was to provide residential treatment, ask clients to complete a questionnaire at discharge and continue to do follow-up questionnaires.

- In the majority of cases, it was not clear whether program objectives had been met. Several agencies had not included measurable targets or outcomes and thus had no basis for determining whether or not they had achieved their objectives.

  For example, in their plans for the 1997/98 fiscal year, several agencies did not indicate the projected number of clients to be treated. Therefore, no comparative analysis of the actual number of clients treated could be completed to determine whether significant year-to-year variances had occurred. Although the Bureau usually requires agencies to include client treatment targets in their operating plans, that requirement was omitted for the 1998/99 fiscal year. We understand this was due to an oversight.

During the 1997/98 fiscal year, the Bureau asked district health councils (DHCs) to review the proposed operating plans of treatment agencies in their districts. The DHCs commented that the type, scope and details of information in the operating plans varied significantly and recommended that the Bureau provide more clearly defined guidelines and process requirements.

We compared the operating plans with descriptions of agency programs and treatment services compiled by the Drug and Alcohol Registry of Treatment (DART), a centralized registry of information on treatment programs and services. We noted that 10 withdrawal management centres reported a total of 57 fewer treatment beds in their operating plans than were reported by DART. The Bureau was not aware of these discrepancies. Specifically, five centres collectively reported 33 fewer treatment beds than were recorded by DART, and five other centres had collectively converted 24 treatment beds to stabilization beds. The use and operating costs of stabilization beds are significantly different than those of treatment beds.

The external consultants who led the October 1996 rationalization exercise used DART's registry of treatment services as their database. However, many agencies indicated to the external consultants that DART's description of their treatment resources was inaccurate and many claimed to offer other services or services for specialized groups. This highlights the need for the Bureau to review the services being funded and the services actually being provided by treatment agencies.

Another required element of the accountability framework is entering into an agreement with the treatment agencies. The agreement should ensure that there is an understanding of the objectives and results to be achieved and the responsibilities for reporting performance. The Bureau's draft operating manual, prepared during the 1996/97 fiscal year, requires service agreements with all treatment agencies outlining the Ministry's expectations for each agency. A draft service agreement was developed in late 1996 but could not be finalized until approved by the provincially appointed Red Tape Commission. The Bureau submitted the agreement to the Commission in early 1997. At the time of our audit, the Bureau was still waiting for a response from the Commission. Accordingly, no agreements were in place.

In reviewing the draft service agreement, we noted that it did not include a requirement for agencies to submit data to the Ministry's Drug and Alcohol Treatment Information System or DART, and it did not require agencies to meet any developed program standards, quality of care standards or service outputs or outcomes.

Recommendation

To better hold addiction treatment agencies accountable for the services provided and the prudent management of the funds they receive, the Ministry should ensure that all basic elements of a transfer payment accountability framework are appropriately addressed.

Ministry Response

We agree with the recommendation. As a first step, the Ministry is in the process of developing a service agreement template for all community health transfer payment agencies.

Compliance with the terms of the service agreements, including performance expectations and the submission of accurate and timely data to the Drug and Alcohol Registry of Treatment (DART) and the Drug and Alcohol Treatment Information System (DATIS), will be made a condition of continued funding for addiction treatment agencies.

The Ministry will continue to monitor programs through regular program visits (at least once per year) and the review of annual operating plans and budgets, audited financial statements, settlement forms, and DART and DATIS submissions. The Ministry is developing a standard form to be used to document program visits.

Program reviews will continue to be conducted on programs at risk of non-compliance with ministry expectations of transfer payment agencies (for example, non-submission of financial or program information, or client or staff complaints indicating problems within the agency).

FINANCIAL APPROVALS AND REPORTING

The Bureau's draft operating manual requires all treatment agencies to submit an annual operating plan and budget and to identify other sources of revenue related to bureau-funded programs. All agencies are also required to submit quarterly operating reports for the second and third quarters of each fiscal year. The quarterly reports are used to explain any significant variances between projected and actual expenditures.

At year-end, all treatment agencies are required to submit settlement forms and audited financial statements. The purpose of the settlement process is to report all revenues and expenditures related to programs funded by the Bureau. Any surpluses or ineligible expenditures are to be recovered by the Bureau.

We reviewed a sample of agency program files for the 1996/97 and 1997/98 fiscal years, and noted that:

- The Bureau approved agency budgets late in the fiscal year. For example, the majority of budget approval letters for the year ending March 31, 1997 were sent to agencies in February and March 1997.

