

# Addiction Programs

## Background

At the time of our last audit in 1999, the Ontario Substance Abuse Bureau (Bureau), part of the Ministry of Health and Long-Term Care (Ministry), was funding addiction treatment services in Ontario, under the authority of the *Ministry of Health and Long-Term Care Act*. The Bureau's mandate included reducing or eliminating substance abuse and other addictive behaviours.

By the 2002/03 fiscal year, the Ministry of Health and Long-Term Care had transferred all operational aspects for direct services to seven regional offices across the province, and reassigned the Bureau's other responsibilities to the Ministry's Mental Health and Addiction Branch.

With the passage of the *Local Health System Integration Act, 2006*, the Ministry's seven regional offices were closed effective April 1, 2007. Their responsibilities and operational functions were delegated to 14 Local Health Integration Networks (LHINs) across the province. The role of these LHINs is to plan, fund, and co-ordinate services offered by hospitals, long-term-care homes, Community Care Access Centres, community support service providers, mental health and addiction service providers, psychiatric hospitals, and Community Health Centres. In addition, the Ministry reassigned its Mental Health and Addiction Pro-

gram Branch responsibilities to other ministry branches.

The Ministry still retains ultimate accountability for the health-care system. It is responsible for ensuring that there are checks and balances that hold the LHINs accountable for the performance of their local health system and that people across Ontario have access to a consistent set of health-care services.

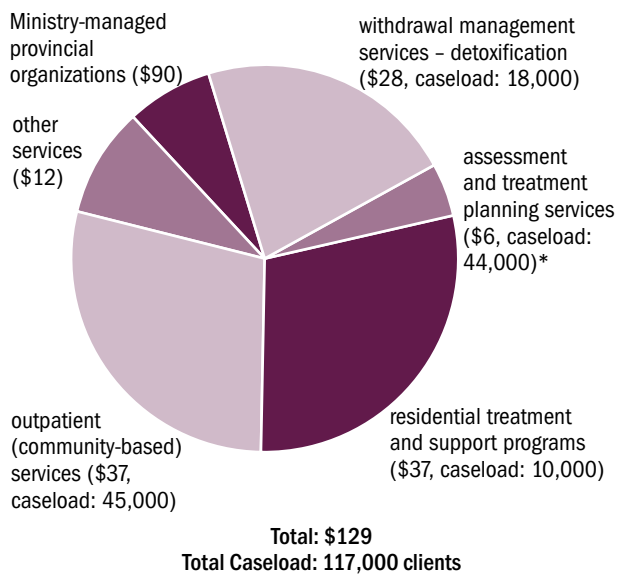
More than 150 addiction service providers across the province provide Ontario's addiction treatment services. Effective April 1, 2007, these providers' service agreements with the Ministry were assigned to their area's LHINs. As Figure 1 illustrates, for the fiscal year ended March 31, 2007, the Ministry provided \$129 million in addiction transfer payments to combat substance abuse and problem gambling. Of this:

- addiction service providers received \$120 million to treat an estimated caseload of 117,000; and
- Ministry-managed provincial organizations received \$9 million to conduct specific studies or work for the sector on behalf of the province.

This \$129 million represented a \$31 million, or 32%, increase in funding from our last audit in 1998/99. Of this \$31 million increase, substance-abuse funding received only \$7 million, while problem gambling received a \$24 million, or about 700%, increase.

**Figure 1: Addiction Funding Expenditures, 2006/07**  
(\$ million)

Source of data: Ministry of Health and Long-Term Care



\* based on ministry standardized service definitions

## Audit Objective and Scope

The objective of our audit was to assess whether the Ministry of Health and Long-Term Care, in partnership with the Local Health Integration Networks, had mechanisms in place to:

- meet the needs of people requiring addiction treatment services;
- monitor payments and services to ensure that appropriate legislation, agreements, and relevant policies were followed; and
- measure and report on the effectiveness of the province's addiction programs.

The scope of our audit included review and analysis of relevant files and administrative procedures, and interviews with appropriate staff of several different Ministry of Health and Long-Term Care branches, as well as the Ministry of Health Promotion and the Ministry of Public Infrastructure Renewal, regarding problem-gambling revenue. We visited three LHIN offices (Toronto Central, Central

East, and North East), which accounted for about 40% of total LHIN expenditures, to review relevant documents and interview staff. At each of these three LHINs, we visited several addiction service providers to interview senior management staff and to review service-provider documentation.

We also conducted a telephone survey of a sample of service providers. We met with external groups such as Addictions Ontario, the Centre for Addiction and Mental Health, the Federation of Community Mental Health and Addictions, the Canadian Mental Health Association (Ontario Division and Toronto Division), Ontario Problem Gambling Research Centre, and ConnexOntario (which maintains a database on the availability of addiction treatment services). In addition, we reviewed relevant audit reports issued by the Ministry's Internal Audit Services. Wherever possible, we relied on their audit work to reduce the extent of our audit.

Our audit followed the professional standards of the Canadian Institute of Chartered Accountants for assessing value for money and compliance. We set an objective for what we wanted to achieve in the audit, and developed audit criteria that covered the key systems, policies, and procedures that should be in place and operating effectively. We discussed these criteria with senior management at the Ministry of Health and Long-Term Care. Finally, we designed and conducted tests and procedures to address our audit objective and criteria.

## Summary

Ontario's addiction treatment services did not historically develop as part of a planned, integrated system. Rather, local agencies and programs grew over time to respond to local needs. In our 1999 audit, we noted that the Ministry of Health and Long-Term Care (Ministry) recognized that several key changes were needed to increase treatment capacity and effectiveness and reduce wait times.

Key amongst these was a more multi-faceted approach that included merging smaller treatment agencies into larger, more multi-functional agencies that would enhance the continuity of care and improve efficiency. For example, mergers and amalgamations could reduce administrative costs and duplication of services.

During our current audit, we noted that, while significant organizational changes occurred at the Ministry with the establishment of the LHINs, program delivery at the local community level has remained relatively unchanged. As a result, there is still significant work to be done to ensure that people with addictions are being identified and are receiving the services they need in a cost-effective manner. Also, the LHINs are relatively new to the field of addiction-treatment services and, at least in the short term, most LHINs will be challenged in effectively assuming the Ministry's responsibilities for overseeing local service providers. For instance:

- More than 90% of the population that the Ministry estimated as needing addiction treatment have not been identified as needing treatment, have not actively sought treatment, or the treatment services were not available. Some people with addictions may have received treatment from their family physicians, Alcoholics Anonymous, or other sources, which the Ministry did not track in its system.
- The majority of addiction service providers did not report wait times for some or all of their services, as required by their service agreements. For the service providers that did report, there were significant wait times as well as large variances between service providers. For example, youths seeking help for substance abuse could wait for their initial assessment for a period as brief as one day to as long as 210 days, with an average wait time of 26 days.
- Although one of the Ministry's objectives is for addiction treatment to be provided as close as possible to the client's home, the Ministry did

not have information on how many Ontarians were seeking treatment in other Canadian provinces. It did have information on those who sought treatment out of country. Over the past four years—between and including 2004/05 and 2007/08—about 200 youths seeking help for their addiction problems were sent out of country for treatment at an average cost of about \$40,000 each.

