

Women and Alcohol Expert Panel Report: Alcohol Treatment Services for Ontario Women

Key Messages

1. Young women are drinking at progressively higher levels and are at increased risk for experiencing alcohol-related problems.
2. Ontario has effective gender-sensitive treatment services, but services are not available to women in all regions of the province.
3. Stigma is a major barrier for women needing treatment for alcohol misuse and interferes with women seeking help.
4. Better guidance and training for primary care should be a focus for immediate improvement.

Background

Canadian women are drinking alcohol, and they are drinking more of it than ever before. Alcohol use is a health concern for women because women metabolize alcohol more slowly than men, alcohol can interrupt a woman's reproductive cycle as well as cause fetal abnormalities if she is pregnant, and alcohol use can increase a woman's risk of injury and chronic disease, including developing breast cancer. Moreover, alcohol consumption (by women and men) may put women at risk for assault. Therefore, serious social and economic ramifications will be associated with both the increase, as well as the shrinking gender gap, in alcohol consumption.

Echo: Improving Women's Health in Ontario is an agency of Ontario's Ministry of Health and Long-Term Care. Echo promotes equity and improved health for women by working in collaborative partnerships with the health system, communities, researchers and policy-makers. Our mandate is to be the focal point and catalyst for women's health at the provincial level. Echo has brought together leaders from across the province knowledgeable about alcohol use by women to serve as an Expert Panel (see Appendix A). The purpose of bringing these leaders together is to develop a shared understanding of the current state of knowledge and best practices regarding treatment services for women with problematic alcohol use in Ontario.

This initiative will inform Echo's input to the evolving mental health and addiction system in Ontario, specifically informing how integrated high quality care delivery for women with alcohol misuse issues can be improved. This document looks at the issue of problematic alcohol use by women, recognizing that gendered health inequities resulting from women's social status and social roles impacts on women's alcohol use, and biologically-based sex differences are also significant.

Why is women's health important?

Women face health conditions that are unique to them (e.g., gestational diabetes, cervical cancer) and some health conditions can affect women more seriously (e.g., multiple chronic conditions and depression and anxiety) [1-3]. Women's social roles also influence health: they are typically the primary caregivers in their families; they face different barriers to accessing care; they are more likely to spend their discretionary money and time differently, with priorities on better health and quality of life of their children and family. Additionally,

targeted education of women regarding health, results in greater health benefits to their children and families [4]. Addressing women's health strengthens health in our communities overall and provides support that is essential to sustaining and supporting our health system.

Key Terms

Problem drinking: In simple terms, problem drinking is when drinking alcohol begins to interfere with a person's life; for example, being repeatedly late for work, getting lower grades at school, having arguments with family or friends, developing health concerns or having alcohol-related accidents, or being charged with impaired driving (see Appendix B for table comparing at-risk drinking, alcohol abuse and alcohol dependence) [5].

Low-risk drinking guidelines: Guidelines suggest that women should not consume more than two drinks in a day, and no more than 9-10 drinks per week [6, 7].

Alcohol and drug related harms: Includes harms in any of the following areas: physical health; friendships and social life; financial position; home life or marriage; work, studies or employment opportunities; legal problems; difficulty learning; and housing problems [8].

Introduction

The majority of Canadian women drink alcohol [7], and alcohol use for men and women has been rising [9, 10]. Only small gender differences are now evident amongst university and college students, as young women in particular are drinking more frequently and larger quantities of alcohol [9]. For women in Ontario, daily drinking has increased from 2.6 percent in 2001 to 5.3 percent in 2007, and hazardous or harmful drinking increased from 5 percent in 1998 to 8 percent in 2007 [11]. Alcohol has differential effects on women - they feel its effects more quickly, they develop dependence and health issues more rapidly, and at lower ingestion rates than men. Stigma in seeking treatment for problematic alcohol use is a significant challenge, as women tend to be more stigmatized than men, particularly if they are parents [12, 13].

According to the World Health Organization (WHO), alcohol consumption ranks second behind tobacco use as a risk factor for disease, with injuries contributing the highest burden [14]. Alcohol has been causally linked with over 60 medical conditions, including injury (e.g., impaired driving, drowning, falls, fires, suicide, homicide, sexual assault and other violence) and chronic disease (e.g., liver disease, some cancers including breast cancer, high blood pressure, stroke, and mental health problems) [10, 15, 16]. While the misuse of alcohol can lead to dependency in some people, for the majority of the population, alcohol-related harm

stems from patterns of use. Drinking to intoxication is most prevalent amongst the young [17] and can be a useful indicator for at-risk drinking.

Costs attributable to alcohol in Canada total close to \$15 billion for health care, enforcement and lost productivity [18]; in Ontario, costs total \$5.3 billion [18]. Despite the revenue generated by alcohol sales in the province, alcohol-related costs including enforcement and health care are significant. In a comparison of direct alcohol-related revenue and costs in Ontario in 2002-2003, the deficit totalled more than \$456 million [19]. Alcohol-related harms are a significant problem in the province of Ontario [20-22], and alcohol use issues are of increasing interest to health professionals (particularly public health) and yet sometimes a limited focus remains on addiction [15]. Ontario data on the number of women in treatment by program, presenting problem substance, availability of treatment, and wait times by type of treatment program and by Local Health Integration Network (LHIN) can be found in Appendixes C, D, and E. Ontario is embarking on a renewal of the systems of support for Mental Health and Addiction with the release of 1) the report of the Select Committee on Mental Health and Addictions [23], and 2) Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy [24] creating the possibility of a renewed focus on this issue.

Why women use alcohol

Gender differences in risk factors and consequences for alcohol use exist [25]. Women use alcohol to address negative feelings, cope with problems or to increase confidence [25, 26]. The level of perceived stress has been found to be a powerful predictor of alcohol and other drug use (after peer substance abuse)[27]. Women are highly influenced by the drinking patterns of husbands, siblings and friends [28] and by alcohol advertising targeted at women [29, 30]. However, women's drinking is highly stigmatized. The issue of stigma interferes with women seeking help and providers offering help [7] and it is particularly challenging for mothers who fear apprehension of their children [31]. Substance abuse affects parenting and shared practice guidelines have been developed in a coordinated effort between Children's Aid Societies and treatment centres [32] to increase the effectiveness of their interventions and to strengthen family functioning.

Why are women at risk?

Research has shown that women process alcohol differently than men with a variety of adverse results [15, 33, 34]. Elimination of alcohol is less efficient in female bodies and therefore women are more sensitive to the adverse effects of alcohol. Women have less water in their bodies; have a higher concentration of adipose tissue resulting in slower alcohol absorption; and lower levels of the enzyme needed to metabolize alcohol. The removal of alcohol from the body is further impaired as we age, making older women even more vulnerable [34]. As a result, women develop cirrhosis of the liver more readily at lower levels of intake than men [26] and they progress more rapidly to dependence on alcohol [35, 36]. Alcohol use is also linked to an increased risk of osteoporosis [36] and breast cancer [37]. Heavy alcohol use may also increase the risk for Alzheimer's disease as women seem to be more vulnerable to alcohol-induced brain changes [27].

Alcohol also impacts women during different life stages; for example, female puberty, reproductive function, and hormonal levels in postmenopausal women are all affected by alcohol use [34, 36]. Women's unique role as child bearer has led to a focus on controlling women's behaviour in order to avoid Fetal Alcohol Spectrum Disorder (FASD). FASD is a permanent and irreversible condition for the child that is associated with alcohol use in pregnancy [38]. The use of alcohol during pregnancy is often linked to other issues, including difficult relationships, mental health problems, and history of violence and/or trauma that affect women's ability to address the use of alcohol [21, 39]. The complexity around the use of alcohol during pregnancy is more recently being discussed.

Which women are at increased risk?

Particular groups of women are at increased risk for alcohol problems, such as women who have a history of or are currently experiencing violence [39], have a family history of addiction [40], concurrent disorders [30], and/or are lesbian, gay, bisexual, or transgendered [41]. Young adult women are now using alcohol in similar patterns as young men, which puts them at risk for health problems and other harms [9, 35, 42]. An examination of substance use and stressors for women accessing shelter for abused women and children demonstrated a complex set of issues including psychosocial, relational, structural, and environmental issues contributing to the interplay between violence and substance use [43]. This web of issues may improve or deteriorate in parallel, as support from the shelter was pivotal in helping women in this study to restructure their lives and contributed to a decreased reliance on alcohol and

stimulants three months post-admission [43]. The linkage of violence, substance use and mental health concerns predominantly affect women [21, 39].

