Confidential

Malachy Tohill
Regional Director
BC Housing, Northern Region
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Prince George BC V2L 3S6

July 19, 2011

Dear Mr. Tohill,

The following are the initial operational findings relating to our review of the Baldy Hughes Addiction Treatment and Therapeutic Community. This report reflects an initial overview of Baldy Hughes and is by no means complete or final. We hope that the information provided will be helpful as you begin the very important process of ongoing planning and quality improvement practices to enhance programs and services.

1. Introduction

On July 7, 2011, you asked us to perform an operational review of the *Baldy Hughes* residential *Addiction Treatment Centre and Therapeutic Community*. The scope of our review was to provide an external opinion as to the way in which the centre was operating, to evaluate the treatment model and methods, provider records and documentation, human resource policies and procedures, current staffing, financial performance, and compliance with regulatory requirements. The process of our review involved surveying the following:

- Tour of the facility by Malachy Tohill
- Review of available documentation to include an Operations Manual, Procedure Manual, Resident Handbook, Transformative Change Report, Human Resource Manual, and Staff and Resident files
- Communication with staff members and current and past residents to clarify the site review, to verify how the review would be conducted, and to identify the services that would be reviewed
- Meetings and communication with medical, addiction, and mental health professionals and local agencies in the community

2. Licensing

Northern Health sets forth and monitors essential health, safety, and quality care standards for residential facilities in the Northern community. These standards have been developed to ensure a base level of protection for all individuals in care facilities throughout Northern British Columbia.

Northern Health defines a Community Care Facility as "a premise or part of a premise in which a person provides care to 3 or more persons who are not related by blood or marriage to the person and includes any other premises or part of a premise that, in the opinion of the medical health officer, is used in conjunction with the community care facility for the purpose of providing care."

"Care" means supervision that is provided to an adult who is:

a. Vulnerable because of family circumstances, age, disability, illness or frailty, and
a. Dependent on caregivers for continuing assistance or direction in the form of 3 or more prescribed services.

Of the six "Prescribed Services" listed, four currently apply to Baldy Hughes:

a. Central storage of medication, distribution of medication, administering medication or monitoring the taking of medication;
b. Maintenance or management of the cash resources or other property of a resident or person in care;
c. Structured behavior management and intervention; and
d. Psychosocial rehabilitative therapy, which refers to "community support systems."

The licensing process includes an inspection of the facility and review of the operations and policies and procedures in all areas of care.

Findings

Baldy Hughes is not presently licensed under the Community Care and Assisted Living Act and Adult Care Regulation and it does not appear that it would currently meet licensing requirements for standards of care. Numerous examples of non-conformance with licensing standards have been observed in all cornerstones of the facility and program to include: clinical, health and safety, human resources, and business practices. Important areas include: Physical Facility, Staffing, Policies and Procedures, Records and Reporting, Food Services, Nutrition and Medication.

A. Medication:

1. No training or inadequate training has been provided to staff regarding Medication storage, administration, and record keeping;
2. Current Medication Administration Records (MAR) are difficult to read and not up to date;
3. There is no staff signature sheet, meaning there is no way to reconcile the signed initials of the staff on the MAR (those who dispensed medication) with the actual staff; and
4. Multiple sources report medication errors occur on a regular basis.

We spoke with the contracted Pharmacist who has "numerous and serious concerns about medication management the past year and a half." He specifically cited lack of trained staff administering medication and lack of clarity and implementation of Baldy Hughes internal medication policies and procedures.

B. Community:

While meeting with several other local medical, addiction and mental health professionals throughout our visit, licensing was uniformly one of their first questions about the facility and all expressed significant concern about the lack of licensing, and others inquired further as to the lack of accreditation. They also mentioned knowing very little about the facility and program and were not aware of any working relationships within the local medical, addiction and mental health community. They recounted efforts to connect with the staff and learn about the program. They made verbal requests to visit the facility, discuss referent care, and liaison regarding case consultation of some of their former clients attending the facility. Their experience was that it was "a closed community," which reflects concerns regarding the accountability and transparency of the program and facility.

We observed nothing that would comfortably assure us that the facility was in the process of raising the standards of care.