- Several agencies used bureau funding for expenditures that had not been included in their approved budgets. For example, one agency was allocated $70,000 for rent but used the funds for cleaning and household repairs. The same agency was also allocated $12,000 for property taxes but used the funds for vehicle leasing and operating expenses.
- Several agencies did not report other sources of revenue. For example, during the budget process for the 1996/97 and 1997/98 fiscal years, one agency identified an estimated $275,000 per year of other revenues. During our audit, we noted that the revenues had not been disclosed on the year-end settlement forms. As a result, the agency may have been overfunded by approximately $275,000 in each of the two years. At our request, the Bureau contacted the agency. However, by the end of our audit, the Bureau had taken no action to address the possible overpayment.
- Although required to submit non-consolidated financial statements, several agencies that received funding from other sources submitted consolidated financial statements. Accordingly, the Bureau could not determine whether its funds had been spent for the intended purposes.

Recommendation

To improve the usefulness of the financial approval and reporting process of addiction treatment agencies, the Ministry should:

- **review and approve budgets on a timely basis;**
- **ensure that agencies submit budgets for approval that accurately reflect agency spending;**
- **monitor all other revenue sources related to bureau-funded programs; and**
- **recover any agency surpluses.**

Ministry Response

We agree with the recommendation to review and approve budgets on a timely basis.

The Bureau will be requiring agencies to submit budgets that more accurately reflect their spending of bureau funding.

Agencies are permitted to have other sources of income. The additional income is often used to supplement bureau funding and/or to make purchases that are not covered by the Bureau.

The Bureau will be reviewing the "other sources of income" information and settlement forms, assessing whether additional explanation is required and/or whether an adjustment to the base budget is required.

PERSONAL NEEDS ALLOWANCE

In July 1996, the responsibility for recovery homes was transferred from the Ministry of Community and Social Services to the Ministry of Health and Long-Term Care. Although clients in recovery homes are no longer to receive provincial social assistance, the Ministry decided to provide a personal needs allowance (PNA) of $112 per month to eligible individuals.

Each recovery home received funds for the personal needs allowance based on the number of beds funded by the Bureau. Unspent funds were to be recovered by the Bureau at year-end.

In December 1998, the Bureau surveyed all recovery homes and found that only $800,000 of the $1.2 million in PNA provided for the 1997/98 fiscal year had been allocated to clients. As of April 1999, the Bureau had not determined whether the unallocated funds had been recovered in the annual year-end settlement process or if agencies had used the funds for other purposes. The Bureau had not determined whether any PNA funds had not been allocated to clients for the 1996/97 fiscal year.

3.10

We reviewed the Bureau's reconciliation of PNA funding for the 1997/98 fiscal year and noted that approximately $90,000 had been allocated for 68 beds that were either nonexistent or not funded by the Bureau. We also reviewed a sample of recovery-home budgets, year-end settlement forms and audited financial statements for the 1996/97 fiscal year that had been reviewed by the Bureau and found that:

- The Bureau had not noted that several recovery homes had over $100,000 of unused PNA funding. These funds should have been returned to the Ministry.
- In some instances, it was not possible to determine whether PNA funding was used properly because the those funds were not segregated from normal operating expenses on the annual operating budget and settlement form.

Recommendation

To ensure that personal needs allowance funds are properly allocated and utilized, the Ministry should:

- **compare the funding allocated to all recovery homes to an accurate inventory of bureau-funded beds; and**
- **reconcile the funding to actual expenditures and recover any surpluses.**

Ministry Response

We agree with the recommendation to compare personal needs allowance funding allocated to recovery homes to an inventory of bureau-funded beds and to reconcile funding to actual expenditures and recover any surpluses. This initiative will be implemented with the overall settlement process.

PROBLEM GAMBLING

In 1996, Cabinet approved a comprehensive strategy for the treatment, prevention and research of problem gambling in Ontario. The Ministry of Health and Long-Term Care was given primary responsibility for managing problem gambling programs. In 1999, the government commenced the installation of 6,600 slot machines at racetracks in 18 communities across the province. Commencing with the 1999/2000 fiscal year, 2% of gross slot machine revenues (a minimum of $10 million annually) is to be allocated to expand problem gambling initiatives.