- While the demand for substance-abuse treatment services had increased over the past decade, with long service wait lists at many providers, service providers advised us they were forced to reduce their staff numbers and services, including closing beds, because funding had not kept pace with inflationary increases.
- Addiction funding was based on historical funding rather than assessed needs. The Ministry's recent analysis indicated that per capita funding across the 14 LHINs ranged from about \$3 per capita to more than \$40 per capita. This can result in clients with similar addiction needs receiving significantly different levels of service, depending on where in Ontario they live.
- We were satisfied that accountability mechanisms exist between the Ministry and the LHINs. However, the transfer to the LHINs of the responsibility for overseeing service providers has resulted in some loss of corporate knowledge about provider operations and a reduction in the oversight and monitoring of whether funded services are actually being delivered to people with addictions in an effective manner.
- We found wide variations in caseloads and costs among service providers for similar treatments that warranted follow-up by the Ministry and the LHINs. For example, the problem-gambling funding guideline suggested a caseload of 50 to 60 clients per year for each agency's first counsellor and 100 to 120 clients per year for each additional

counsellor. However, almost half of the service providers served fewer than 50 clients per year per counsellor. One service provider served only three clients per counsellor, at a cost of \$26,000 per client for the year.

- The Ministry's information systems have the potential to provide management of the service providers, the LHINs, and the Ministry with excellent information for decision-making and monitoring. However, data in the Ministry's information systems was found to be incomplete and inaccurate.

## OVERALL MINISTRY RESPONSE

Over the past 10 years, the Ministry has been in the process of reforming the addiction-treatment system by leveraging new and existing resources.

The Ministry funded an Early Childhood Development Addiction Treatment program for pregnant women after becoming the only province to receive funding from the federal government for this purpose. Over five years, this initiative increased the addiction-treatment-system capacity to provide services to these women and improved their health outcomes.

The Ministry, through one-time initiatives, supported the development of standards for women-specific agencies and for youth-specific programs.

The Ministry also funded methadone case managers in 14 communities across the province, greatly improving the likelihood of successful treatment for people on methadone.

As well, the Ministry provided funding to enhance innovation in withdrawal-management services, moving the system from a bed-only model to one that offers more options, including in-home and day withdrawal-management services. The options have meant that women and older adults are better able to access the services.

Finally, the Ministry established standardized assessment tools to be used in all addiction-treatment programs, along with standardized service definitions and standardized admission/discharge criteria. These initiatives have been evaluated and changes are being made.

As well, the Ministry embarked on a major initiative between 2005 and 2008 to enrol all community addiction-service providers in a new management information system. While significant success was achieved in having providers submit information, as the Auditor General indicated, the LHINs and the Ministry must now turn their attention to improving the health service providers' compliance with reporting requirements, with particular attention to data quality in order to optimize use of the information for management of addiction service providers as well as for system-planning purposes.

These changes have all been accomplished at a time of transition, with the closure of the Ministry's regional office structure in March 2006, the establishment of the 14 LHINs, and the related devolution of ministry responsibilities to the LHINs on April 1, 2007. The Ministry continues to be responsible for legislation, policy, and program standards; the 14 LHINs are responsible for managing the local health systems, including planning, funding, and managing the service providers. The relationship between the Ministry and the LHINs is guided by the *Local Health System Integration Act, 2006*, the Memorandum of Understanding, and the Ministry/LHIN Accountability Agreement. In turn, the LHINs establish service accountability agreements with health-service providers, who report to the LHINs. The LHINs determine local needs, priorities, and strategies as well as improvements required to increase accessibility, co-ordination, and capacity. The Ministry and the LHINs are working together closely to achieve success for the health system.

## Detailed Audit Observations

### MEETING THE NEEDS

#### The Need for Treatment and the Treatment Gap

Historically, local agencies and programs provided addiction treatment services in Ontario, growing over time to respond to local needs rather than being part of a formalized, planned, integrated system. In our *1999 Annual Report*, we noted that the Ministry recognized that a more integrated addiction treatment system was needed and proposed a number of changes to increase treatment capacity and effectiveness and reduce wait times. Key amongst these was a more multi-faceted approach that included merging smaller treatment service providers into larger, more multi-functional service providers that would enhance the continuity of care and improve efficiency. Through service-provider mergers and amalgamations, the system as a whole could reduce various costs, such as administration, and reduce duplication of services.

During our current audit, we noted that program delivery at the local community level has remained relatively unchanged in most areas of the province since our last audit in 1999.

As a result, there is still significant work to be done to ensure that people with addictions are being identified and the services they need are being delivered in a cost-effective manner. As well, with the introduction of the *Local Health System Integration Act, 2006*, the LHINs have been assigned the responsibility to integrate the health system. The LHINs assumed operational responsibilities on April 1, 2007. Given the short time since the assumption of their responsibilities, the LHINs have experienced challenges in overseeing local addiction service providers (see also the Accountability at the Ministry and LHIN Levels and Addiction Services Provider Accountability sections).

According to a 2006 study conducted by the Canadian Centre for Substance Abuse, alcohol and

drug abuse cost Ontario more than an estimated \$8 billion annually. This \$8 billion included direct costs arising from health care, law enforcement, research and prevention, and indirect costs arising from lost productivity. At present, no similar study is available to estimate the costs of problem gambling in Ontario.

Our research in other jurisdictions indicated that every \$1 spent to treat substance abuse could result in \$4 to \$7 of potential savings in health care, law enforcement, social services, and other costs. The estimated savings for each \$1 spent in Ontario would likely also fall within this range. In addition to savings in dollar costs, treating substance abuse results in savings in costs to society. These costs include human suffering, which is difficult to price, premature deaths, and injuries to victims from motor vehicle crashes and crimes. It is therefore important to identify the people who need treatment for substance abuse and, as early as possible, provide treatment that meets their needs and mitigates the potentially high costs to society of not providing such treatment.

The vast majority of Ontario's population needing addiction treatment services did not, however, receive the required services. On the basis of the Ministry's estimate of this population using 2002 population data, more than 90% of the population the Ministry identified as needing addiction treatment had not actively sought treatment, had not been identified as needing treatment, or the treatment services were not available. According to these data, only 7% of people suffering from substance abuse, and only 3% of people suffering from problem gambling, were treated. Our review of available statistics found that for about 6,800 people who were assessed with both substance abuse and gambling problems in 2006/07, only about 900 of them received treatment for both problems. The Ministry indicated that some people with addictions may have received treatment from their family physicians, Alcoholics Anonymous, or other sources, which the Ministry did not track in its system.



Neither the Ministry nor the LHINs had reliable information identifying the local communities in which people who need treatment reside.

## RECOMMENDATION 1

To effectively meet the needs of people with addictions and to reduce the societal costs of addictions, the Ministry of Health and Long-Term Care should work with the Local Health Integration Networks (LHINs) to:

- better identify the population needing treatment for addictions; and
- develop approaches that will encourage individuals with addictions to seek the necessary treatment services.