The experiences of Aboriginal women's lives put them at high risk for alcohol use and abuse. Research on the connections of substance use, FASD, and the impact of residential schooling are now becoming available [38]. Aboriginal women are working hard to cultivate community and foster a better life for themselves and others, while dealing with the impact of colonialism, cultural genocide and violence [44, 45]. Understanding the issue with a cultural lens is critical, due to the high numbers of Aboriginal women living in Ontario. Aboriginal women have a much higher birth rate than other Canadian women, and have children at younger ages [46]. These women are also considered the caregivers for the family, are often the main breadwinner, and head up the family unit in single parent families. Lack of access to childcare and woman-centred services are barriers to treatment for Aboriginal women [47]. The Native Women's Association of Canada reported that Aboriginal women represented only 40 percent of the Aboriginal treatment population in alcohol treatment centres, which reinforces the need for culturally and accessible treatment centers for Aboriginal women [47]. Much of the research does not address the issue from a cultural perspective. Funding responsibility between the municipal and federal governments and Band Council further complicates the issues for prevention and treatment programming.

Ethnoracial communities are also vulnerable to substance use problems due to trauma, racism and discrimination [48, 49]. Ethnoracial communities are not a homogeneous group, and at present, we do not have sufficient information regarding treatment barriers among diverse groups and/or by gender. As well, lower levels of health literacy may cause barriers to seeking treatment [48]. Health programs need to play a role in creating conditions in which people and communities are more able to enjoy well-being by communicating health promotion messages effectively and by embracing culturally-sensitive services [48]. Targeted programs that are culturally appropriate, women-sensitive and safe can be helpful in supporting women regarding health behaviours [48, 50].

Bringing Sex and Gender into the Treatment System

In Canada, the importance of sex and gender in addiction and substance use has been reflected in various programs and policy documents. For example, Poole and colleagues produced a series of papers about women and substance abuse, including *Mothering and*

Substance Use approaches to prevention, harm reduction and treatment - Gendering the National Framework [31, 51-53] which has brought focus to the particular needs and challenges for women. Ontario has built on a decade of excellent work in this country [22, 54-56] to bring sex and gender aspects into the addiction treatment system. In 2006, the MOHLTC conducted a review of the compliance of treatment programs with the standards [12]. The guidelines were assessed through a cross-provincial survey and interview process and found the substance abuse treatment system was “undergoing profound shifts in its understanding of best practices and its approaches to women’s substance abuse” (p. vi)[22].

Best Practices for Women and Alcohol Use Treatment

Best practices for women and alcohol have been described in the areas of health promotion and healthy public policy; screening and brief intervention; and treatment (including client outreach, contact and engagement, treatment principles, specific approaches, client retention, treatment organization and duration, delivery of adjunctive services and measurement of effectiveness) [50]. The *Best Practices in Action: Guidelines and Criteria for Women’s Substance Abuse Services in Ontario* [13] focused their review of best practices on the addiction treatment system and they covered operational practices, addressing barriers, treatment planning issues, and clinical practice issues with a focus on women’s needs. Both the Ontario and National best practice documents identify best practices principles for women as needing to:

- provide a menu of options,
- provide a menu of approaches,
- be holistic and address practical needs,
- be gender-specific or provide gender-specific elements in the context of co-educational services, support connectedness between women,
- employ supportive, collaborative, non-hierarchical approaches,
- provide treatment based on empowerment model,
- address issues of primary concern to women including childcare,
- be respectful and client driven,
- support client education and awareness,
- provide treatment based on client strengths not deficits
- provide a continuum of services to meet client needs, and
- work with women on realistic objectives and accept that relapse is a learning experience and not a defining point in treatment.

Same sex treatment settings

Women in same sex treatment settings seem to have better outcomes (i.e., fewer relapses, less alcohol consumed on relapse) [13]. In 2006, only 16 percent of Ontario treatment services were found to be specialized (i.e., women-only) [12] despite the finding that gender-sensitive and women-only treatment settings are preferred [13]. When women-only services cannot be achieved, then gender balancing the treatment groups is essential. Mixed gender groups need to be balanced, with at least 30 percent women, and supported by a female therapist to be effective [12]. Appendixes D and E identify the current services available to women in women-only or mixed gendered programs.

Women who are planning to be pregnant or who are pregnant

There has been attention paid to informing women and society about the harms of using substances in pregnancy and the help available to stop or improve their health at this time [38]. The Public Health Agency of Canada (PHAC) along with other partners has developed [*Alcohol Use and Pregnancy Consensus Clinical Guidelines*](#) [7]. A recent Ontario survey of family physicians identified some barriers for primary care providers in addressing these expectations, including provider confidence in how to ask the question and how to create effective connections should the need arise [57]. Public health also has a role to play through the programs under the *Reproductive Health Standard* (Family Health Program Standard) which mandates the provision of programs related to healthy pregnancy, including a requirement to engage in outreach [58]. The Reproductive Health Standard includes the provision of the *Healthy Babies Healthy Children* program which includes provision of prenatal screening, postpartum screening and supports to at-risk families [59]. Ontario health service providers are supported in primary prevention efforts through *Best Start: Ontario's Maternal Newborn and Early Child Development Resource Centre* [60]. The Centre provides workshops and conferences, resources, consultations, and subject-specific information to support the provision of effective health promotion for women and their families, including health promotion about alcohol use.

Self-Help Resources

Addiction treatment has grown out of a history of community supported self-help programs where people with similar problems help and support each other (e.g., Alcoholics Anonymous). These groups are often open-ended allowing people to participate as they wish. There are many on-line resources including womenshealthmatters.ca, CONNEX Ontario

(www.connexontario.ca), AWARE Resource (www.aware.on.ca), and checkyourdrinking.net. Ontario also has an *Ontario Self-Help Network* (<http://www.selfhelp.on.ca/index.html>) which will link women with local self-help resources; and there are programs specific to women. *Women for Sobriety* (www.womenforsobriety.org) is a group-based peer-facilitated self-help program for women with alcohol and substance abuse problems. It is based on positive thinking, meditation, group dynamics, and the pursuit of health through nutrition.

Aftercare Programs

Post-treatment programs are increasingly recognized as essential supports to clients after more intensive involvement in alcohol treatment. These programs can include sober housing supports and generally include long-term contact with the program to support problem-solving and maintenance of goals. Aftercare treatment is a critical component of a woman's support system; however, women often encounter many barriers to participation in aftercare treatment, such as lack of transportation, mobility issues, and lack of childcare [54].

Culturally- relevant, community-based aftercare is a critical component of a woman's support system after she leaves prison [17], particularly for those women at increased risk (e.g., high rates of Aboriginal and First Nations women in the correctional system).

Aftercare programming does not always exist in First Nation communities and transportation to support aftercare is complicated by funding limitations. On-Reserve programming is the fiduciary responsibility of the Federal Government and in remote or rural settings, aftercare may be provided off-Reserve, and is therefore inaccessible due to transportation barriers. Poverty rates are high in First Nation communities; and transportation to health appointments is often program-limited and has frequency restrictions. Focusing on developing strategies that improve access to community aftercare is imperative for improving the life chances and health of Aboriginal women [17].

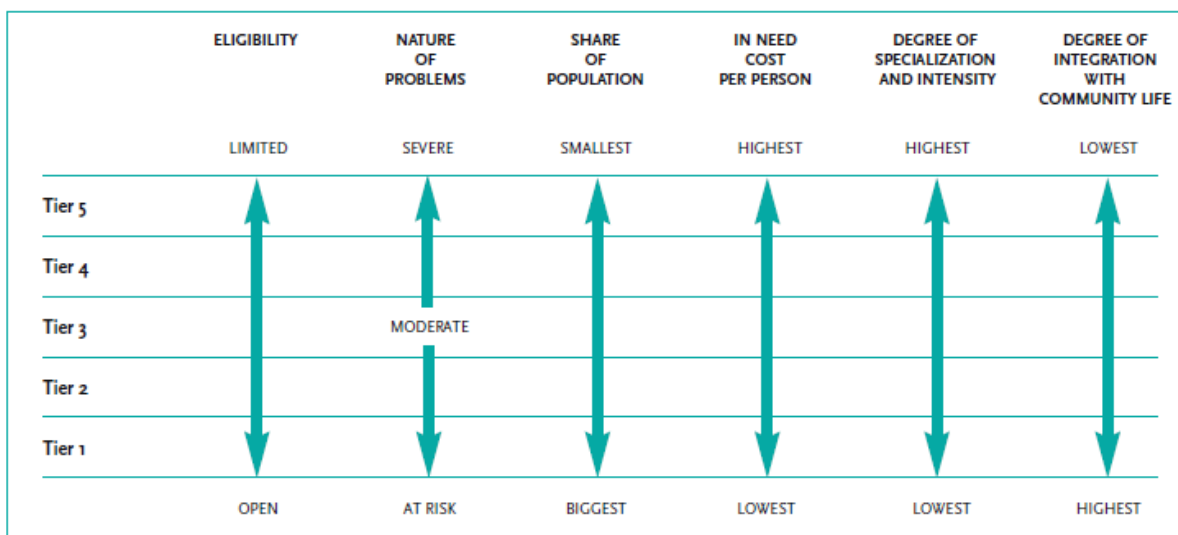
The next section will discuss the role that the health system plays in addressing alcohol use in women.