Recommendations

A. ***As a minimum standard for an addiction treatment centre, Baldy Hughes needs to be compliant with Provincial Legislation and local regulatory requirements in the form of becoming Licensed by Northern Health.***

B ***The facility is not accredited. Accreditation offers a high level of standards, increases accountability, and lessens risk. It can significantly reduce government monitoring and streamline regulation processes. Examples of appropriate accrediting bodies are provided :***
www.carfcanada.org
www.accreditation.ca

3. Addiction Treatment Centre Model and Methods

Findings

A. The Baldy Hughes website www.baldyhughes.ca is the only documentation we were able to find on the treatment program and methods. Our observation is that the treatment program that currently exists is undocumented. Group work is the primary treatment modality utilized and it is facilitated by one clinician and a few support staff. Several short-term manuals and workbooks for Cognitive-Behavioral Treatment Curriculum was noted e.g. "Criminal and Addictive Thinking." Upon inquiry, the majority of the staff were unsure as to how to uniformly present the material and stated that the residents have not been receptive to the material presented in these manuals. Individuals are also encouraged to utilize the 12-step principles in their recovery and five on-site meetings are offered weekly. There was no individual or group support for basic life skills with which to support a base-line level of self-care.

B. Intake and Assessments:

1. Intake Information and assessments were not complete;
2. There was no evidence of assessments using validated research and reliable instruments;
3. Dual diagnosis patients are at a high risk for suicide. No standard suicide assessment was available, and
4. Baseline health data such as blood pressure, allergies, and medical alerts are not available or clearly identified.

C. Discharge Planning and Aftercare Plans:

1. Upon review of open and closed files, discharge plans were not consistently documented, not appropriately completed, or non-existent.
2. Upon inquiry, staff stated reasons of staffing constraints, lack of training, and high levels of unplanned departures.

D. Resident Charts:

1. Confidential information is not appropriately secured;
2. Charting is narrative in nature without a clearly defined standard format to identify goals and objectives and current and ongoing needs for process notes; and
3. Charts are not complete or legible on a consistent basis

E. Internal Policy and Procedure Manual:

Confidentiality Waiver: There are concerns regarding accuracy and informed consent for the signing individual. While the form gives consent to release and exchange information to several parties (e.g. Ministry of Housing , Ministry of Education), it is not specified if these groups within themselves have permission for release, receiving, and exchanging of information.

F. Nutrition and Exercise:

1. The menu does not appear to follow Canada's Food Guide to promote healthy eating; e.g. it presents as high in carbohydrates and fat and there are no healthy snacks available between meals;
2. Powdered milk was being served to residents;
3. Residents expressed wanting their food preferences to be taken into consideration;
4. Residents expressed wanting guided instruction for nutrition and fitness and exercise boundaries to assist in healthier lifestyle behaviors; and
5. Residents have no guided nutrition or exercise plans

G. Lack of Life Skills Programming:

1. Many residents described histories significant with difficulty in life skills and self-care, and cited the examples of cooking, managing finances, making their beds, and brushing/flossing their teeth daily were difficult for them to do and maintain.
2. A newly hired mental health professional offered the observation that "there does not appear to be an actual program; rather a small number of individuals attend groups led by a single individual."

H. Transformative Change: A Benchmarking Report for the Baldy Hughes Addiction Treatment Centre and Therapeutic Community, prepared by William J. Owen, 2010, For the BC New Hope Society.

Upon review of this report, we contacted Dr. William Owen to discuss details of the report and he kindly offered to meet to review the study with us but unfortunately was going away on holiday during the time of the review.

While it is beneficial to know how effective a program is in relation to similar treatment programs, caution should be used when interpreting

proxy data as is the case for determining cost-effectiveness of different treatment modalities by comparing Staff: Client Ratios for Baldy Hughes with Pacifica, MRTC, and Crossroads Treatment Facilities.

1. Baldy Hughes is not a licensed community care facility, and upon review, is not meeting licensing standards of care to include the area of staffing.
2. Pacifica is licensed by the Vancouver Coastal Health Authority.
3. MRTC is licensed by the Fraser Health Authority.
4. Crossroads is licensed by the Interior Health Authority.

In the New Hope Business Case dated November 14, 2007, pg. 39, it lists as a "Next Critical Step" the establishment of "a clinical advisory board to develop the treatment regime." We could not find any supporting documentation of a clinical advisory board or the development of a treatment regime.