## MINISTRY RESPONSE

The LHINs have been mandated to plan for the local health needs of their communities, including the needs of people with addictions. The majority of the LHINs have identified the need to address addictions and mental health as priorities and will need to explore with their local providers strategies for encouraging people to seek treatment.

The Ministry will continue to consult and work with the LHINs about local priorities for addiction treatment to inform provincial initiatives and strategies.

To support the LHINs' efforts, the Ministry will continue its work to incorporate demographic and other data related to addictions into the new Health-Based Allocation Methodology initiative.

The Ministry will also continue to work with ConnexOntario and other provincial providers to enhance services that will encourage people with addictions to seek the necessary treatment services.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

**The LHIN responses in this report are joint responses from the three LHINs we visited as part of our audit.**

All LHINs identified addictions (and mental health) as a priority in their Integrated Health Service Plans. Through extensive community engagement with stakeholders and local health system planning documents, the LHINs have a better understanding of both the extent and magnitude of the issues related to addiction in their local communities, which has been incorporated into planning and program development. The LHINs are committed to working with the Ministry to ensure that funding allocations support an equitable and integrated health-care system and effectively address unique local priorities and health-care needs.

## Wait Times for and Availability of Addiction Treatment Programs

The Ministry recognized that early identification of addiction(s) increases people's likelihood of managing their addictions and recovery. Many service providers also indicated that access to timely and appropriate services is important because people who have to wait a long time for services tend to drop off wait lists, and can end up in shelters, hospital emergency departments, or jails, or returning to their addictions.

Management of the services available and the wait times related to these services could help identify areas that need action to address service needs. Service agreements require addiction service providers to regularly report to ConnexOntario (which maintains a database on the availability of addiction treatment services) on the treatment services they offer and the next available service treatment date. Our audit indicated, however, that more than three-quarters of substance-abuse and

problem-gambling service providers did not report their service availability as required. This makes it difficult for the Ministry and the LHINs to reliably estimate the unmet demand for services or reallocate resources to high-priority areas. The following three sections present our findings on services and their availability from service providers we visited and surveyed by telephone and from those that did report to ConnexOntario.

### Substance Abuse

Virtually all of the service providers that we surveyed by telephone had reported wait times for services. One provider reported an initial assessment wait of up to four weeks. Another provider reported a residential services wait of up to six months. Another indicated that delays in its ability to provide timely services required it to refer people out of province for treatment.

We also reviewed the substance-abuse services and the availability-dates data for the service providers that updated their data in 2008. Service wait times varied significantly between service providers:

- Adults seeking help could wait for an initial assessment for treatment from a low of one day to a high of 189 days, with an average wait of 24 days.
- Youths seeking help for substance abuse could wait for an initial assessment from a low of one day to a high of 210 days; their average wait was 26 days.
- Adults seeking residential treatment could wait from a low of seven days to a high of 340 days, with an average wait of 62 days.

When we visited service providers and reviewed their wait lists, we identified similar concerns. For instance, one service provider had 78 people waiting for substance-abuse residential treatment services, with an estimated wait time of about five weeks. This same service provider also had 75 people waiting for initial assessment for treating heroin addictions. The service provider informed

us that the treatment program was full, so none of these people were being scheduled to receive an initial assessment for treatment unless the service provider could expand the program.

### Problem Gambling

The Ministry's operating manual for addiction treatment services indicated that problem gambling was fully funded, so that clients would not need to be put on wait lists. However, our review of the service-availability data updated in 2008 found that there were wait lists. Specifically:

- People awaiting a problem-gambling initial assessment for treatment could wait from a low of one day to a high of 210 days, with an average wait of 22 days.
- People awaiting problem-gambling residential treatment could wait from 35 to 37 days.

We identified similar concerns during our service-provider visits. One service provider we visited had a two- to three-month wait for problem-gambling residential treatment. Another had a problem-gambling initial assessment wait time of about four weeks.

We found that neither the Ministry nor the LHINs regularly reviewed service wait times to help identify variability that could signal unacceptable service gaps requiring further follow-up or where funding could be reallocated to balance availability of services across the province.

### Availability of Youth Residential Addiction Treatment

A ministry substance-abuse strategy document, released in 1999, noted that there were few services for youths with concurrent disorders (those involving both substance abuse and mental illness), and that there was an urgent need for short-term residential treatment services for youths suffering from addictions. Our current audit found that there was still an urgent need for such services. Our review of the data for youth substance-abuse residential treatments showed that youths could wait from a

low of 49 days to a high of 93 days, with an average wait of 65 days.

One component of the Ministry's substance-abuse strategy was that clients would receive care as close as possible to their homes. This has not occurred. In fact, we found that many youths had to go out of province to receive addiction treatment.

Our review found the following:

- The Ministry did not track the total number of youths sent to other Canadian provinces for addiction treatment. The Ministry indicated that community-based addiction services are not covered under the *Canada Health Act* and thus there are no interprovincial billing arrangements that would enable Ontario to track this data.
- The Ministry had information available only on youths sent out of Canada for addiction treatment. Between and including 2004/05 and 2007/08, about 200 youths were sent out of the country, at a cost of over \$8 million, or about \$40,000 each. They received treatments in Florida, Illinois, New York, Texas, Utah, and elsewhere.

At the time of our audit, the Ministry was funding a pilot project to treat youths in a designated Ontario-based service provider's facility to try to reduce out-of-country treatments. The Ministry informed us that the pilot results would be available in 2009.

## RECOMMENDATION 2

To more effectively and consistently meet the needs of people seeking addiction treatment in a timely manner, the Local Health Integration Networks (LHINs) should work with their local health service providers, as well as neighbouring LHINs, and consult with the Ministry of Health and Long-Term Care, as appropriate, to identify unreasonably long treatment gaps and reduce them by implementing strategies to increase more immediate treatment-service availability.

In the case of youths requiring addiction residential treatment, these strategies should be consistent with the objective of providing treatment as close as possible to the clients' homes.

## MINISTRY RESPONSE

Many LHINs have identified addiction services as a priority and are working with their health-service providers to develop strategies to improve co-ordination of services and wait-list management. The Ministry supports the recommendation that LHINs should work together on strategies that would result in services meeting the needs of people living in different LHINs.

The Ministry is committed to working with the LHINs to improve access to addiction treatment, including services for youth. The Ministry has provided funding to the Champlain LHIN to establish an additional 20 beds for youth with addictions in Ottawa. In addition, Waterloo Wellington LHIN has received funding to increase capacity by another 16 beds. All residential services are available to youth from across the province.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the ministry response.

## Addiction Funding

### Funding increases

Addiction service providers generally receive funding based on the amounts they historically received in previous years, plus any base inflationary increases for the year. Additional one-time funding or special-initiative funding was also provided to selected service providers for special activities such as methadone maintenance, withdrawal management, and programs for women.