Tiered Approach to Substance Use Treatment Services

The report, *A Systems Approach to Substance Use in Canada - Recommendations for a national treatment strategy* [20], recommended that treatment services be considered as a

tiered and integrated continuum of services and supports, informed by a population-informed response. The adoption of a tiered system can improve care and co-ordination of services and make the delivery of care more efficient and effective. The tiered approach recognizes the need to integrate addiction treatment services with other health and social service players to effectively meet the needs of this diverse group [20, 61]. The tiered approach to addiction services specifically considers the role of related parts of the health care system (i.e., public health and primary care) and recognizes that individual clients will move across the tiers depending on changes in circumstances and/or needs (see Figure 1) [20].

FIGURE 1: DIMENSIONAL DESCRIPTION OF THE FIVE TIERS



Source: *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada*. 2008: Ottawa.

The tiered approach is guided by a set of concepts that cross all of the tiers and these concepts are articulated in Appendix F.

The Tiered System in Ontario

Tier 1 in Ontario

Tier 1 of the treatment system includes population health interventions, such as primary prevention and health promotion initiatives, as well as those targeted to at-risk populations. Self-help resources and after-care supports for people in recovery are also found in Tier 1. Tier 1 programs are primarily supported by public health and community resources and need to be available in all communities [20].

Primary prevention efforts aim to avoid the development of alcohol-related problems before they begin and reducing harm from risky drinking. These efforts include both population level and individual level approaches. Primary prevention efforts should include risk factor recognition, legislation and regulation, community action, and health education [28]. Evidence-informed interventions and healthy public policies are available to reduce alcohol-related harm. Giesbrecht and colleagues [62] recommend a two-level response: first, focusing on population level approaches, and then targeting priority populations. Effective action at the first level is an essential support to the second level interventions.

Table 1. Two-tiered alcohol policy response

First Level: Policies and interventions	Second Level: Focused policies and interventions
<ul style="list-style-type: none"> • Effective Alcohol Pricing • Controlling Physical Availability • Curtailing Alcohol Marketing • Maintaining Alcohol Control Systems 	<ul style="list-style-type: none"> • Drinking and Driving Legislation • Changing the Context of Drinking • Education and Persuasion Strategies • Increased Access to Brief Interventions

In Ontario, the Public Health Standards - *Prevention of Injury and Substance Misuse* and *Chronic Disease Prevention* - provide guidelines for mandatory health programs and services in all Ontario health units [58]. The standards require that all public health departments conduct epidemiological analysis including monitoring trends over time, emerging trends, and priority populations in the area of alcohol and other substances; to work with community partners, including enforcement agencies, to reduce the injury potential for the population; and to increase public awareness regarding injury and substance misuse [58]. Public health professionals and others working in health promotion are supported in Ontario by the Alcohol Policy Network (APN), a program of the Ontario Public Health Association [63]. APN provides educational opportunities, evidence-based resources, and consultation services to support alcohol policy and prevention efforts in Ontario [63].

The development and publication of low-risk drinking guidelines (LRDG) has been a major step forward as they clearly indicate the relative risk for women [6]. Generally, women need to be more knowledgeable about alcohol, and more willing to seek intervention, particularly at earlier stages [28]. Targeted health promotion initiatives have been developed related to

particular groups: women who are planning and/or are experiencing pregnancies, and Aboriginal women. Based on emerging evidence on consumption patterns, young adult women should be prioritized for targeted interventions as well [9, 42]. It is important to note, however, that although the LRDG provide a way to educate women on how to drink at a low-risk level, there is, as yet, limited research on the impact of alcohol drinking guidelines on drinking behaviour and related problems [15].

Tier 2 in Ontario

Tier 2 supports provide early identification and intervention mechanisms, which may include screening, brief intervention and referral. These services are often provided by primary care, social services, emergency services, public health and employment programs. These are outpatient services that need to be available in all communities. Examples of Ontario Tier 2 programs include: Family Health Teams that have substance abuse supports, shelter health physicians, Ontario Early Years programs, and Early Childhood Development programs.

Some significant tools have been developed in Ontario and Canada to support women and providers to be aware of, and equipped to address women and substance use, particularly related to alcohol. The Centre for Addiction and Mental Health's resource, *Action on Women's Addictions- Research and Education (AWARE)*, is tremendous [64]. This group, in partnership with 'Breaking the Cycle', developed *The SMART guide: Motivational approaches within the stages of change for pregnant women who use alcohol: A training manual for providers* [65]. The Best Start program also has a variety of resources to support women, with understanding the risks of alcohol in pregnancy; and health care providers, to screen women effectively [60].

To support the provision of high reliability Tier 2 services, guidelines are essential. One guideline is the [Alcohol Use and Pregnancy Consensus Clinical Guidelines](#) [7]. The objective is "to establish national standards of care for the screening and recording of alcohol use and counselling on alcohol use of women of child-bearing age and pregnant women based on the most up-to-date evidence" (pg. S1)[7]. This guideline defines that all pregnant women and women of child-bearing years should be screened for alcohol use with linkage to appropriate intervention as necessary. However, at present, alcohol use is not one of the discussion topics outlined on the standard antenatal form in Ontario. Inclusion of the expectation that providers discuss alcohol use would improve the proportion of health care providers who discuss smoking, alcohol use or addiction history with women of childbearing age, which is

currently less than 50 percent [66]. The Canadian Centre on Substance Abuse has developed a Fetal Alcohol Syndrome (FAS) toolkit that helps groups promote their work related to FAS and fetal alcohol exposure (FAE), and creates awareness of the effects of FAS/FAE [67].

Further supports to primary care to allow for the delivery of brief interventions include appropriate billing codes, mentoring, and trained multidisciplinary team members. Currently, it is felt that there is lack of capacity for primary care regarding early intervention and brief supports and that billing codes need to be developed related particularly to brief interventions for women in childbearing years [68, 69]. Significant changes in drinking behaviour can result from brief intervention, even for heavy drinkers [15, 62]. The National Alcohol Strategy Advisory Committee is currently working on developing a web resource for family physicians on screening and brief intervention. It is hoped that a more coordinated national approach to screening, brief intervention, and referral will help facilitate and support primary care in screening women for problematic alcohol use.

Tier 3 in Ontario

Tier 3 programs are expected to focus on people with defined substance use issues, with the intention of reducing secondary harm and prompting access to formal treatment services. The services in this tier include active outreach, risk management, formal assessment and referral, and home-based withdrawal management. This level serves as the doorway to the formal addiction service system and this level of service should be available in most semi-urban or urban communities (where service demand is high enough to warrant).

In 2000, Ontario developed and implemented a standardized assessment and referral process. This process is not gender-specific and hence misses some of the key issues in alcohol use for women, but this approach does provide an essential building block for system development.

Generally, addiction service treatment approaches for women must include consideration of physical and mental health issues, interpersonal issues, relapse prevention and management in all intervention models [50, 55]. The substance abuse system is comfortable and supportive of the need to integrate treatment approaches with related social support systems, and impressive results have been achieved as a result [17, 70]. Adherence to treatment is also supported utilizing a multi-component treatment model, as this addresses the barriers/inhibitors to women remaining in programs [50]. Outreach services which are provided where women live and/or work can help with access [54]. Finally, relapse must be included as an expected occurrence in substance use programs without it being a defining

point in recovery. The historical roots of addiction services have focused on abstinence, and some programs are now taking harm reduction as the primary goal. They both aim to help people reduce the harms they experience because of their substance use.