Recommendations

A. ***A fundamental responsibility of the organization is to provide a comprehensive program structure. A written plan that guides the delivery of services should include: a description of the program, the philosophy of the program, the population of the program, program goals, description of the service modalities to be provided to achieve the program objectives, and assurance that adequate resources are available to deliver the identified goal. The program plan can be an internal document that is included in the policies and procedures.***

B. ***It is imperative that a sustainable treatment model and methods be developed by a clinical advisory board and documented specific to the needs of Baldy Hughes residents. The program needs to demonstrate that it has the facilities, space, materials, and staffing to provide the proper amount of care for the proper length of time based on the needs of the person served.***

C. ***The addition of a registered dietitian to review and guide menu planning to ensure it meets the recommendations of Canada's Food Guide to Healthy Eating. The dietitian could further assist in developing an audit program, which could include: a menu checklist, resident satisfaction survey, and a nutritional care plan checklist for those residents requiring a nutritional assessment and plan.***

D. ***A fitness/ exercise professional to assist in setting up healthy exercise programs***

E. *Evidence-based and outcome focused curricula should be implemented by a qualified and experienced team of clinicians who represent the integration of the fields of addiction and mental health. There is a high level of co-morbidity between substance abuse and trauma-related mental health and social problems. As a result, substance abuse problems need to be addressed in the context of a trauma-informed treatment.*

F. *The holistic program needs to be strength – based and the system needs to support the resident's ability to recover. The service planning process should be individualized, establishing goals and objectives that incorporate the unique strengths, needs, and abilities of the person served. The program should be monitored and updated to meet the evolving needs of the resident community. The persons served need to have the opportunity to transition easily through a system of care that integrates and establishes necessary community supports and resources when the individual returns to the community. Generally, the more "wrap-around" services provided, the better the outcomes.*

G. *Existing research and pre-evaluation and post- evaluation tools should be consulted and used to set recovery goals, design the program, set staffing levels, and plan aftercare services. Outcome measures may include the following domains:*

- *Abstinence from alcohol and drugs e.g. Addiction Severity Index (ASI)*
- *Mental health e.g. Global Assessment of Functioning (GAF);*
- *Employment/Education*
- *Crime and Criminal Justice*
- *Access/Service Capacity*
- *Retention in Treatment*
- *Housing*
- *Social Support/Social Connectedness*
- *Cost-Effectiveness*
- *Use of Evidence-Based Practices*
- *For individuals staying in residences supervised for extended periods of time, repeating measures related to daily functioning and quality of life are important e.g. Quality of Life Inventory (QOLI)*

These types of measures represent progress toward ultimate reintegration and recovery as well as desired outcomes.

Baldy Hughes should address in its data collection procedures how it demonstrates reliability and validity of the data collected. The data collection system should include measures for indicators in the areas of effectiveness and efficiency of services. It is recommended that Baldy Hughes develop for each performance indicator a performance goal based on an industry benchmark or a target established by Baldy Hughes or other stakeholders and that the extenuating factors be considered when analyzing performance, as applicable.

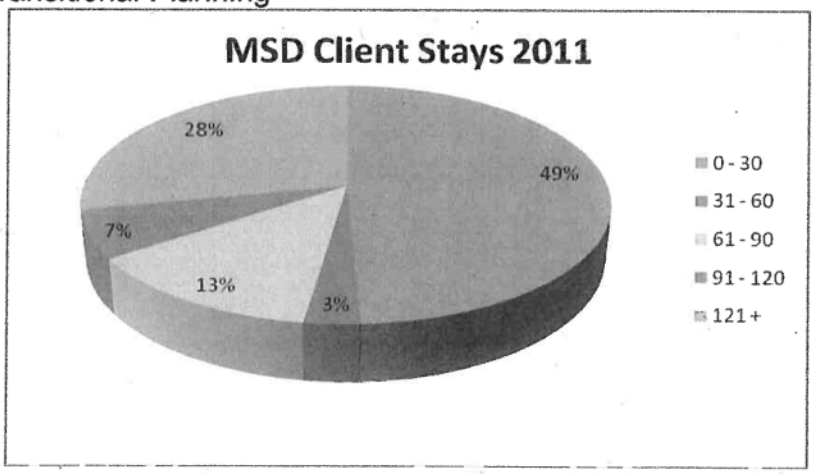
4. Therapeutic Community Model

The *Therapeutic Communities of America, Inc* definition is "The primary goal of a Therapeutic Community is to foster individual change and positive growth. This is accomplished by changing an individual's lifestyle through a community of concerned people working together to help themselves and each other." With such a broad definition there are many interpretations and models.

Findings

Based on the intake information the majority of residents have come to Baldy Hughes for Addiction Treatment. They expect to return to healthy functional lives in their communities. As a result, very few consider a long-term stay. There were no residents in the Therapeutic Community Phase when we arrived. We could find no written documentation of the Baldy Hughes Therapeutic Community "multiphase treatment model," other than described in the Transformative Change Report and on the Baldy Hughes website.