Since 1995/96, the Bureau has spent $9 million on problem gambling initiatives, of which $3.4 million was used for research and training treatment providers and $1.5 million was allocated for the start up of a problem gambling hotline. In October 1997, the Bureau initiated funding to 44 treatment agencies that provide gambling-related outpatient treatment services. We reviewed these initiatives and noted that:

- The agencies were not required to submit operating or project reports detailing whether the funds were used as intended or the results achieved with the funding. We found no evidence that the Bureau had visited any agencies providing problem gambling services or reviewed any problem gambling programs.
- Agencies did not have to sign funding letters or service contracts detailing their roles and responsibilities or expected deliverables.
- The funding allocated to the 44 treatment agencies was based on a standard client load per staff. Many agencies reported that in the 1997/98 and 1998/99 fiscal years, the client load was less than planned. As a result, many agencies had excess funding for problem gambling.

Recommendation

To ensure that funding for problem gambling is properly managed and used as intended, the Ministry should:

- **develop service agreements for and require the submission of project reports from agencies providing treatment for problem gambling; and**
- **base funding for problem gambling services on the need for those services.**

Ministry Response

We agree with the recommendation. Service agreements for problem gambling will be made part of each agency's overall service agreement. Project reports will be an annual requirement.

A formula for establishing funding for problem gambling treatment services has been established to ensure equitable funding allocation where need exists.

MEASURING AND REPORTING ON EFFECTIVENESS

PERFORMANCE MEASUREMENT

Information about costs and outcomes is essential for assessing and improving the performance of treatment services and obtaining the best outcomes at the lowest possible cost. However, the Bureau did not have adequate information about the costs and outcomes of the services that it funds. The Drug and Alcohol Treatment Information System (DATIS), under development since 1994, recently began capturing demographic, health status and other information on clients using addiction treatment services.

3.10

At the request of the Ministry, the Centre for Addiction and Mental Health has developed evaluation tools that can be used to measure the costs and outcomes of different treatments. Depending on the results of a pilot study, those measures may be used across the addiction treatment system.

Information on costs and outcomes along with information on the client characteristics could be used to determine whether the higher costs of residential treatment are justified in terms of superior outcomes and if so, for which clients. It could also be used to establish performance expectations and benchmarks for different services and client groups. These expectations could then be incorporated in service contracts with individual providers, as is already being done in some jurisdictions.

At the time of our audit, no systematic information about the effectiveness and efficiency of the Bureau or the addiction treatment system was being reported to ministry senior management, the Legislature or the public. For the most part, such information had not been gathered or compiled. Other jurisdictions are using information systems similar to DATIS to report on the performance of their addiction treatment services.

Recommendation

To help ensure that addiction treatment services are provided efficiently and effectively, the Ministry should use cost and outcome information:

- **to develop and implement performance expectations and benchmarks for treatment agencies; and**
- **to measure and report on the effectiveness of the Bureau and the addiction treatment system.**

Ministry Response

We agree with the recommendation. When the results of the cost/ outcome pilot are known, the Ministry will take steps to implement the above recommendation.

TREATMENT AVAILABILITY

ACCESSIBILITY

To address service gaps, agencies must be able to provide appropriate treatment to specific groups of clients. Certain populations, such as youth and older adults, need to be clearly defined to ensure their particular treatment needs are met. For example, according to treatment experts, services for youth must be tailored to reflect the various developmental stages of clients and must be seen as discrete and specialized.

Many treatment agencies define the population they serve as clients from 0 to 99 years of age. However, agencies that treat clients from 0 to 99 years of age do not necessarily offer specialized treatment for youth or older adults. As a result, these groups are often treated in settings that are not appropriate or effective. For example, a 16-year-old client could be referred to an agency that claims to provide services for clients between 0 and 99 years of age. However, if the treatment services offered do not meet that individual's needs, the client must seek specialized treatment either at an another agency or not at all. We noted that, while the Bureau defines youth as age 12 to 24 years, the age range for youth has not been standardized at the treatment agencies.

The first priority of the Bureau's current planning for residential services is to be the unmet needs of special populations such as youth. The Bureau, in collaboration with district health councils and treatment agencies, intends to review the need for residential services for youth and identify opportunities to enhance existing youth facilities or convert adult facilities.

Recommendation

To ensure that all clients seeking treatment for addictions are adequately served, the Ministry should clearly define client populations with special needs and ensure that services are provided to meet those needs.

Ministry Response

We agree with the recommendation. District health councils have been asked to include in their integrated plans a description of the populations with special needs in their districts and strategies for addressing those needs. In addition, the Bureau, through the annual operating plans, has requested that agencies indicate which populations they are currently serving and how much of the budget is allocated to those programs. Data from the Drug and Alcohol Treatment Information System can also be used to indicate which populations are currently being served by which agencies. In this way, the Ministry will have a baseline from which to monitor service for populations with special needs.