Tier 4 in Ontario

Tier 4 supports are specialized services for people with substance abuse problems. People needing this level require service support for more than one issue or from more than one sector. This tier can include case management, intensive day programming, structured residential services, complex support for people with concurrent disorders and active outreach services. These services should be available in most semi-urban and urban communities or where demand warrants.

Ontario Tier 4 program examples include *New Choices* and *Breaking the Cycle*. The intersection of gender with other determinants of health and/or sources of discrimination makes service access more difficult for many women, with associated increases in the need for comprehensive service support [12]. Women who are heavy substance users rarely use a single substance [26]. Specifically, more complex clients generally require supports from multiple agencies which can best be facilitated by a case management or navigator approach to help create practical alignment across health, child welfare, supportive housing organizations, etc. *Breaking the Cycle* - offered by Mothercraft - has effectively targeted homeless pregnant women, demonstrating the efficacy of both the comprehensive, integrated program model and of a targeted outreach approach [70]. A targeted outreach approach is often used for mothers with children - supportive housing with links to residential treatment or intensive day treatment. Residential treatment is generally used for people who are more resistant to treatment, have few financial resources, come from environments that are not conducive to recovery, or have coexisting medical or psychiatric conditions [15, 31].

Tier 5 in Ontario

Tier 5 supports are intended for those with highly acute, chronic and/or complex needs for whom lower tier supports are inadequate. Examples of supports at this level include: intensive treatment in correctional facilities, hospital-based withdrawal management, residential programs for concurrent disorders, and 'safe beds' for at-risk women. These programs are supports for services in lower tiers and they should be available in urban communities and accessible to a broad catchment area. The services at this level provide

intensive, multidisciplinary, specialized treatment for severe and complex substance use problems.

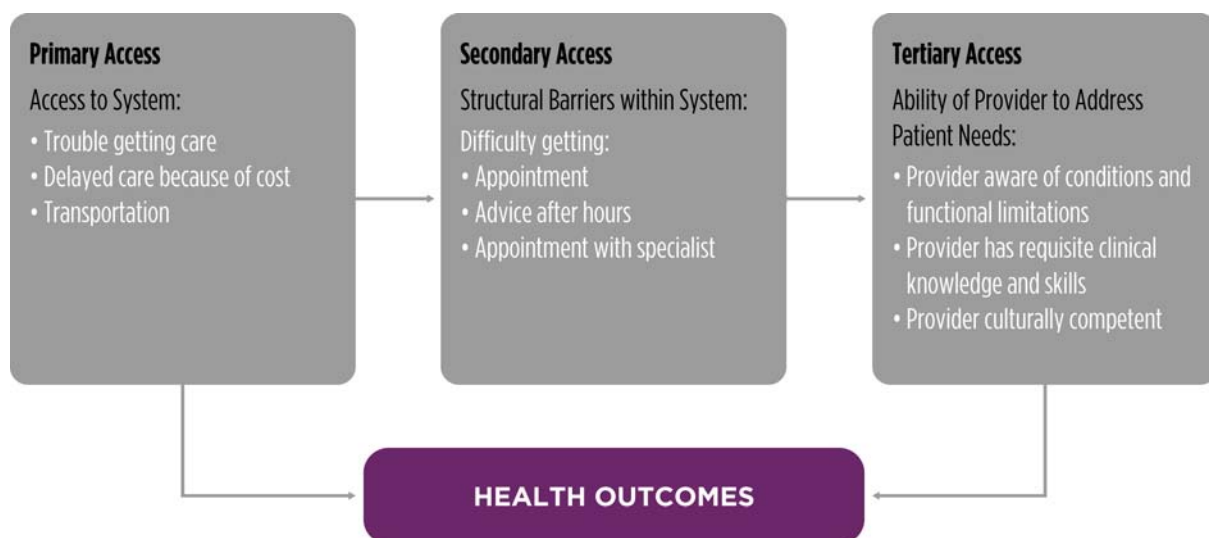
The next section of the report identifies primary, secondary, and tertiary barriers to treatment in the addiction system.

Barriers to treatment

The lack of integration of the addiction treatment system in Ontario and the complex multifaceted needs of many women make the development of the needed coordinated approaches more difficult to achieve [71]. The recent release of a new Mental Health and Addictions Strategy for Ontario may help to move the addiction system to be more linked to the other system players, including primary care and essential social support programs such as housing [24]. In moving toward an effective and integrated system, barriers need to be understood and addressed.

The conceptual model depicted in Figure 2 can help us to understand areas that could be improved [72]. Primary barriers represent direct access barriers, such as a lack of a locally available service. Secondary barriers are barriers that are created by the processes used in providing the programs or services. Tertiary barriers are barriers created by the ability of providers and/or the health system to understand and respond to the user's needs because of knowledge or skill gaps.

Figure 2. Conceptual framework for improving access, quality, and health outcomes.



Source: Bierman, A.S. & Clancy, C.M. (2001). *Health disparities among older women: Identifying opportunities to improve quality of care and functional health outcomes*. JAMWA, 56: 155-159.

Primary Access Barriers

Some groups of women have particular difficulty getting care, often starting with challenges at the primary care level. Women who experience being marginalized (e.g., women with mental health issues) are less likely to have access to primary care [73] and this is intensified with concurrent alcohol misuse [48]. Low income women experience barriers which are mostly outside the control of the service providers; however, many addiction treatment services try to respond to needs like transportation, childcare, and health care costs [12]. For northern, rural, and remote women, a lack of confidentiality and privacy due to small social networks, isolation from services that are at a distance, lack of ability to bridge distance with transportation, and lack of flexible services that respond to their needs impact adversely on rural women needing addiction services at many levels [50]. Finally, barriers for some women may include a lack of support (e.g., family, partners, communities) from those who do not want to acknowledge the issues that women are struggling with or support change [74].

In general, women-only services have significant waiting times and there are gaps in availability of these programs across the province (see Appendix C, D, and E); for example, there appear to be few women-only aftercare programs in Ontario. There are no community withdrawal management programs for women-only across the province; only Toronto, Hamilton, and Niagara have women-only residential withdrawal management programs/services. Ten out of the 14 LHINs have women-only residential treatment programs. The Central, North Simcoe/ Muskoka, and the Southwest LHINs do not provide women-only programs.

Secondary Access Barriers

Barriers are also created by limited service hours, location limitations and lack of cultural appropriateness. These types of program limitations are particularly challenging for women with more complex challenges, such as social assistance, concurrent medical and/or psychiatric needs.

One specific barrier that has been identified is narrow service mandates that do not address the realities for women, or trap women in 'catch 22' situations. "Currently women in Canada who have experienced violence who have varying levels of mental health and/or substance

use are often unable to access support that recognizes and responds to their lived experiences of the connection between these concerns” (pg. 22) [39]. Women who are depressed are more likely to misuse alcohol; but women who speak about other issues may have difficulty accessing services due to exclusionary policies across anti-violence, mental health, and substance abuse sectors [39]. Aboriginal women seldom experience services that incorporate essential spiritual values and traditional ceremonies [44]. A lack of gender specific programming, community supports, and modelling, limits the accessibility and effectiveness of services for Aboriginal women [74]. Some treatment centres (e.g., Iris Addiction Recovery for Women) have Aboriginal staff and/or teachings incorporated into their programs. Agencies in rural settings find it difficult to link with medical, mental health and methadone services when needed [12], creating barriers for these clients in accessing needed services. There has been some success with high patient satisfaction, in offering supports through telemedicine [75].

Tertiary Access Barriers

Tertiary barriers include provider/system knowledge or skill gaps in meeting or understanding users’ needs including:

- a. Women with a current or history of violence and trauma. Links between violence against women, substance use and mental health issues are strongly seen but the relationship between these issues is complex and multidirectional [21, 39, 43]. The 2005 guidelines adopted in Ontario include a specific section on trauma and post-traumatic stress disorders, recognizing the overlap of trauma in the population accessing addiction services [55]. In 2006, over 50 percent of addiction services in Ontario reported delivery of trauma informed programming [12]; however, there is not a universal understanding of the need to include trauma or violence informed approaches when treating women with alcohol use issues. The Ontario Woman Abuse Screening Project (www.womanabusescreening.ca) works with providers in the addictions, mental health, and violence against women sectors in order to provide training for frontline workers to increase the understanding of the issues facing women who have experienced violence and trauma and the links to mental health and addiction issues [76]. This project will result in better programming and screening for women.
- b. For women who are new to Canada, barriers include: language/literacy, lack of culturally-specific programming, and lack of effective culturally-specific outreach. Health service

providers need to link with agencies in touch with these women in order to mount an effective response to the recognized risk profile for ethnoracial women [48].