Phase 1: Intake 0-30 Days
Phase 2: Treatment Phase 31-90 Days
Phase 3: Therapeutic Community 90+ Days
Phase 4: Transitional Planning



We were informed by staff that the website has been changed at various points but the uniform feedback from staff, long term residents, and former residents is that the four phases of treatment and recovery presented were never fully developed or executed.

A. Phase 1: By the end of this Assessment/Orientation phase, residents are aware of the rules and procedures, are feeling comfortable as a member of the Therapeutic Community, and have committed themselves to the treatment program

B. Phase 2: Program planning relies on a singular approach that does not reflect building life skills and services available in the community. This does not transition individuals or establish necessary community supports when the individual returns to the community.

C. Phase 3: Therapeutic Community

1. Working farm not in operation
2. Greenhouse not complete; ceramics program not complete
3. On-site work programs not operating:
4. Kitchen program: not all residents working in the kitchen had completed a food safe training with certificates in HR files; there was confusion as to schedule of duties
5. No documentation of work duties and therapeutic duty assignments
6. Education program

We spoke with the head of the school program at Baldy Hughes. The program offers on site Adult Dogwood Program and during its 31/2 years of operation, it has served over 200 students.
A student records flow chart and the process for records management has been developed and appears to have overall good adherence. The feedback offered was that the long-term residential model works well in supporting residents in achieving their educational goals. Through a process of interviewing, file reviewing, and assessments, the educational needs of each resident whom wished to complete their Adult Dogwood Diploma is determined.

The head of the school program expressed concerns about students not having access to his contact information upon departure as an example of continuing care resources and discharge planning not being completed. He also spoke of a written proposal for students to participate in Distance Education courses via the internet but stated that the internet connection for the school building has never been turned on and that " the process has never been developed."

D. Phase 4: Transition/Re-entry

Discharge/transition plans are not being developed or completed. This is not supporting treatment goals or maximizing recovery gains. Community resources are key to allowing for the successful transition and reintegration of the residents back into their communities. A former client who returned back to Baldy Hughes to celebrate his one year of sobriety spoke of the " real difficulty" re-integrating back into his community due to a lack of life skills, constructive work support, and no discharge/aftercare plan linked to goals and services.

Recommendations

A. ***The Therapeutic Community is a sophisticated human services model with a developing body of Therapeutic Community related research. If Baldy Hughes wants to develop a sustainable Therapeutic Community model, offering addiction and behavioral health treatment, it is necessary that this model and program be designed and implemented by the clinical advisory board. The clinical advisory board could take the best elements of a Therapeutic Community social learning approach with evidence-based treatment to develop a program and methods that are well-defined and consistent with its goals to assist the residents in achieving independent and responsible lives.***

The therapeutic community model views the community as the modality for individual change e.g. the community as healer. The program's written plan needs to clearly identify the therapeutic community model through: the use of the mutual-help principle; program structure; schedules; rules; responsibilities; behavioral expectations; feedback mechanisms; therapeutic learning interventions and written work assignments etc.

B. ***Rehabilitation unfolds as a developmental process made up of incremental stages of learning. The phase system is designed to provide residents entering treatment with maximum structure and then assist them with gaining increased responsibility. In order to assist clients in rebuilding their lives through sequential phased integration, concrete and distinct program phases and progression through the phases needs to be distinguished by clear criteria defining success and readiness and by the attainment of specific behaviors and goals. The phase system is designed to assist patients in applying internalized treatment gains and recovery skills in their real life environments and maximize integration into the***

community. It would be helpful to align the specific needs of the residents group with the goals of recovery, the planned length of care, and the nature and extent of aftercare services (e.g. transitional housing, help finding a job, counseling aftercare resources, etc.)

Phase One: Intake and Orientation

1. *The use of standard tests and assessments using research validated and reliable instruments would be appropriate for the Baldy Hughes population in the intake phase.*

2. *The organization is urged to ensure that the primary assessment results in the form of the preparation of an interpretive summary based on the assessment data, be used in the development of the individual plan, and identify any co-occurring disorders and how they will be addressed in the development of the individual plan. Motivational interviewing strategies during individual sessions would assist in emphasizing individuals' responsibility and self-efficacy for change. Considering the high drop out rates of Therapeutic Communities, the addition of a focused orientation process would better engage the persons served at the beginning of services and may help to increase their commitment to the program.*