Funding to treat substance-abuse addictions had increased by only 7% from 1998/99 to 2006/07, as shown in Figure 2. According to ministry documents:

- For the nine years between 1991/92 and 2000/01—and in 2002/03 and 2003/04—substance-abuse service providers did not receive any inflationary increases.
- In 2001/02 and 2004/05, service providers received a 2% base increase.
- In 2005/06 and 2006/07, service providers received additional 1.5% base increases annually.

In 2007/08, substance-abuse agencies received funding increases of 3%.

In our service-provider survey and during our service-provider visits, service providers made it quite clear to us that the lack of inflationary increases over the years has meant that ministry addiction funding has been insufficient for their ongoing operating needs. For instance, service providers with unionized staff contracts were required to pay salaries that increased 2% to 3% annually on average, while ministry base funding has not increased by that amount for most of the past decade.

In addition, our survey results indicated that the demand for substance-abuse treatment doubled for some service providers, and even tripled for others within the past decade. Service providers did not have the capacity to meet this increased demand, and the clients they were treating were presenting with increasingly complex conditions such as mental illness, homelessness, and multiple drug use.

To manage within their funding allocations, the service providers we visited stated that they had engaged in one or more of the following:

- When service providers sponsored by hospitals incurred substance-abuse expenditures greater than their ministry funding allocations, the hospitals absorbed the service providers' deficits. Of the providers we reviewed, we noted that sponsoring hospitals absorbed

**Figure 2: Funding for Substance Abuse and Problem Gambling**

Source of data: Ministry of Health and Long-Term Care

	1998/99 (\$ million)	2006/07 (\$ million)	% Increase
substance abuse	94.5	101.10	7
problem gambling	3.5	27.65	690

excess addiction expenditures ranging from \$147,000 to \$1.6 million in 2006/07.

- Independent service providers in the community reduced their numbers of clinical staff (resulting in reduced services) and administrative staff. One service provider we visited informed us that inflationary pressures had forced it to reduce staff numbers by about 8% over the past decade, though demand had increased, and there were long service wait lists. Another service provider informed us it had temporarily closed residential treatment beds, so it could reduce costs to balance its budget. Service providers also reduced staff training to cut costs.
- Some of the service providers devoted resources from fundraising activities to support their operations. Our review of the Ministry's revenue data for all service providers found that more than 30% of addiction service providers had conducted fundraising to support their operations. We noted that some service providers generated more than 20% of their total revenue from fundraising, with one service provider generating about 35% of its total revenue from fundraising.
- Our review of the Ministry's revenue data for all service providers found that about 15% of service providers charged fees for services. More than half of this fee-charging group generated more than 5% of its total annual revenue from these fees. In a few cases, service providers generated more than 20% of their total revenue from fees.

In contrast, as Figure 2 demonstrates, problem-gambling funding has increased significantly since our last audit in 1999. The 690% increase over the past eight years was owing to the government's increased minimum commitment to problem gambling, which is based on a calculation of 2% of the gross slot-machine revenue from charity casino and racetrack slot-machine operations. Of the current \$36.65 million in annual funding for problem gambling, \$9 million is an annual allocation to the Ministry of Health Promotion that commenced April 1, 2006, and \$10 million has been approved by Cabinet to treat clients with gambling problems who also had substance-abuse problems.

### Per Capita Funding

In 2007/08, the Ministry analyzed per capita community addiction funding in each of the 14 LHINs. Funding ranged from a low of \$1.92 to a high of \$40.29 per capita. The Ministry noted that the differences could be attributable to factors such as rural versus urban, and residential versus outpatient treatment services. The Ministry did attempt to act on the results of its analysis by addressing these funding inequities through a new funding allocation. However, the allocation methodology still left significant funding inequities, with the per capita funding per LHIN ranging from a low of \$2.97 to a high of \$40.99. We noted that the Ministry was developing for the hospital sector a population-based funding methodology with adjustments for health status and patient flows. The Ministry informed us that it had yet to develop a similar funding approach for the community addiction sector. The current funding inequity can result in clients with similar addiction needs receiving a significantly different level of service depending on where in Ontario they live.

### RECOMMENDATION 3

To ensure that substance-abuse and problem-gambling funding is based on appropriately established priorities and is equitable across the

province, the Ministry of Health and Long-Term Care should work with the Local Health Integration Networks (LHINs) to:

- ensure that the allocation of funding between substance abuse and problem gambling recognizes the number and types of clients needing treatment;
- allocate addiction funding based on specific community client needs rather than on historical funding; and
- implement strategies that will address funding inequities across different regions so that clients with similar addiction issues receive similar and appropriate levels of treatment services wherever they live in Ontario.

### MINISTRY RESPONSE

To support the LHINs' efforts, the Ministry will continue its work to incorporate demographic and other data related to addictions into the new Health-Based Allocation Methodology (HBAM) initiative. The intent of HBAM is to recognize the characteristics of the population within a LHIN for planning purposes and to allocate resources on a more equitable basis across the province.

### LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs support HBAM in principle and agree with using population health as a basis for developing a funding allocations model. However, it is important for whatever funding model is used to consider LHIN-specific issues. An important LHIN-specific issue relates to the unique differences in the delivery of addiction services among LHINs. Specifically, the delivery of addiction services in a northern LHIN will differ from delivery in a totally urban LHIN.

There are a number of factors when considering per capita funding. Funding allocation decisions must consider and address issues of

geography, language, culture, variable patient inflows and outflows across LHINs, large migrations of people to a particular LHIN, provision of high-cost and specialized service supporting clients both within and outside the LHIN, and the complexities of health human resources and maintaining an academic mission. For instance:

- *Isolation*—Northern LHINs provide addiction services to isolated communities with specific linguistic and cultural issues. Typically, there are long distances between communities and service providers.
- *Delivery of care models*— These differ across agencies.
- *Inflow of clients from other LHINs*—Urban LHINs provide services to a significant number of residents of other LHINs. There is a large migration of people from outside the LHIN to work or attend school within the LHIN. Many receive care within that LHIN.
- *Specialized service client inflow for addiction services*—As many as half of the people who receive specialized addiction services from urban LHINs are residents of other LHINs.
- *Large numbers of homeless and marginalized clients*—Urban LHINs serve a large and highly diverse population with a broad range of addiction services.

The LHINs will work with the Ministry in the development of a funding model that ensures allocations support an equitable and integrated health-care system and effectively address unique local priorities and health-care needs.

### Provincial Assessment Tools

In 2000, the Ministry implemented, and required service providers to use, provincial substance-abuse standardized assessment tools to gather client information, and to determine the type and severity of their clients' addictions. Substance-abuse service providers were also required to apply specific cri-

teria for admission and discharge. These tools and criteria were meant to streamline the assessment process, and help ensure that clients were assessed consistently and provided with the appropriate level and intensity of substance-abuse treatment at that point in time. In addition, the Ministry required service providers with problem-gambling clients to apply a different standardized assessment tool.