- c. Lesbian, gay, bisexual, and transgendered women are recognized as an at-risk group; however, there is little known about their challenges in accessing addiction treatment and they were not specifically addressed in the review done in 2006 in Ontario. Other best practice guidelines have been developed to help address sexual minority women's treatment needs [77] .
- d. For women with concurrent disorders, providers feel ill-equipped to deal with the complexity of their issues [39] and clients risk inadequate diagnoses in either the addiction service or the mental health setting [50]. The 2005 guidelines identified the expectation that addiction service providers will work in concert with the mental health system to better support women with concurrent problems [13]; however, there are complex barriers to be overcome except in some highly specialized integrated programs [12].
- e. Approximately 12-14 percent of women report having used alcohol in their last pregnancy [32, 78]. A guiding framework for practice has been articulated which emphasizes mother/woman- centred services, harm reduction orientation, and a coordinated system of perinatal services working in collaboration across agencies and disciplines in a health-oriented approach (e.g., Sheway program in Vancouver)[31, 38, 65, 70, 74]. A comprehensive treatment system/model would include services covering medical/health, child related, family, skills training, psycho-social, community supports, employment training, life needs, and addressing cultural sensitivities for diverse population needs [74]. Families may be engaged with both the child welfare and addiction treatment systems, necessitating clarity about the roles, responsibilities, and expertise of the two sectors [32].

Recommendations

1. Women who use alcohol need to be viewed in the context of their lives where health and social problems or issues of dependency can impact on their alcohol use and need a compassionate response from the health system that supports positive, informed action. The stigma associated with alcohol misuse interferes with women seeking help and thus impacts on the effectiveness of the treatment system. When this stigma is added to other forms of discrimination, the barriers are even more significant. Reducing stigma and discrimination is central to improving mental health and addiction services in general [24, 79]. Specific actions should include:

- a. Public education regarding alcohol use and low-risk drinking guidelines. Generally, women need to be more knowledgeable about alcohol and more willing to seek intervention [28]. Programs should use “messages that are not overly threatening, that speak to women in diverse circumstances, and that promote positive, informed action by women, their partners and their communities” are needed (pg. 16)[31].
 - b. Implementing gender-specific additions to standardized assessment and referral used by the addiction sector in Ontario.
 - c. Establishing stricter advertising standards for alcohol, particularly those aimed at young people.
2. Build capacity for frontline care providers, particularly primary care providers, to question alcohol use patterns and to educate and link women with information, programs and services particularly related to early and brief interventions. Gatekeeper training has been shown to increase intervention and support earlier treatment [28]. Ontario can build on some of the work from The National Alcohol Strategy Advisory Committee [80].
 - a. Expand the use of the Canadian Centre for Substance Abuse web-based *screening, brief intervention and referral* protocols developed to support primary care providers in providing care to moderate alcohol use patients who exceed recommended guidelines, but are not alcohol-dependent.
 - b. Provide training regarding alcohol use and alcohol use intervention to all primary care and emergency trainees through mandatory student placements.
 - c. Alcohol use is not one of the discussion topics outlined on the *standard antenatal form 2*, despite awareness of the significant potential to impact the health of both mother and baby. Adapting the form to support inquiry and action related to alcohol use would support improved health outcomes.
 - d. Develop and implement a training curriculum for frontline mental health and substance workers and other health professionals on the connections between violence, substance use and mental health, building on the work of the Tripod pilot [76] (www.womanabusescreening.ca) and Dr. Robin Mason’s work, including the Intersections of Mental Health Perspectives in Addictions Research Training (IMPART) program (<http://www.addictionsresearchtraining.ca>).

- e. Increase understanding of the treatment needs of Aboriginal women and women from different sexual orientations (e.g., lesbian, gay, bisexual, transgender).
3. Adopt a population health approach related to mental health and addiction emphasizing harm reduction, as well as abstinence, as the primary goal of services targeting alcohol use.
- a. Conduct a formal review and impact analysis of the health and economic effects of alcohol in Ontario and thereafter develop a provincial alcohol strategy.
 - b. Examine service use patterns to identify who is not accessing services based on epidemiological data. Challenge service suppliers to respond by eliminating barriers to access, including stigma. Eliminating barriers may entail use of a different service model (e.g., use of the Ontario Telemedicine Network to support access to specialized services for rural and northern women).
 - c. Support 'Housing First' and other housing policies. Ontario has recently implemented an Addictions Rent Supplement Program, providing housing to those who have frequently used the addictions treatment system and are homeless due to substance abuse.
 - d. Provide policy support to programs who respond to the broad needs of women in their programs; either through cross-sectoral collaboration, or through direct practical responses to needs like transportation, childcare, health care costs [12], recognizing that women are marginalized by a number of factors, most of which are outside the control of addiction services.
 - e. Implement a mandated social responsibility role for government run retailing to protect public health and safety, and to provide a balance to the profit orientation in recognition of the public health costs of alcohol.
 - f. Include in the Assessment and Treatment planning process support for tobacco use reduction recognizing the research evidence supporting concurrent intervention [81, 82].

Conclusions

Ontario is blessed with strong leadership within the addiction sector advocating for the needs of women and supported by a body of academic work from across Canada. This has supported the development of some excellent programs available to some women in the province. It is clear that much is known about how the approach to care can be improved. What is needed is

support - including targeted funding demonstrating this as a priority for the MOHLTC. Alcohol abuse costs the current Ontario system \$1.5 billion in health care costs, with only \$262 million of those costs reflecting the estimated treatment costs [83]. Contributing to system shifts in culture and implementation of best practices has happened when: targeted funding has been applied to catalyze change, MOHLTC has shown interest in emerging practices, leadership has come from those providing specialized services, and when funding has been available to stabilize core services [12]. Consistent adoption of best practices could enhance outcomes and support health for many more Ontario women who misuse alcohol.

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Appendix A: Expert Panel Members

Echo would also like to acknowledge the contributions of the Expert Panel in the creation of this recommendations report:

Samina Talat, CEO, Aurat Health Services, Brampton/Mississauga/Toronto (Expert Panel Chair)

Debbie Bang, Integrated Manager, Womankind Addiction Services, Hamilton

Nancy Black, Manager, Mental Health, Addiction & Problem Gambling Programs, Sister Margaret Smith Centre, Thunder Bay

Nancy Bradley, Executive Director, Jean Tweed Centre, Toronto

Pat Campbell, CEO, Echo: Improving Women's Health in Ontario

Cathy Edwards, Public Health Nurse, KFL&A Public Health, Kingston

Dr. Kathryn Graham, Senior Scientist and Head, Social and Community Interventions and Policy Research Group, CAMH, London/Toronto; Dalla Lana School of Public Health, University of Toronto; National Drug Research Institute, Curtin University, Perth, Western Australia

Dr. Simone Kaptein, Knowledge Translation Specialist, Echo: Improving Women's Health in Ontario

Dr. Nazilla Khanlou, Echo Chair on Women's Mental Health and Addiction, York University

Gundel Lake, Counsellor, Amethyst Women's Centre, Ottawa

Susan Macphail, Director of Women's Mental Health Resources, WOTCH Community Mental Health Services, London

Cris Rego, Provincial Aboriginal Training Consultant, CAMH, Sudbury Office

Kathryn Irwin-Seguin, Executive Director, Iris Addiction Recovery for Women, Sudbury

We also acknowledge the contribution of Dr. Leigh Hayden in the creation of the Expert Panel for this project.

Appendix B: Definitions

The following table outlines the distinction between at-risk drinking and the DSM diagnoses of alcohol abuse and alcohol dependence:

- **At-risk drinking** refers to consumption above the low-risk guidelines.
- **Alcohol abuse** refers to hazardous or socially inappropriate behaviour while drinking (e.g., dangerous driving).
- **Alcohol dependence** is a psychological syndrome characterized by compulsive drinking and loss of control over consumption

Indicators	At-risk drinking	Alcohol abuse	Alcohol dependence
Withdrawal symptoms	No	No	Almost always
Tolerance	Mild	Mild	Marked
Weekly consumption	Above low-risk guidelines	Binge drinking	40 or more drinks per week
Fewer than four drinks per day	Often	Sometimes	Rarely
Social consequences	Nil or mild (e.g., occasional argument with spouse, fatigue at work)	Often severe (e.g., legal, job loss)	Often severe
Physical consequences	Nil or mild (e.g., hypertension, insomnia, fatty liver, hypertriglyceridemia)	Trauma and violence	Often severe (e.g., cirrhosis, pancreatitis)
Socially stable	Usually	Usually	Often not
Neglect of major responsibilities	No	During a binge	Yes

Source: CAMH Knowledge X website, Copyright, 2010, CAMH and St. Joseph's Health Centre, Toronto.