Phase Two: Treatment

1. *A systematic and individualized method for goal planning and achieving treatment goals is needed. Activities, events, education, skill development, and support should all focus on empowering individuals to live and work in the community. A variety of psycho-educational and life skills groups designed to teach essential cognitive and psycho-social skills can provide residents with concrete information, specific behavioral and problem solving skills, and assist residents in dealing and practicing these newly learned skills in structured daily living situations (e.g. hygiene and grooming; sleep; nutrition; exercise; budgeting; cooking etc.). Residents can explore alternatives in their lives, develop self-confidence, and be engaged in goal setting.*

2. *Residents can learn and practice problem solving through an active learning process to include group discussions, films, psycho-education, guest speakers, written exercises, role playing and community outings. Relapse prevention and discharge planning groups should be implemented throughout treatment at the earliest point. All staff could contribute to the program (e.g. psychiatric nurses could do life skills and psycho-educational groups) ; community agencies could provide in-service workshops e.g. anger management groups, community outings.*

3. *It is recommended that the signed and dated progress notes consistently document events or changes in the life of the person served, the deliver of services and specific interventions that support the individual plan, and movements to other phases of care.*

Phase Three: Therapeutic Community

1. *A well-defined phase system based on long-term residency is necessary as a defining element of the program structure.*

2. *In 2009 certain work programs were being developed, including culinary, horticulture, electrical, and mechanics. These programs were being developed to provide residents with certification upon completion. These projects have since been discontinued. The work program needs to be fully developed to provide certification upon completion and enhance the sense of community, build social responsibility and self-esteem, and to develop communication, organizational, and interpersonal skills.*

There is individual progression up the hierarchy of job functions as it is in society.

3. *The Education Program: when residents who complete the Adult Dogwood Program are ready to transition back into their communities, they should have continuing care plans which include: their teacher's contact information; information about college and continuing education programs; those in need of writing a college entry test can request this form from the school program teacher and can be included in their discharge paperwork; include a list of all continuing education locations and resources in their communities; assistance in transitioning*

from attending school at Baldy Hughes and continuing to advance their education upon leaving.

A review of the written proposal for distance education courses via the internet to advance the education program is suggested.

Phase Four: Transitional Planning

1. *The preparation for re-entry involves greater flexibility in the resident's personal program and increased attention to relapse prevention, integrating the skills, insights, and behavioral change gained through treatment, to support maintenance of a positive lifestyle change outside the community in a self- reliant manner. For example, currently residents only attend 12-step meetings on-site. As residents transition through the phases as part of increasing their autonomy and responsibility and exposure to outside community life, outside meetings could be incorporated into their plan. This could also include off -site family visits and so on as they work towards independent reintegration into their families and communities.*

2. *An implicit goal is to provide a platform for transition and prioritize the initiation of planning during the transitional phase to focus on a comprehensive discharge plan that incorporates aftercare and support services, including but not limited to:*

    - *Alcohol and other drug services*
    - *Case management*
    - *Community housing programs*
    - *Crisis intervention services*
    - *Day habilitation programs*
    - *Domestic violence services*
    - *Educational resources*
    - *Employment services*
    - *HIV/Aids & STD services*
    - *Legal resources*
    - *Medical services*
    - *Medication management*
    - *Out-patient therapy services*
    - *Physical/occupational therapy*
    - *Psychiatric care*

- *Recreation services*
- *Relapse prevention groups*
- *Self-help groups*
- *Social services*
- *Vocational rehabilitation*

3. *The discharge/transition plan is a clinical document that includes information about the person's progress in recovery and describes the completion of goals and the efficacy of services provided. Transition planning should begin at the earliest point of services and the person served should play an active role. It is prepared to ensure a seamless transition to another component of care, or an aftercare program. A discharge summary, identifying reasons for discharge, is completed when the person leaves service for any reason (planned discharge, against medical advice, infringement of program rules, etc.).*

4. *Staff with continuing care duties are responsible to build support networks with various community resources and agencies. Individual and group work should assess progress on a regular basis, assist in determining if the goals set in the discharge planning are being met, and adjust them accordingly. Support services are identified, appointments are made, and linkages to appropriate community based providers are established. The primary objective of this phase is for each resident to develop a detailed and individualized "recovery road map" that will guide all activities in the first few days, weeks, and months after his discharge from Baldy Hughes.*

5. *A competency-based checklist could be designed to assess how the resident's are able to apply the information and principles of recovery acquired in the earlier phases of the program A systematic tool could be developed which requires the resident to demonstrate skills in communication, information gathering, consequential thinking, and planning. The purpose of the tool is to ensure each resident is prepared for successful reintegration by addressing various domains (as previously identified above) considered critical to continued recovery.*

6. *Just as the assessment is critical to the success of treatment, the transition services are critical for the support of the individual's ongoing recovery or well-being. In order to support ongoing recovery, treatment gains, or increased*

community inclusion, the program needs to follow its procedures for referrals, transition to other services, and discharge.