In 2006, the Ministry hired addiction experts to evaluate the impact of the substance-abuse admission and discharge tools and criteria. One of the more significant comments noted in this ministry review was that, in general, most service providers were using the required substance-abuse assessment tools to assess clients. The review also indicated, however, that service providers did not consistently apply the admission and discharge criteria in the intended systematic manner, in order to determine the appropriate level of care. The review further stated that the lack of systematic use of the criteria reflected a lack of understanding of the use and importance of the criteria. In addition, the review indicated that a number of service providers had expressed the view that they needed more training, particularly on how the tools were meant to be used in conjunction with the criteria.

The expert review also noted that the time required to complete an assessment ranged from one to nine hours. The times varied because of the way in which the tools were used, the type and comprehensiveness of the additional information collected, and the structure and content of assessment variables. These variables were above and beyond the differences in practice that could be attributed to client characteristics. These differences could be attributed to differing expectations of what constitutes an initial assessment, and to the level of commitment to, and understanding of, the tools and criteria. According to the staff we interviewed at our agency visits, it took between one-and-a-half and four hours to complete assessments.

At our visits we also found that service providers were using the substance-abuse tools in conjunction with other tools they deemed necessary. However,

we found that they often did not use the specified criteria for admission and discharge because, according to service-provider management, staff had sufficient experience to apply professional judgment in determining the treatment appropriate to their clients' needs.

All the service providers we visited indicated that they had concerns with the problem-gambling assessment tool. Their concerns included the fact that the tool sometimes falsely identified people as pathological gamblers, the tool was too basic, the questions asked generated many “yes” and “no” answers with little detail provided, and the language used was considered to be offensive in that it labelled the assessed client as a pathological gambler. Half of these service providers used other tools they considered more appropriate to assess clients, instead of the common assessment tool.

#### RECOMMENDATION 4

To ensure that addiction clients are assessed consistently to determine the appropriate type and level of treatment, the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs) should:

- encourage local health-service providers to obtain appropriate training on the application of the substance-abuse assessment tools and criteria; and
- determine the appropriateness of the problem-gambling assessment tool currently in use and consider replacing or supplementing it with other more useful tools, if necessary, to address the concerns of the service providers.

#### MINISTRY RESPONSE

To optimize the outcome for the treatment of people with substance-abuse issues, the Ministry and the LHINs will encourage addiction agencies throughout Ontario to access and take advantage of the training currently offered by

the Centre for Addiction and Mental Health on the application of the substance-abuse assessment tools and criteria. The Ministry has also evaluated the use of these assessment tools and criteria and continues to work in that area to ensure appropriate use by agencies.

With respect to problem-gambling assessment tools, there is only one tool that experts consider valid and reliable, and it is this tool that is currently in use in Ontario. However, the Ministry is prepared to investigate the availability of new tools that would be useful and applicable in Ontario.

#### LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the ministry response.

### MONITORING FOR COMPLIANCE

#### Accountability at the Ministry and LHIN Levels

The Ministry created Local Health Integration Networks (LHINs) to manage the local health-service-provider system and work with community members, and to determine the health service priorities within each of Ontario's 14 regions. The rationale for the LHINs, according to the Ministry, is that the best way to plan, co-ordinate, and fund community-based care in an integrated manner is to do this at the community level. It was felt that the LHINs would be better able to address unique local population needs and priorities, consistent with the Ministry's strategic direction.

The LHINs are not-for-profit organizations governed by appointed boards of directors. They are responsible for administering their local health system to ensure that services are integrated and co-ordinated; they do not provide services directly. Their mandate, as set out in legislation, includes engaging communities on an ongoing basis to

develop an Integrated Health Service Plan (Plan). This Plan must include a vision, priorities, and strategic directions for the local health system, and strategies to integrate the local health system, including its addiction sector.

In our visits to the three LHINs, we found that all had conducted community engagement through activities such as community consultations and focus groups to help identify the priorities for their regions. These priorities contributed to the LHINs' development of their Plans. Two of the LHINs had conducted environmental scans to determine socio-demographic information, health behaviours, and health status of their populations in order to help them identify their local needs and priorities. The three LHINs submitted the required Plans that included actions to address the treatment of people with addictions, although the degree of action to be taken varied between Plans.

### Addiction Service Provider Accountability

Approximately 150 addiction service providers, each governed by its own independent board of directors, are responsible for the delivery of treatment services. The responsibilities of these service providers are outlined in signed service agreements that set out ministry expectations, terms, requirements for receiving funding, and the conditions under which the agreement can be changed, amended, or terminated. This is in line with the government's Transfer Payment Accountability Directive.

Under the *Local Health System Integration Act, 2006*, these signed service-provider agreements were assigned to the LHINs effective April 1, 2007. These service-provider agreements remain effective until the LHINs develop new addiction-service-provider accountability agreements. These new agreements are to come into effect from April 1, 2009 onwards.

### Operating Plans

Before the Ministry transferred operational responsibilities to the LHINs on April 1, 2007, service agreements required each service provider to submit an annual operating plan to the Ministry for each program. These operating plans detailed information such as the target population to be served, services to be provided in the current year, program goals, objectives, and measurable outcomes. The purpose of this information was to enable the Ministry to monitor the service providers' operations and assess whether the outcomes of the services provided were in accordance with stated goals and objectives and funding provided.

The LHINs we visited, however, informed us that the LHINs did not require service providers to submit 2007/08 operating plans, and that they instead relied on the service providers' 2006/07 operating plans for service-provider service information and monitoring purposes.

Our audit found the following:

- The three LHINs we visited were missing 40% to 72% of the 2006/07 operating plans from their addiction service providers. The LHINs indicated that they had only what the Ministry had transferred to them when it closed the local regional offices; the Ministry said that all operating plans had been transferred to the LHINs.
- We noted in our review of ministry files for the service providers we visited that the files for 60% of the service providers did not contain copies of all their programs' 2006/07 operating plans.
- At the time of our audit, there was no formal monitoring being done to assess whether the funded services were being provided.

The service providers we visited told us that they were not sure how the LHINs would be aware of their current operational goals and services to be delivered as the requirement to report on achievement of them had been discontinued after the 2005/06 fiscal year, and they had not been required



to submit any operating plans to the LHINs since the inception of the LHINs in 2007.

### Required Reporting by Service Providers

Service providers were and are required, after the establishment of the LHINs, to report regularly various types of information to the Ministry, for the purposes of monitoring, assessment of treatment-service usage, referral, and outcome and cost-analysis purposes. This information included:

- expenditures to the Ministry's Management Information System (MIS) on a quarterly basis. Ministry guidelines stated that service providers spend a minimum of 80–85% on direct services costs and a maximum of 15–20% on central administration costs;
- client demographic and service-utilization data and information on services offered, on a quarterly basis; and
- availability dates for substance-abuse and problem-gambling treatment services, on a weekly basis.

Our review of reported data indicated significant non-compliance with the reporting requirements identified above. For instance, about one-fifth of all service providers did not report their 2006/07 expenditures, and more than three-quarters of substance-abuse and problem-gambling service providers did not report service-availability dates as required. Among those that had submitted the required information, we found unreasonable variations from norms or established guidelines suggesting that either performance or data-quality issues existed and were generally not followed up on.