Appendix C: Ontario Treatment Data by Sex, Problem Substance, Type of Treatment, and by LHIN

Open Admissions by Gender (excludes Family Member) April 1, 2007 to March 31, 2010

Note:

1) Only includes clients where client received a service in a MoHLTC funded substance abuse (SA) program

Gender	2007 - 2008		2008 - 2009		2009 - 2010	
	N	%	N	%	N	%
Male	69,549	67.3	68,860	67.3	71,046	67.7
Female	33,736	32.6	33,368	32.6	33,865	32.3
Other	60	0.1	44	0	43	0
Total	103,345	100	102,272	99.9	104,954	100

This report is prepared by DATIS from:

Data extracted on May 25, 2008 for 2007 - 2008.

Data extracted on May 2, 2009 for 2008 - 2009 .

Data extracted on May 9, 2010 for 2009 - 2010.

Open Admissions by Presenting Problem Substance (excludes Family Member) April 1, 2007 to March 31, 2010

Note:

1) Up to five substances may be reported in an admission, therefore column totals may not add up to the total number of admissions and percentages may not add up to 100. All Presenting Problem Substances reported are counted in the table.

Presenting Problem Substances	2007 - 2008						2008 - 2009						2009 - 2010					
	Male		Female		Other		Male		Female		Other		Male		Female		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Alcohol	49,160	47.6	21,049	20.4	35	0.0	49,340	48.2	21,178	20.7	21	0.0	50,875	48.5	21,337	20.3	30	0.0
Cannabis	22,674	21.9	10,419	10.1	23	0.0	23,205	22.7	10,560	10.3	15	0.0	23,873	22.7	10,296	9.8	13	0.0
Cocaine	15,654	15.1	7,361	7.1	6	0.0	13,738	13.4	6,946	6.8	4	0.0	12,007	11.4	5,928	5.6	3	0.0
Crack	13,703	13.3	7,195	7.0	22	0.0	12,986	12.7	6,705	6.6	19	0.0	11,472	10.9	5,850	5.6	7	0.0
Amphet. & other stimulants exc. methamphetamines	1,159	1.1	722	0.7	0	0.0	1,071	1.0	661	0.6	1	0.0	1,090	1.0	614	0.6	1	0.0
Benzodiazepines	2,078	2.0	1,467	1.4	3	0.0	2,113	2.1	1,432	1.4	1	0.0	2,330	2.2	1,494	1.4	3	0.0
Barbiturates	169	0.2	160	0.2	0	0.0	168	0.2	164	0.2	0	0.0	161	0.2	143	0.1	0	0.0
Heroin/Opium	1,381	1.3	592	0.6	1	0.0	1,486	1.5	614	0.6	2	0.0	1,724	1.6	692	0.7	1	0.0
Prescription opioids	8,575	8.3	5,469	5.3	5	0.0	9,795	9.6	6,257	6.1	7	0.0	11,637	11.1	7,460	7.1	12	0.0
Over-the-counter codeine preparations	798	0.8	716	0.7	1	0.0	852	0.8	719	0.7	1	0.0	972	0.9	687	0.7	1	0.0
Hallucinogens	927	0.9	459	0.4	0	0.0	851	0.8	382	0.4	0	0.0	736	0.7	295	0.3	0	0.0
Glue & other inhalants	525	0.5	132	0.1	0	0.0	492	0.5	129	0.1	0	0.0	565	0.5	83	0.1	0	0.0
Steroids	91	0.1	26	0.0	0	0.0	92	0.1	30	0.0	1	0.0	98	0.1	23	0.0	0	0.0
Ecstasy	2,135	2.1	1,393	1.3	3	0.0	1,671	1.6	1,242	1.2	2	0.0	1,579	1.5	950	0.9	3	0.0
Other psychoactive drugs	564	0.5	515	0.5	0	0.0	562	0.5	484	0.5	0	0.0	571	0.5	477	0.5	1	0.0
Methamphetamines (crystal meth.)	712	0.7	444	0.4	3	0.0	884	0.9	486	0.5	2	0.0	1,041	1.0	495	0.5	0	0.0
Tobacco	12,686	12.3	6,590	6.4	7	0.0	13,595	13.3	7,027	6.9	7	0.0	15,456	14.7	7,339	7.0	3	0.0
Undifferentiated	171	0.2	94	0.1	1	0.0	64	0.1	35	0.0	1	0.0	4	0.0	7	0.0	0	0.0
None	972	0.9	851	0.8	0	0.0	1,011	1.0	840	0.8	0	0.0	1,105	1.1	1,025	1.0	2	0.0
Unknown	983	1.0	709	0.7	6	0.0	893	0.9	531	0.5	2	0.0	1,074	1.0	653	0.6	1	0.0
Missing	92	0.1	91	0.1	0	0.0	106	0.1	75	0.1	0	0.0	135	0.1	57	0.1	0	0.0

This report is prepared by DATIS from:

Data extracted on May 25, 2008 for 2007 - 2008.

Data extracted on May 2, 2009 for 2008 - 2009 .

Data extracted on May 9, 2010 for 2009 - 2010.

**Open Registration by Provincial Service Category (excludes Family Member)
April 1, 2007 to March 31, 2010**

Notes:

1) Only includes clients where client received a service in a MHLTC funded substance abuse (SA) program.
2) If a client is registered in one or more programs in the same Provincial Service Category (PSC) during the same admission, those program registrations are counted as one registration for the PSC. If a client has one or more program registrations in this PSC in one or more admissions during the fiscal year, one registration to this PSC is counted for each admission.

Provincial Service Category	2007 - 2008						2008 - 2009						2009 - 2010					
	Male		Female		Other		Male		Female		Other		Male		Female		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Case Management	17,280	59.6	11,733	40.4	7	0.0	16,759	59.61	11,347	40.4	8	0.0	17,567	61.8	10,843	38.2	12	0.0
Community Treatment	19,890	60.2	13,161	39.8	14	0.0	20,832	60.39	13,657	39.6	8	0.0	22,617	61.7	14,054	38.3	13	0.0
Community Day/Evening Treatment Services	1,638	58.2	1,175	41.8	1	0.0	1,690	59.47	1,149	40.4	3	0.1	2,066	62.7	1,228	37.3	2	0.1
Community Medical/Psychiatric Treatment Services	131	58.5	92	41.1	1	0.5	128	53.11	112	46.5	1	0.4	118	53.2	104	46.9	0	0.0
Community Withdrawal Management Services	684	49.6	675	50.4	0	0.0	916	57.72	670	42.2	1	0.1	879	51.7	819	48.2	1	0.1
Initial Assessment Treatment Planning	24,890	64.9	13,445	35.1	20	0.1	25,650	64.82	13,905	35.1	17	0.0	26,287	65.1	14,066	34.8	18	0.0
Residential Medical/Psychiatric Treatment Services	92	51.4	87	48.6	0	0.0	123	55.16	100	44.8	0	0.0	110	51.4	104	48.6	0	0.0
Residential Support Treatment Services	1,821	83.8	349	16.1	2	0.1	1,802	85.04	315	14.9	2	0.1	1,722	83.0	351	16.9	1	0.1
Residential Treatment Services	4,270	64.2	2,376	35.7	2	0.0	4,031	63.38	2,325	36.6	4	0.1	4,060	63.9	2,296	36.1	3	0.1
Residential Withdrawal Management Services	29,433	75.9	9,329	24.1	26	0.1	28,365	76.54	8,679	23.4	15	0.0	29,282	76.9	8,773	23.1	13	0.0

This report is prepared by DATIS from:
Data extracted on May 25, 2008 for 2007 - 2008.
Data extracted on May 2, 2009 for 2008 - 2009.
Data extracted on May 9, 2010 for 2009 - 2010.