As Baldy Hughes is a new Therapeutic Community, it would be prudent to establish memberships and affiliations with regional, national, and international Therapeutic Community Associations to ensure high professional standards for program content, treatment approach, and staffing. Expansion should be phased in gradually and take place according to clear criteria defining success and readiness. The organization should implement a process to ensure that personnel providing direct services demonstrate skill in the application of the therapeutic community core competencies that include an understanding of:

- ***Practicing positive role modeling***
- ***Promoting mutual help***
- ***Promoting a system of earned privileges and graduated responsibilities***
- ***Social learning***
- ***Creating a belief system in the community***
- ***Positive boundaries in clinical and ethical areas***

5. Health and Safety

Findings

A. The population presents with dual diagnosis issues, meaning these residents are struggling with both addiction and mental health issues. Untreated dual disorders increase relapse rates. At present, there is no Medical Director or physician on-site nor are there any scheduled visits. Currently patients utilize the walk-in clinic in Prince George for medical concerns. From our inquiries, it appears that while the center has provided limited services from a MD, it has never provided the residents with psychiatric consultation or care. Psychiatric and substance abuse disorders should be regarded as primary disorders when they co-exist, each requiring specific and appropriate treatment, diagnosis, and treatment with established practice guidelines.

For example, residents with concurrent psychiatric disorders may have a more difficult time attending and benefiting from self-help groups because of social skills deficits. In order to support the willingness of residents with a concurrent disorder to attend and benefit from self-help groups such as

Twelve Step groups, staff should work to address social skills deficits through social skills training.

B. Occupational Health and Safety concerns were verbalized by staff and residents who shared that they do not feel prepared in the event of an emergency.

1. The assigned first aid responders are not identified.
2.. We could not find any records confirming that first aid equipment is regularly inspected and/or maintained and there was no trauma kit in the medication room.
3. The facility lacked basic medical supplies such as blood pressure cuffs, stethoscope, thermometers, gloves, epi-pens, glucose monitor, etc.
4. We could not find any documentation of fire drills or checking of fire equipment.
5. No on- site first aid or Non-Violent crisis intervention trainings

C. Water Report

A recent inspection visit by a public health protection officer from Northern Health resulted in requirements for a new plan for a change in the water system e.g. water tanks needed cleaning.

Recommendations

A. A comprehension and longitudinal medical plan needs to be developed and implemented providing residents with access to the necessary areas of healthcare, to include physical health, psychiatric and mental health, and dental care. As appropriate, physician medical services will be publicly funded, in accordance with the Canada Health Act.

B. A Medication Safety and Advisory committee needs to be developed to oversee all medication transactions and reactions at Baldy Hughes. Upon inquiry, the contracted pharmacist was willing and motivated to be part of this team development practice.

C. A dietician to oversee menu planning and Health and Safety

D. Immediate hiring of psychiatric nurses to provide assessment and direct support and care for the residents.

E. ***Baldy Hughes is providing minimal training to personnel. This training is not competency-based in nature, in that staff members are not being evaluated for demonstrated competency in the areas addressed in the training. Therefore, it is recommended that Baldy Hughes ensure that personnel receive competency-based training upon hire and annually in the areas of health and safety practices, identification of unsafe environmental factors, emergency procedures, fire drills, evacuation procedures, identification of critical incidents, reporting of critical incidents, medication management (as appropriate), first aid, and the reduction of physical risks.***

6. Human Resources

Findings

Baldy Hughes has published human resource policies and procedures which are not being adhered to. Generally staff members are unqualified, lack experience to perform their duties and do not have core competencies at a base level. We spoke with several employees who shared that upon hiring, they had received no employee orientation or job training.

Example: We could find no evidence of documented supervision of clinical or direct service personnel. As such, there is no ongoing supervision of: accuracy of assessment and referral skills; the appropriateness of the treatment or service interventions; treatment/service effectiveness as reflected by the person served meeting his individual goals; the provision of feedback that enhances the skills of direct service personnel; issues of ethics, legal aspects of clinical practice, and professional standards; clinical documentation issues identified through ongoing compliance reviews, and cultural competency issues.

Recommendations

A. ***Once a decision is made on the direction of Baldy Hughes the staffing requirements should be determined and the necessary changes made; ensure ongoing training and supervision and that professional development standards are implemented.***

B. ***It is recommended that the organization consistently determine competency of staff members and provide and/or arrange for competency-based training to personnel providing direct services. The training should include areas that reflect the specific needs of the person served, clinical skills that are appropriate to the employee's position, individual plan development, interviewing skills, and program-related research-based treatment approaches.***

7. Risk Management

Findings

No documented risk management plan exists.