For example, our review of the 2006/07 reported data indicated the following:

- More than 40% of service providers reported administration expenses higher than the ministry maximum of 20%, while another 20% of the service providers reported no administration expenses at all. Some service providers reported that more than 50% of their expenses went to administration, and

one service provider reported that 100% of its expenses went to administration, which is, clearly, highly unlikely.

- The funding guideline for problem gambling was a caseload of 50 to 60 clients per year for each agency's first counsellor and 100 to 120 clients per year for each additional counsellor. The reported data indicated that almost half of the service providers served fewer than 50 clients per counsellor (fewer than half the minimum guideline). One service provider served only three clients per counsellor, at a cost of \$26,000 per client for the year.
- Residential treatment for substance abuse had no funding guideline. According to the reported data, the average caseload was 23 clients per full-time staff, with an average cost of \$2,800 per client. About one-third of the service providers, however, served less than half the average caseload. One service provider served only three clients per full-time staff, at a cost of \$19,000 per client for the year.
- Community treatment for substance abuse also had no funding guideline. According to the reported data, the average caseload was 110 clients per full-time staff, with an average cost of \$600 per client. More than 20% of the service providers served fewer than half of the average caseload. One service provider served only 10 clients per staff, at a cost of \$7,500 per client for the year.

When we followed up on these variances with the Ministry, we were informed that it would review the problem-gambling area this year, but it would be up to the LHINs to make any program or service-provider changes. The Ministry also informed us that it funded each service provider participating in the residential and community substance-abuse treatment programs on the historical basis of how much it had asked for about 20 years ago, rather than on any formula of how much a service should cost. The Ministry further indicated that it did not have reliable data on these programs' utilization.

The current Ministry-LHIN Accountability Agreement required the Ministry to conduct routine data-timeliness and quality checks on data and information submitted by health service providers, including:

- contacting health-service providers on behalf of the LHIN about late reports, missing data, and inconsistent data;
- measuring the timeliness and quality of data submitted by health service providers; and
- providing reports to the LHIN in the event of an issue with data timeliness and quality submissions by health service providers.

However, ministry information-systems staff indicated, in our discussions, that there were no mechanisms to review and verify the data submitted in the required reports from service providers. For 2007/08, we were informed, the Ministry would prepare standard template reports for the addiction sector, to help in its review of the reported data. These reports would provide expenditures by LHIN, by service provider in each LHIN, and by types of services. Revenue reports would also be generated.

As indicated elsewhere in this report, we had significant concerns with the quality of data reported. This lack of quality data impeded the ability of the Ministry and the LHINs to monitor and assess the service providers' performances. A more detailed discussion follows in the Quality of Data in the Information Systems section.

Service providers we visited indicated that they did not know if the required information they submitted was used, because they rarely received any comments or feedback from the Ministry about this information. Even when they did not submit the required data, they never received specific follow-up requests to submit the information. As well, like most small service-delivery operators, they have limited resources to meet reporting requests, making it critically important that only operational data that is needed is requested.

Although the accountability agreements required that the Ministry and the LHINs jointly

develop guidelines for the LHINs on conducting audits, inspections, and reviews of service providers in 2007/08, these guidelines had not yet been developed at the time of our audit.

### Quality of Data in the Information Systems

In addition to the information system ConnexOntario maintains (a referral system with data on addiction treatment and service availability), the Ministry funds and maintains other information systems to capture different types of data relating to addictions in Ontario. Two of them are the Management Information System (MIS) and the Drug and Alcohol Treatment Information System (DATIS).

The Ministry maintains MIS to collect standardized financial and statistical information on service providers' treatment services. The Ministry provides funding to the Centre for Addiction and Mental Health to maintain DATIS. DATIS tracks client demographic and service-utilization data from service providers across the province. To help ensure that the data reported to the information system in areas such as case management, initial assessment, and community treatment are consistent, the Ministry has developed standardized service definitions.

These three information systems have the potential to provide management of the service providers, the LHINs, and the Ministry with excellent information for decision-making and monitoring. For instance, the Ministry has been using these data to arrive at a set of pre-determined indicators that service providers could use to evaluate their financial, staffing, utilization, and volume performance and compare it with that of other service providers.

For the Ministry to properly review identified needs, service utilization, and the resources required to assess and treat addiction throughout the province, the data that service providers submit to the systems must be complete and accurate. However, we found the following:

- At more than half of the service providers we visited, there were discrepancies between

the financial information reported in the Ministry's MIS for the 2006/07 fiscal year and the service provider's supporting documents. For example, one service provider incorrectly reported \$837,000 of its residential treatment expenses under another treatment program.

- Most of the service providers we visited had overstated the number of clients served. For example, one service provider reported the same clients twice—once under the community treatment service category and a second time under the day/evening care service category. This resulted in double counting by about 300 individuals. Another service provider overstated its number of clients served by almost 80% for the year. It had added the year's 12 monthly numbers of clients served in its residential withdrawal-management program, and reported this total as the total number of clients that had been served in the year. Therefore, individuals who had received withdrawal-management treatment in more than one month of the year were counted more than once.
- Only one service provider we visited had correctly recorded case-management activities in accordance with the Ministry's case-management definition. The rest either did not report any case-management data or only reported case-management activities for one of their many programs.
- There was no ministry standard definition in place that defined the length of time a case could stay active with no ongoing activity. Service providers we visited had not closed files that had been inactive for various lengths of time, ranging from two months to more than two years. This resulted in overstatement and inconsistent reporting of the number of active cases.

As noted earlier, under the Ministry-LHIN Accountability Agreement, the Ministry is responsible for conducting routine data-timeliness and

quality checks on data and information submitted by service providers, including contacting service providers about late reports, missing data, and inconsistent data. The LHINs are to work with the service providers to improve data quality and timeliness. Ministry and LHIN staff informed us that they had not conducted such checks.

## RECOMMENDATION 5

To ensure that people with addictions are receiving the services being funded, the Local Health Integration Networks (LHINs) should continue to obtain knowledge of service providers' operations (through operating plans or other means) for the funded services and the related goals and outcomes.

In addition, the Ministry and the LHINs should:

- develop guidelines for conducting reviews of service-provider operations to determine whether funded services are being delivered cost-effectively;
- reassess service-provider data-reporting requirements so that the LHINs and the Ministry collect only the necessary information they actually need to oversee their providers; and
- establish processes to ensure that the needed information maintained in various information systems is complete and accurate to maximize the benefits offered by these systems.

## MINISTRY RESPONSE

Effective April 1, 2007, the LHINs assumed the role of health-system manager. They determined that in the 2007/08 fiscal year, they would request only a budget and not a full operating plan from the addiction-service providers because this was a transitional year and the budget increases provided by the LHINs would not result in significant service changes.

The Ministry and the LHINs are currently finalizing new accountability mechanisms that will apply to the addiction sector. The new approach will require health-service providers to submit Community Annual Planning submissions in fall 2008 that will describe their services, budgets, and other matters and serve as the basis for negotiation of a new Service Accountability Agreement beginning in the 2009/10 fiscal year. This proposed agreement provides for the LHINs to conduct periodic reviews of the health service providers.