**Open Admissions by LHIN of Treatment(excludes Family Member)
April 1, 2007 to March 31, 2010**

LHIN OF TREATMENT	2007 - 2008						2008 - 2009						2009 - 2010					
	Male		Female		Other		Male		Female		Other		Male		Female		Other	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Central	1,672	1.6	480	0.5	8	0.0	1,841	1.8	560	0.5	4	0.0	1,980	1.9	588	0.6	2	0.0
Champlain	6,730	6.5	3,901	3.8	4	0.0	6,672	6.5	3,941	3.9	1	0.0	6,658	6.3	3,761	3.6	0	0.0
North East	8,123	7.9	4,048	3.9	14	0.0	8,036	7.9	4,132	4.0	1	0.0	7,919	7.5	4,143	3.9	3	0.0
North West	9,279	9.0	3,622	3.5	1	0.0	8,703	8.5	3,223	3.2	4	0.0	8,795	8.4	3,240	3.1	4	0.0
South East	3,646	3.5	1,579	1.5	2	0.0	3,449	3.4	1,460	1.4	2	0.0	3,736	3.6	1,519	1.4	6	0.0
South West	3,641	3.5	1,589	1.5	1	0.0	4,155	4.1	1,692	1.7	1	0.0	4,272	4.1	1,820	1.7	0	0.0
Central East	6,532	6.3	3,424	3.3	2	0.0	5,213	5.1	2,777	2.7	1	0.0	5,585	5.3	2,744	2.6	2	0.0
Central West	1,352	1.3	524	0.5	2	0.0	1,384	1.4	465	0.5	0	0.0	1,599	1.5	490	0.5	2	0.0
Erie St. Clair	3,127	3.0	1,561	1.5	1	0.0	3,041	3.0	1,653	1.6	1	0.0	3,247	3.1	1,850	1.8	1	0.0
Toronto Central	9,846	9.5	5,248	5.1	12	0.0	11,219	11.0	5,622	5.5	15	0.0	11,708	11.2	5,754	5.5	18	0.0
Mississauga Halton	2,050	2.0	998	1.0	0	0.0	1,685	1.6	992	1.0	0	0.0	1,823	1.7	1,066	1.0	1	0.0
Waterloo Wellington	2,816	2.7	1,406	1.4	0	0.0	2,923	2.9	1,537	1.5	2	0.0	3,343	3.2	1,656	1.6	1	0.0
North Simcoe Muskoka	2,343	2.3	1,248	1.2	1	0.0	2,390	2.3	1,206	1.2	0	0.0	2,342	2.2	1,291	1.2	0	0.0
Hamilton Niagara Haldimond Brant	8,392	8.1	4,108	4.0	12	0.0	8,149	8.0	4,108	4.0	12	0.0	8,039	7.7	3,943	3.8	3	0.0

This report is prepared by DATIS from:
Data extracted on May 25, 2008 for 2007 - 2008.
Data extracted on May 2, 2009 for 2008 - 2009.
Data extracted on May 9, 2010 for 2009 - 2010.

Appendix D: Ontario Services Available to Women

Ontario Services Available to Women		* accept men and women										C women only services		Provincial and Regional resources		Women focused programs		
		Available in to all communities				Available in most semi urban and urban communities						Tier 4		Tier 5				
		Tier 1	Tier 1	Tier 2	Tier 2	Tier 2/3	Tier 2/3	Tier 3	Tier 3	Tier 4	Tier 4	Tier 4	Tier 4	Tier 4/5	Tier 5	Tier 5		
		Public health Injury and Substance Misuse included in mandatory standard for public health	After care Programs - included in community treatment statistics	Primary Care and emergency services support early identification and brief intervention	Early Years and Early Child Development programs	Initial Assessment and treatment planning	Support within housing program - (rent subsidy)	Community day/evening treatment services	Community Withdrawal Management Services	Community treatment	Residential Treatment services	Community Medical/Psychiatric Treatment Services	Case Management - included in community treatment statistics	Residential Withdrawal Management services	Residential Support treatment services (addiction treatment is not part of the service)	Residential Medical/Psychiatric Treatment Services		
LHIN																		
Central	*			Primary care is available across the province but no assessment was made regarding how primary care offers alcohol use supports nor primary care availability for women who experience marginalization		*C		*	* 2	*C				*3	* 2			
Central East	*					*C			*C	* 2	*C	*C	*		*2			Jean Tweed, Lakeridge Health (Destiny)
Champlain	*	C				*C			*C	* 1	*C	*C	*		*2+3	* 1 + C 1	*	Amethyst, Fraternity House for women, Empathy House, Newgate 180- women's program, Vesta Recovery
Hamilton Niagara, Haldimand Brant	*	C				*C			*C		*C	*C		* MMT	* 1 + *C 2	* C 2 and *C 1		Womankind, Niagara Health System (Newport, ABC program)
Mississauga Halton	*	*C				*C			*C	* 1	*C	*C	*	* MMT	*2			Hope Place
North East	*	*C				*C	*		*C	* 2	*C	*C	*	* MMT	*2	* C 1 and * 2		Iris, Breton House
North Simcoe Muskoka	*					*C	*			* 1	*C		*		*2		*	
North West	*					*C	*				*	*C	*	* MMT	*2	*C 1 + * 2		Sister Margaret Smith, Changes (Clarissa), Dilco
South East	*					*					*	*C	*	* MMT	*2			Brock Cottage (Tenant House)
South West	*					*			*		*C	*	*		*2	* Level 1		
Toronto Central	*	*C				*C	*		*C	* 2 +C2	*C	*C	*	* MMT	* C2	* - Level 1		416 Community Support for women, Breaking the Cycle, Elizabeth Fry, Jean Tweed, Salvation Army Homestead, Streethaven, Women's Own WMS, Grant House, Graham Munroe, Loft, CAMH
Waterloo	*																	
Wellington	*	*				*C			*C		*C	*C					*	House of Friendship, Bridges to Health, Stonehenge
Erie St Clair	*	*C							*C		*C	C			*	C		House of Sophrosyne
Central West	*				*			*		*	*		*	*2				

Data Source: Drug and Alcohol Registry of Treatment

Level 1= non medical

Level 2= with medical consultation

Appendix E - Wait Times for Addiction Treatment in Ontario

Data Source: **ConnexOntario** Health Services Information.

As part of the transfer payment agreement with the Ministry of Health and Long-Term Care (MOHLTC), all organizations that receive ministry funding to provide mental health and addictions services must enter into an agreement with **ConnexOntario** Health Service Information for the provision of information to the Drug & Alcohol Helpline (DAH), Ontario Problem Gambling Helpline (OPGH) and Mental Health Helpline (MHH) registries, including regular reporting of the availability of service.

Availability or 'wait time', as reported to **ConnexOntario**, refers to an estimated date of the next available treatment slot, where treatment slot refers to the next available bed, appointment date, and/or caseload opening, depending on the type of service. Note that the wait time information includes programs where there was no wait for service (0 days).

The reports include the average, median and range in wait times for service during the fiscal quarter by the LHIN where the service is located.

The service categories presented are based on the Provincial service Categories for addiction, which submit availability information to **ConnexOntario**. Note that residential withdrawal management services are not required to report availability information to **ConnexOntario**. The categories and reporting frequency are described below.

Limitations:

Organizations are to report availability information regularly to **ConnexOntario**. It is worth noting, however, that some organization may not provide updated information when scheduled. The reported information reflects the expected wait for service, which may differ from the actual wait time.

As noted, the wait time reflects the time to the next available treatment slot and is reported by the agency providing the service. It is worth noting that this may differ from the experienced wait time for specific service recipients.

The categories of service located within a LHIN differ, which complicates the comparison of wait time between LHINs. Note that services may provide service to residents of other LHINs.

Wait times (in days) for treatment by type of program from 2005 - 2010 for the province.