Recommendations

A risk management assessment plan needs to be initiated which will identify loss exposures; evaluate loss exposures; identify how to rectify identified loss exposures; implement actions to reduce risk; monitor actions to reduce risk; report results of actions to reduce risk; and include risk reduction in performance improvement activities. An annual review could be accomplished by concurrently reviewing the risk management plan with the annual review of the organization's insurance package.

8. Business Practices

Findings

A. Good administrative policies and procedures have been written to ensure strong internal controls but are not being followed. For the most part good staff judgment has been effective in controlling expenditures.

B. Baldy Hughes has been and continues to be hampered by funding constraints which results in the lack of important and necessary services to the residential population. Lack of financial resources has put the community at risk.

Recommendations

A. Staff need to become familiarized with documented policies and procedures and encouraged to adhere to them.

B. Services and supports that are needed must be identified, prioritized and it must be determined how they are to be funded and properly implemented.

C. New partners need to be identified and incorporated into existing and new programs to enhance the delivery of services and the system of care.

D. System-level changes are required to establish formal structures for inter program collaboration at the administrative level that, in turn, support the work at the program level.

E. ***The service system should not begin or end at the boundaries of formal treatment programs; rather, it may include interventions to engage the most detached individuals; for example, those who are homeless and living in shelters and transition houses.***

F. ***For a sustainable approach, investments along the continuum are required. Community Partnerships with other provincial resources such as Burnaby Centre for Mental Health and Addictions could be considered. Currently residents there receive comprehensive treatment and require aftercare options such as extended residential care when their nine months to one year are up.***

9. Conclusion

A. Baldy Hughes strengths:
   1. The Residential Facility and natural setting is far removed from the wider community;
   2. Facility resources include elements for a working farm, greenhouse, trades training; successful education program
   3. Abstinence-based
   4. Long-term recovery
   5. Provincial resource
   6. Secure facility
   7. Community based
   8. Multiple points of access: primary health; hospital; community; justice system

B. A valid picture of Baldy Hughes as an Addiction Treatment Centre (and) Therapeutic Community requires clarification of issues concerning models, labels and perceptions.
One effect of this labeling of Baldy Hughes has been to cloud the addiction centre model and therapeutic community model as addiction treatment approaches. In particular in relation to how well they work, differing costs, staffing, standards, and for which clients it is most appropriate.

C. Baldy Hughes should seek improvement in the areas identified by the recommendations in this report.

D. Baldy Hughes needs to realign to strengthen its viability and overall cohesiveness in order to provide an integrated service delivery model built and monitored by a clinical advisory board and based on the cornerstones of safety, clinical integrity, best practices, and outcome based.

E. The centre needs to develop a core capacity defined through specific components of program infrastructure like policies, procedures, clinical practice infrastructure and standards, and clinical competencies and scopes of practices, to provide appropriate services.

F. The development of Performance Improvement and Corporate Compliance Plans would assist in the early stages of moving towards quality improvement and compliance of professional standards of care and program fidelity.

The Need

There is a clear need for an integrated, community-based comprehensive system of care. B.C. has the highest rate of alcohol-related disorders in Canada and a high percentage of people with additional issues have co-occurring mental disorders. Baldy Hughes' population is reflective of the targeted population and need for an integrated care environment. The challenge within the context of scarce resources is how to provide services in a manner that is consistent with their existing mission and program design, but that will meet the needs of their service population.

10. Next Steps

Our initial findings are sufficient for us to determine that Baldy Hughes needs to be changed and an identified plan of action needs to be developed. The current model does not meet the best practice standards for a treatment centre or a therapeutic community. We could continue to spend more energy on supporting this opinion but feel that the most expeditious course would be to provide an outline of the two solutions: Addiction Treatment Centre model or " modified" Therapeutic Community model providing appropriate addiction and mental health treatment. This basic philosophical model of treatment has recovery and treatment occurring more out of participation and interaction with the community than through top down addiction programming. The associated budgets will be provided in order for an informed decision on the direction of Baldy Hughes to be made.

We look forward to being of further service and assist in the growth of this innovative resource.

Respectfully submitted,

Dr Beverley J Richardson Psy. D, R.C.C., C. E.D.S.