In addition, the Ministry and the LHINs are working together to develop guidelines for agency audits and reviews, including identification of sentinel indicators that would alert a LHIN that a review or audit may be required.

The Ministry and the LHINs currently have a mutual obligation to identify and discuss data and information gaps, information-management requirements, and data-quality issues.

The Ministry currently supports data-quality efforts through additional business logic rules and focused data-quality sessions with the sector. Both aspects of data quality will be further enhanced over the coming year.

As well, the Ministry will conduct timely data-quality checks and the LHINs will work with the health-service providers to improve their compliance with these requirements.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the ministry response.

### Financial Approvals

The Ministry's operating guidelines required addiction service providers to submit an annual budget package that included forecasted revenues and expenditures for the upcoming year.

To assess whether budgets were submitted and approved on a timely basis, we reviewed the budget-submission processes at the Ministry for the 2006/07 fiscal year, and at the LHINs we visited, for 2007/08. Our review found:

- The budget-submission package for the Ministry's 2006/07 fiscal year was due to the Ministry on April 21, 2006—21 days after the start of its fiscal year. With LHINs assuming their responsibilities on April 1, 2007, the budget-approval-submission process for the 2007/08 fiscal year was delayed. For instance, the process at one LHIN began as late as October 2007. This meant that the budgets of service providers were not approved until much later still—some as late as January 2008.
- One of the three LHINs we visited had taken the initiative to develop an internal checklist for use in review of service-provider budgets. The checklist ensured that all essential budget areas were reviewed, and that the review would be documented for reference or follow-up action. The review itself compared the approved revenue amount to the reported amount. It also compared data from the current year to data for the prior year in areas such as total and administrative expenses, clients served, and staffing. Staff at the other two LHINs informed us that they reviewed service-provider budgets on their computer screens but did not document their work or whether they had any concerns requiring follow-up.
- Budget approvals were not provided to service providers on a timely basis. Our sample of ministry files for the 2006/07 fiscal year, for instance, showed that approvals were given 160 days after the start of the fiscal year on average; one was 283 days late. In addition, a number of the LHINs' approvals were given as late as January 2008—just two months before the service providers' fiscal year-end.

## RECOMMENDATION 6

The Local Health Integration Networks (LHINs) should ensure that:

- service providers submit budgets before the start of a new fiscal year;
- budgets are thoroughly and consistently reviewed and follow-up concerns are documented; and
- service providers' budgets are approved on a more timely basis.

## MINISTRY RESPONSE

The LHINs are responsible for managing their local health service providers and establishing effective budget-submission and review processes to appropriately fulfill those functions.

The Ministry will improve the timeliness of the budget reviews for those agencies that continue to report to the Ministry.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

With the devolution of authority from the Ministry to the LHINs, the LHINs assumed responsibility for negotiating service accountability agreements with health-service providers. Along with other community agencies, the LHINs and Addiction Service Providers are in the process of developing and implementing a new Multi-sectoral Service Accountability Agreement (M-SAA) process to take effect in the 2009/10 fiscal year. As M-SAAs will be signed prior to the new fiscal year, agencies will therefore know their funding allocation prior to the start of a new fiscal year with clearly articulated expectations including performance targets.

### Financial Year-End Settlement

Although the LHINs are now responsible for approving and allocating funds to service providers,

they rely on the Ministry to continue recovering all unspent service provider funds, at year-end, on their behalf.

To this end, both independent and hospital-sponsored service providers were required to submit settlement forms to the Ministry. These settlement forms reported revenues and expenditures related to addiction programs funded by the Ministry before April 1, 2007 and by the LHINs after April 1, 2007. Providers were also to submit Auditor's Questionnaires, which certified that the year-end information agreed with the audited financial statements and underlying financial program records. These questionnaires were to be signed by either external auditors or the service providers' internal audit department (if there is one), or the Chief Financial Officer.

Year-end settlement packages were due by May 31 or August 1, depending on whether or not the service provider had converted to the Ministry's Management Information System.

Our review of a sample of year-end service-provider settlement packages found the following:

- At the time of our visit, the Ministry was significantly behind in its review of the service-provider settlement packages. Its backlog extended back to 2000/01. We estimate that the unrecovered surpluses were about \$3.5 million for 2006/07 alone.
- More than two-thirds of the 2005/06 settlement packages were submitted to the Ministry later than their due dates. They were submitted an average of 75 days late, with one 232 days late.
- About 70% of the files did not report depreciation or amortization expenditures on the settlement form, for removal from total expenditures eligible for funding. There was no ministry follow-up on the non-reporting of such ineligible expenditures.

The lack of timely receipt, review, and follow-up of year-end settlement packages resulted in untimely recovery of surplus funds.



## RECOMMENDATION 7

To ensure prompt and appropriate recovery of surplus funds from service providers, the Ministry of Health and Long-Term Care should:

- review the settlement packages on a timely basis; and
- follow up on ineligible expenditures, such as amortization, for exclusion when determining the final settlement balance.

In addition, the Local Health Integration Networks (LHINs) should require service providers to submit their settlement packages by the due date.

## MINISTRY RESPONSE

The Ministry agrees with this recommendation. It has completed approximately 50% of the backlog of settlements and expects to have all outstanding settlements, up to and including the 2006/07 fiscal year, completed by March 31, 2009. The Ministry is also actively following up on ineligible expenditures, such as amortization, for exclusion if it is deemed material. The 2007/08 version of the year-end report includes specific line items to deal with amortization.

In order for the Ministry to complete settlements on a timely basis, the Ministry will work with the LHINs to ensure that health-service providers submit these reports as required.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the Ministry response. The LHINs monitored budgets in the second and third quarters of the 2007/08 fiscal year to confirm surpluses and deficits, and did reallocations. Quarterly reporting of surpluses is mandated in the new M-SAAs, which will result in early identification and resolution of agency surpluses.

## MEASURING AND REPORTING EFFECTIVENESS

To measure the performance and the effectiveness of the addiction programs, in 2006, the Ministry began developing a strategy-based performance-management process. One critical component of this process is the “Scorecard”—a collection of key performance indicators linked to the Ministry’s strategic goals.

In May 2008, the Ministry produced a draft addiction-system Scorecard that included 13 preliminary indicators to measure some aspects of the strategic goals, focusing on overall provincial performance levels. These performance indicators included, for example, the amount of addiction funding per capita and per person in need of service, and the ratio of residential and non-residential service utilization. At the completion of our audit, the Ministry was still considering the development of additional indicators for measuring effectiveness. While the Ministry has taken the initiative to set the stage for measuring results through the use of such preliminary indicators, it indicated that it would require more work to set targets against which the actual results achieved could be compared.

## RECOMMENDATION 8

To enable the Ministry of Health and Long-Term Care and the Local Health Integration Networks (LHINs) to assess the effectiveness of addiction programs, the Ministry should work with the LHINs to:

- establish acceptable targets for the indicators; and
- measure and report on variances between results achieved and established targets, and implement corrective action where needed.