WAITING TIMES

Starting in 1991, the Ministry has funded the development of the Drug and Alcohol Registry of Treatment (DART), a centralized registry of information on treatment programs, the availability of treatment services, waiting times and program access information. DART also serves as an information and referral service for service providers and the public. DART was designed to assist in finding suitable addiction treatment within Ontario.

Since 1996, all agencies funded by the Bureau have been required to validate, on an annual basis, the treatment services they provide and forward this information to DART. In addition, all agencies except withdrawal management centres are required to provide treatment availability information at established intervals.

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We reviewed the treatment availability information and validations submitted to DART for the 1997/98 fiscal year and noted that the majority of outpatient agencies had not reported treatment availability. Many agencies had not reported in three years. In addition, several agencies had not submitted their validations.

Waiting times can flag potential problems at agencies or indicate funding disparities. However, the Bureau does not receive waiting time information on a regular basis. We reviewed waiting times for agencies providing similar services and noted significant variations. For example:

- For short-term residential facilities, the waiting times ranged from one day to 60 days, with the average being 22 days.
- For recovery homes and long-term residential facilities, the waiting times ranged from one day to 76 days, with the average being 17 days.

Without waiting time reports, it is not possible to determine the reasons for significant variations. One potential cause of long waiting lists could be the length of stay at some agencies. The reported length of stay at recovery homes ranged from 50 to 210 days with the average being 90 days. We noted that the five agencies with the longest waiting times also had the longest lengths of stay.

Recommendation

To ensure that the Drug and Alcohol Registry of Treatment (DART) contains the data needed by the Bureau to properly monitor waiting times and the availability of services, the Ministry should:

- **ensure all treatment agencies submit treatment availability information and validations of treatment services to DART; and**
- **regularly review waiting times for all agencies to assess whether there are any regional inequities in available treatment services and as indicators of the need for agency reviews.**

Ministry Response

We agree with the recommendations. For example, compliance with the requirement to submit accurate and timely data to both DART and the Drug and Alcohol Treatment Information System will be a requirement for continued funding in the addiction treatment agency service agreement.

The Ministry will monitor waiting times at agencies through information supplied to DART as one of the indicators of need for services and possible need for an agency review.

MONITORING AGENCIES

PROGRAM STANDARDS

We would expect program standards to be in place establishing performance expectations or processes for the efficiency and effectiveness of services. Other jurisdictions in North America already have standards for addiction treatment services including standards for quality of care. Accrediting bodies have also developed standards for treatment services.

In its 1990 report, *A Vision for the 90's,* the Provincial Advisory Committee on Drug Treatment recommended the development of treatment standards and an ongoing monitoring and evaluation process to assess compliance. The Bureau's *Partners in Action, Ontario's Substance Abuse Strategy*, issued in 1993, included as an objective the implementation of province-wide standards for the quality of care. At the time of our audit, the standards that had been developed and included in the Bureau's draft operating manual dealt only with agency organizational requirements, program reporting and financial management.

The 158 agencies funded through the Bureau are subject to periodic program reviews as a condition of funding. These reviews are intended to focus on the quality of program management, attainment of program objectives and client outcomes. Until 1995, agencies' programs were reviewed every three years. We understand that the Bureau discontinued this practice due to a lack of staff resources and the belief that targeted reviews achieve greater value for money. However, since the 1996/97 fiscal year, the Bureau has completed only three program reviews; three additional reviews were in progress at the time of our audit. These program reviews were all initiated in response to serious complaints about the agencies being reviewed.

Before the Bureau can assess the quality of the services it funds and determine whether it is receiving value for money, it must develop program standards. However, in many areas the Bureau did not have standards against which programs could be evaluated. For example, the Bureau requires agencies to have an adequate number of experienced and qualified staff to carry out their mandate. However, it had no standards stating what staff experience or qualifications should be or what constituted an adequate number of staff.

While the implementation of the cost and outcomes component of the DATIS information system would greatly assist in monitoring treatment services, the Bureau should make full use of currently available information in order to focus on reviewing those agencies with the

highest risks of non-compliance. This information includes reports from DART and complete information about complaints as well as agency budgets and operating plans.