Type of program	LHIN	Fiscal Year	Case Management	Community Day / Evening Treatment	Community Medical / Psychiatric Treatment	Community Treatment	Community Withdrawal Management Level 1	Community Withdrawal Management Level 2	Initial Assessment / Treatment Planning	Residential Medical / Psychiatric Treatment	Residential Supportive Level 1	Residential Supportive Level 2	Residential Treatment	Support within Housing
			Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
Undifferentiated														
15	Province	FY 2005		16	34	19	12	1	17	33	1	0	42	
15	Province	FY 2006		18	51	21	11	1	16	29	5		62	
15	Province	FY 2007		17	35	20	3	1	20	113	1		38	
15	Province	FY 2008	39	20	69	25	9	2	21	106	6		40	
15	Province	FY 2009	40	13	50	22	1	1	16	90	9		35	
15	Province	FY 2010	22	13	55	19	2	1	15	96	11		45	
All programs														
15	Province	FY 2005		17	32	15	12	0	13	33	20	20	40	
15	Province	FY 2006		20	51	20	11	1	16	29	18	21	46	
15	Province	FY 2007		15	35	18	3	1	18	113	13	12	42	
15	Province	FY 2008	39	17	69	22	9	2	21	106	20	18	48	
15	Province	FY 2009	40	11	50	20	1	1	15	90	22	15	44	
15	Province	FY 2010	22	12	55	18	2	1	14	96	25	17	46	
Male														
15	Province	FY 2005		10	0	1		0	1	0	22	22	30	
15	Province	FY 2006		19		9			7		26	30	40	
15	Province	FY 2007		19		1			6		20	13	41	
15	Province	FY 2008		14		5			13		23	17	51	
15	Province	FY 2009		6		11		2	10		25	15	50	
15	Province	FY 2010	0	4		16			16		30	18	52	
Female														
15	Province	FY 2005		13	0	5		0	3	0	15	16	27	
15	Province	FY 2006		24		13			16		13	10	43	
15	Province	FY 2007		9		8			9		7	11	52	
15	Province	FY 2008		12		6			19		19	19	59	
15	Province	FY 2009		8		10		2	14		24	13	53	
15	Province	FY 2010		11		9		1	9		24	13	48	

Wait times (in days) for treatment by type of program by LHIN for the year 2010.

ALL PROGRAMS													
LHIN #	LHIN	Fiscal Year	Case Management	Community Day / Evening Treatment	Community Medical / Psychiatric Treatment	Community Treatment	Community Withdrawal Management Level 1	Community Withdrawal Management Level 2	Initial Assessment / Treatment Planning	Residential Medical / Psychiatric Treatment	Residential Supportive Level 1	Residential Supportive Level 2	Support within Housing
			Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
1	Erie St. Clair	FY 2010	1	0	0	2	0	18					50
2	South West	FY 2010		15		31		21		36			63
3	Waterloo Wellington	FY 2010	0	9		28		18					81
4	Hamilton Niagara Haldimand Brant	FY 2010	69	4		11	1	15		1	49		73
5	Central West	FY 2010	6	1		23		25					160
6	Mississauga Halton	FY 2010	23			19	0	21					52
7	Toronto Central	FY 2010	0	9		8		2	7	42	2		26
8	Central	FY 2010		0		32		3	25				41
9	Central East	FY 2010	3	28		9		1	13				64
10	South East	FY 2010	0			32		10					26
11	Champlain	FY 2010		31	83	25	0	19	96	17			29
12	North Simcoe Muskoka	FY 2010	73			23	4	13					33
13	North East	FY 2010	30	8		15		0	6	20	13		28
14	North West	FY 2010	9	26		5		4		19		84	

MALE PROGRAMS

LHIN #	LHIN	Fiscal Year	Case Management	Community Day / Evening Treatment	Community Medical / Psychiatric Treatment	Community Treatment	Community Withdrawal Management Level 1	Community Withdrawal Management Level 2	Initial Assessment / Treatment Planning	Residential Medical / Psychiatric Treatment	Residential Supportive Level 1	Residential Supportive Level 2	Residential Treatment	Support within Housing
			Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
1	Erie St. Clair	FY 2010	0										0	
2	South West	FY 2010								40			66	
3	Waterloo Wellington	FY 2010							0				148	
4	Hamilton Niagara Haldimand Brant	FY 2010		0		10			49		1	49	111	
5	Central West	FY 2010		1										
6	Mississauga Halton	FY 2010				18			15				87	
7	Toronto Central	FY 2010		11		4			7		49	2	22	
8	Central	FY 2010		0					0				41	
9	Central East	FY 2010											64	
10	South East	FY 2010											27	
11	Champlain	FY 2010				0			17		14		33	
12	North Simcoe Muskoka	FY 2010											33	
13	North East	FY 2010				24			13		35		19	
14	North West	FY 2010		4		0			0		21		69	

FEMALE PROGRAMS

LHIN #	LHIN	Fiscal Year	Case Management	Community Day / Evening Treatment	Community Medical / Psychiatric Treatment	Community Treatment	Community Withdrawal Management Level 1	Community Withdrawal Management Level 2	Initial Assessment / Treatment Planning	Residential Medical / Psychiatric Treatment	Residential Supportive Level 1	Residential Supportive Level 2	Residential Treatment	Support within Housing
			Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
1	Erie St. Clair	FY 2010			0								37	
2	South West	FY 2010			62				3		53			
3	Waterloo Wellington	FY 2010		14	47				26				96	
4	Hamilton Niagara Haldimand Brant	FY 2010		23	6				6		2		30	
5	Central West	FY 2010												
6	Mississauga Halton	FY 2010			8				47				35	
7	Toronto Central	FY 2010		6	4		1		2		15		25	
8	Central	FY 2010			1				1					
9	Central East	FY 2010		28	4				4				47	
10	South East	FY 2010			18				18				25	
11	Champlain	FY 2010			12				19		25		32	
12	North Simcoe Muskoka	FY 2010			4				4					
13	North East	FY 2010		0	23				18		31	13	49	
14	North West	FY 2010		1	0			0		14		79		

UNDIFFERENTIATED PROGRAMS

LHIN #	LHIN	Fiscal Year	UNDIFFERENTIATED PROGRAMS										
			Case Management	Community Day / Evening Treatment	Community Medical / Psychiatric Treatment	Community Treatment	Community Withdrawal Management Level 1	Community Withdrawal Management Level 2	Initial Assessment / Treatment Planning	Residential Medical / Psychiatric Treatment	Residential Supportive Level 1	Residential Supportive Level 2	Residential Treatment
			Average	Average	Average	Average	Average	Average	Average	Average	Average	Average	Average
1	Erie St. Clair	FY 2010	1	0	0	2	0		18				80
2	South West	FY 2010		15		30			21		12		60
3	Waterloo Wellington	FY 2010	0	0		22			18				41
4	Hamilton Niagara Haldimand Brant	FY 2010	69	4		12		1	15				22
5	Central West	FY 2010	6			23			25				160
6	Mississauga Halton	FY 2010	23			21	0	1	19				
7	Toronto Central	FY 2010	0	10		10		2	14				37
8	Central	FY 2010		0		39		3	33				
9	Central East	FY 2010	3			15		1	18				97
10	South East	FY 2010	0			34			8				
11	Champlain	FY 2010		31	83	28	0		19	96	13		18
12	North Simcoe Muskoka	FY 2010	73			26	4		14				
13	North East	FY 2010	30	9		14		0	6		2		21
14	North West	FY 2010	9	48		5			4				91

Appendix F: Guiding Concepts of Tiered Model

GUIDING CONCEPTS OF THE TIERED MODEL OF SERVICES AND SUPPORTS

No wrong door. A person may access the continuum of services and supports by way of any of the five tiers and, upon entry, should be linked to other needed services and supports, either in the same tier or in a different tier. Co-ordination of this linkage is the responsibility of the system, not the individual. To ensure that this principle can be applied in practice, all sectors should routinely screen people for substance use problems and provide ready access to comprehensive assessment services if needed.

Availability and accessibility. Services and supports in all tiers should be both available and accessible within a reasonable distance and travel time of each person's home community, or should be facilitated by different means (e.g., telehealth, online or mobile services).

Matching. A person should be matched to services and supports whose intensity is appropriate to his or her needs and strengths. Matching implies a need not only for standardized screening and assessment tools, but also for processes that respect each person's informed choice of what type of care may work best for him or her (based on cultural relevance, language group or other considerations).

Choice and eligibility. If more than one service or support meets a person's needs, the person should be able to choose among those services and supports for which he or she is eligible. A person should be able to access services and supports within a given tier and across different tiers, as needed over time, though the focus might be in a particular tier at a given time.

Flexibility. A person should be referred from a lower tier to a higher tier (stepped up) or from a higher tier to a lower tier (stepped down) as appropriate to his or her needs.

Responsiveness. People—and their needs—change over time and with changing circumstances. As a person travels along pathways and through the lifespan, he or she should be given the help needed (e.g., information, referral, assessment, treatment) to ultimately shift the focus to services and supports in lower tiers.

Collaboration. A person's journey through the pathways should be facilitated by collaboration between providers of distinct kinds of services and supports. Collaboration should occur both at the clinical level (e.g., through shared service protocols between different providers) and at the administrative and organizational levels (e.g., through partnerships and inter-agency agreements), and should always include the person seeking help.

Co-ordination. To facilitate service delivery as well as system planning, monitoring and evaluation, health information systems should allow easy sharing of information between systems.

Source: National Treatment Strategy Group, A systems approach to substance use in Canada: Recommendations for a National Treatment Strategy, 2010.