## MINISTRY RESPONSE

The Ministry accepts the recommendation that indicators and targets should be established for addiction services. Currently, indicators

are being incorporated within the new service accountability agreements that the LHINs will sign with their addiction service providers by 2009/10.

The LHINs are monitoring their health-service providers' achievements of targets and taking appropriate action on any variances.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the ministry response.

### Problem Gambling

#### Provincial Strategy and Revenue Accountability

As indicated earlier, through Cabinet approval, the government allocates 2% of gross slot-machine revenue from charity casinos and racetrack operations to problem-gambling initiatives, in order to address the harm that can arise from problem gambling. The Ministry is responsible for funding problem-gambling programs. As a result, the minimum amount allocated to problem gambling increased from \$10 million in 1999/2000 to its current level of \$36.65 million annually since 2003/04.

After a 2005 provincial review of problem gambling and responsible gaming, in 2006, Cabinet approved a new provincial problem-gambling strategy that included prevention, treatment, research, and responsible gaming. The Ministry was to implement this strategy in collaboration with three other ministries—Health Promotion, Public Infrastructure Renewal, and Government Services. The new strategy included a vision, principles, and key outcome measures, as well as goals and objectives.

As part of the new strategy, \$9 million of problem-gambling revenue (at minimum, a quarter of the 2% revenue allocation) was transferred to the Ministry of Health Promotion to conduct provincial prevention activities. The Ministry of Health and Long-Term Care allocated the remaining \$27.65 million to local gambling prevention/

awareness, research, and treatment activities.

These funds were allocated, through base funding, to 50 existing substance-abuse service providers to help them also provide problem gambling services. These funds also supported research activities. Funds were also provided for one-time projects and to provincial agencies for establishing activities such as the Problem Gambling Helpline.

A portion of the funding the Ministry provided to service providers was to be spent on their local prevention and awareness activities. Our service provider visits found that all provided local prevention activities for substance abuse and problem gambling, including distribution of pamphlets and materials, presentations at local schools and community centres, and establishing linkages with local enforcement agencies.

However, the Ministry had not provided strategic direction for these local activities, had not assessed their effectiveness, and had not coordinated local prevention and awareness activities with the Ministry of Health Promotion's provincial activities.

Furthermore, at the time of our audit in April 2008, the Ministry's new problem-gambling strategy, approved in 2006, had still not been released to the public.

In addition, while many ministries were to be involved in developing and implementing the problem-gambling strategy, we found no overall reconciliation to ensure that the \$36.65 million was actually being spent on problem-gambling initiatives.

## RECOMMENDATION 9

To ensure that local problem-gambling-prevention activities are in line with provincial strategic goals, the Ministry of Health and Long-Term Care should ensure that communication occurs between the Local Health Integration Networks and other affected ministries to:

- co-ordinate local prevention and awareness service-provider activities with the Ministry

of Health Promotion's provincial activities;  
and

- assess the effectiveness of local prevention/awareness activities.

## MINISTRY RESPONSE

The Ministry continues to work with the Ministry of Health Promotion, responsible for prevention of problem gambling, the Ministry of Government and Consumer Services, responsible for the Alcohol and Gaming Commission, and the Ministry of Energy and Infrastructure, responsible for gaming policy, to co-ordinate our mutual efforts to prevent and treat problem gambling in Ontario.

The Ministry requires the LHINs to fund only problem-gambling services with the resources it receives for this purpose. The LHINs' problem-gambling service providers offer both prevention and counselling programs.

The Ministry agrees that optimal results will be achieved if provincial and local gambling-prevention activities are co-ordinated, and it will encourage the LHINs and the Ministry of Health Promotion to work together.

## LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE

The LHINs agree with the ministry response.

### Ontario Problem Gambling Helpline

In addition to maintaining data on service providers' treatment services and treatment availability, ConnexOntario maintains helplines for both substance abuse and problem gambling.

The Ontario Problem Gambling Helpline provides problem gambling information and referral services province-wide, to health-care professionals and the public. It provides immediate access to information about treatment services, family ser-

vices, self-help groups, and other resources related to problem gambling, seven days a week, 24 hours a day.

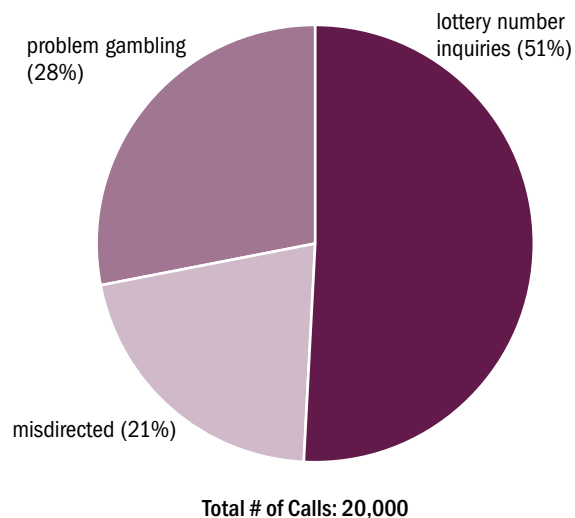
Various studies commissioned by the province indicated that 2% to 4.8% of adults in Ontario—approximately 251,000 to 602,000 adults—were moderate to severe problem gamblers. For treatment purposes, the Ministry estimated that only about 193,000 people were in need of problem-gambling treatment.

Ontario's addiction service providers treated an estimated 5,900 problem gamblers. The number of problem-gambling concern calls made to the helpline was likewise very low. As shown in Figure 3, the majority of the calls received by the helpline (over 70%) were unrelated to problem gambling concerns: they were either inquiries related to winning lottery numbers or misdirected calls. This could indicate that the people calling were not aware of the purpose of the helpline.

Ministry staff indicated that they were concerned with the low number of calls related to problem-gambling concerns and the low numbers of problem gamblers treated. However, they indicated that other jurisdictions experienced similar issues.

**Figure 3: Calls to the Ontario Problem Gambling Helpline, 2006/07**

Source of data: Ministry of Health and Long-Term Care



To increase the effectiveness of the helpline, the Ministry funded a three-year pilot project, commencing in 2007, to expand the services it provided to include:

- referring callers to staff who have in-depth knowledge in dealing with problem gambling;
- offering self-help materials; and
- asking helpline staff to directly book appointments with a selected number of problem-gambling service providers.

### **RECOMMENDATION 10**

To help more problem gamblers receive appropriate treatments, the Ministry of Health and Long-Term Care should work with ConnexOntario and the Ministry of Health Promotion to increase awareness of where problem-gambling treatment is available.

### **MINISTRY RESPONSE**

The Ministry is continuing to work with ConnexOntario on strategies to improve awareness of problem-gambling treatment programs, to refer callers to these programs, and to provide resource materials to callers that may assist a person in making a decision in seeking help.

The Ministry will discuss with the Ministry of Health Promotion and ConnexOntario strategies that could be implemented to expand awareness of the availability of problem-gambling treatment services in Ontario.

### **LOCAL HEALTH INTEGRATION NETWORKS' RESPONSE**

The LHINs agree with the ministry response.