Recommendation

To help ensure that high quality services are provided by addiction treatment agencies, the Ministry should:

- **develop standards against which programs can be evaluated; and**
- **implement a regular program review function, focusing on those agencies where the risk of non-compliance is greatest.**

Ministry Response

The Residential Strategy Subcommittee of the Ontario Addiction Service Advisory Committee is in the process of developing standards for residential treatment. Draft standards are expected in March 2000.

Following the work of the Residential Strategy Working Group, the Ministry will work with representatives from the field to develop program standards for non-residential programs.

We agree with the recommendation to review agencies where the risk of non-compliance is greatest. Currently, bureau staff visit agencies at least yearly, meet with the executive director, agency staff and board members. During these visits, the consultant can gain information about an agency's risk of non-compliance. In addition, a program review may be triggered by a complaint or an irregularity in financial reporting.

COMPLAINTS

Complaints can alert the Bureau to possible problems at a treatment agency. With the elimination of regular program reviews in 1995, the Bureau now relies primarily on complaints to determine whether an investigation or review of an agency is warranted.

We found no procedures to record complaints received by the Bureau or to ensure that they were adequately followed up. In addition, the Bureau did not maintain complaint histories for agencies. We reviewed agency files and found no evidence to indicate that the Bureau's staff had adequately followed up on 50% of the complaints made against agencies. For example, an allegation that an agency had used bureau funds for other purposes resulted only in a follow-up meeting. No detailed financial review was conducted.

While individual agencies may have procedures to address complaints, the Bureau has no assurance of the adequacy of these procedures. In addition, because the Bureau does not require agencies to provide information on the number, nature and resolution of the complaints they receive, it may not be aware of serious complaints made about agencies.

The Bureau also has no program standards dealing with the rights of clients. Clients need to know their rights and the roles and responsibilities of treatment agencies and the Bureau.

Currently, clients may not know that they can complain to the Bureau. Some other jurisdictions have established client rights and procedures to ensure that client rights are respected.

Recommendation

To ensure that complaints are dealt with appropriately, the Ministry should:

- **develop adequate procedures to deal with the complaints it receives;**
- **require treatment agencies to inform the Bureau of any complaints they receive and how those complaints were resolved; and**
- **establish program standards for agency complaint procedures and client rights.**

Ministry Response

It should be noted that as standard practice, follow-up occurs on all complaints. However, documentation standards for follow-up will be developed and implemented.

We agree that agencies should be required to inform the Bureau of complaints they receive and how those complaints were resolved. Follow-up procedures will be incorporated into documentation standards.

The draft operating manual is being revised and the format for incident reporting will be outlined. The original draft operating manual was sent to all agencies in April 1999. The covering letter alerted agencies to the requirement for reporting incidents. In addition, a template to record complaints, concerns and incidents is being developed. The information will be kept centrally as well as in individual agency permanent files.

OTHER MATTER

PREVENTION

Many different organizations are engaged in activities related to the prevention of addiction to drugs and alcohol. For example, local public health authorities are required to engage in specific prevention activities under a mandatory provincial program, while the Ministry's Health Promotion Branch provides $2.4 million annually and has committed to provide $12 million over the next five years for prevention to agencies in 21 high-risk communities.

Another ministry-funded agency, the Center for Addiction and Mental Health, estimates that it spends roughly $3.5 million annually to support prevention activities. The Ministry also provides $225,000 annually for the Alcohol, Cannabis and Tobacco Health Promotion Project for Youth (ACTION).

We found no evidence of an overall strategy for the prevention of addictions. Although individual activities may have been evaluated, there has been no assessment of the overall effort.

While the Bureau is responsible for coordinating government-wide planning and policy on substance abuse issues, its role regarding prevention is not clear. In most jurisdictions we surveyed, the organization responsible for addiction treatment was also responsible for prevention. This arrangement takes advantage of specialized knowledge about addictions

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Recommendation

To help ensure that prevention activities are having the intended result of decreasing addictions to alcohol and drugs, the Ministry should:

- **clarify the role of the Ontario Substance Abuse Bureau with respect to prevention; and**
- **assess the effectiveness of all of its current prevention efforts.**

Ministry Response

The Bureau's primary role is the funding for treatment for addictions to drugs and alcohol. The problem gambling strategy contains a commitment to prevention through public awareness and education. Activities in this area are being initiated in the 1999/2000 fiscal year as the base funding for problem gambling has increased to allow for this activity to occur.

The Ministry recognizes the value of prevention in dealing with substance abuse issues and supports the activities undertaken by the agencies it funds. The Ministry agrees that the effectiveness of its prevention efforts should be assessed.