Stuart Longair, CA

BALDY HUGHES ADDICTION TREATMENT CENTRE AND THERAPEUTIC COMMUNITY

FACT SHEET

BACKGROUND

- The British Columbia New Hope Recovery Society (the Society) and Baldy Hughes Addiction Treatment Centre and Therapeutic Community (Baldy Hughes), located 36 km southwest of Prince George, BC, were founded by Lorne Mayencourt (former MLA) and have been in operation since December 2007.
- In December 2010, the Provincial Rental Housing Corporation of BC Housing invested $3 million to purchase Baldy Hughes and the 26-hectare (65-acre) property that is home to the residential treatment program.[1]
- Baldy Hughes, operated by the Society, is a non-profit facility with potential for 85 addiction beds providing residential addiction treatment to male British Columbians, using a one year multiphasic treatment model.
    - Between March-July 2011, the number of residents at the facility dropped from 65 to 48. Several key staff members and board members also left the facility.

KEY FACTS

Baldy Hughes Addiction Treatment and Recovery Program

- During the one year treatment, residents move through four phases of treatment and recovery including intake phase, treatment phase, long term aftercare or therapeutic community, and transitional planning[2]. The last two phases focus on academic education and employment skills development. For example, participants may complete their full Grade 12 Dogwood Diploma.
- In July 2011, BC Housing hired addictions specialist Dr. Beverly Richardson to assess the treatment model used at Baldy Hughes.
- The Province of BC is dedicated to providing a stable, safe and secure environment at Baldy Hughes, where people can recover from their addictions, improve their lives and make a positive contribution to the community.

Funding sources and referrals:

- The New Hope Recovery Society received a $250,000 one-time funding grant through the government's Housing Endowment Fund to cover lease payments for Baldy Hughes for the period of 2008-2010.
- Northern Health Foundation provided one time funding of $30,000 in 2010 to pay for a Prince George physician to attend Baldy Hughes clients on a regular basis.
- Baldy Hughes accepts private pay clients and clients eligible for Ministry of Social Development (MSD) funding. Private pay clients are charged $3,000 per month of treatment.

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[1] http://www2.news.gov.bc.ca/news_releases_2009-2013/2010PSSG0109-001604.htm
[2] http://www.baldyhughes.com/www.wellnesswheel.ca/Program_Phases.html

- Baldy Hughes receives support recovery/residential funding from MSD through a daily payment of $30.90 for occupied recovery beds. The per diem payment is in lieu of support and shelter normally available to MSD clients outside the facility.
- The health authorities, including the Northern Health Authority, do not provide operational funding to Baldy Hughes, and as such, Baldy Hughes will not be required to adhere to the forthcoming Ministry of Health (the Ministry) standards for residential substance use treatment.[3] The health authorities do not refer clients directly to Baldy Hughes, but health authority staff may assist clients in completing the application form to access the resource, if assistance is requested.

FINANCIAL IMPLICATIONS

- In July 2010, the Ministry provided Baldy Hughes with a one-time grant of $500,000 that allowed for renovations to existing buildings on the site.[4]
- Under the Operator Agreement, BC Housing provides the Society with an annual operating subsidy of just over $277,000 to assist the Society in providing programs. The Society also receives operating funds of $100,000 through provincial gaming grants and a maximum of $676,000 in support recovery per diem funding from MSD.[5] [6]

CONTACT

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APPROVALS

Approved by:

Teri Collins, Executive Director, on behalf of Heather Davidson, Assistant Deputy Minister
Health Authorities Division – September 16, 2011

Manjit Sidhu, Assistant Deputy Minister
Financial and Corporate Services –

Nick Grant, Executive Director
Health Systems Planning Division –

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[3] Standards are applicable only to health authority funded facilities.
[4] http://www2.news.gov.bc.ca/news_releases_2009-2013/2010HSERV0041-000828.htm
[5] http://www2.news.gov.bc.ca/news_releases_2009-2013/2010PSSG0109-001604.htm
[6] The $676,000 is the maximum amount of support recovery home per diem funding that Baldy Hughes could receive assuming that all the 60 approved beds are filled with MSD clients.

MINISTRY OF HEALTH SERVICES
INFORMATION BRIEFING DOCUMENT

Cliff #869858

PREPARED FOR: Heather Davidson, ADM, Health Authorities Division
- FOR INFORMATION

TITLE: An Analysis of the Evaluation Report for Baldy Hughes Addiction Treatment Centre and Therapeutic Community

PURPOSE: To provide information regarding Baldy Hughes Addiction Treatment Centre and Therapeutic Community in regards to the evaluation done by William J. Owen, 2010.

BACKGROUND:
The Baldy Hughes Addiction Treatment Centre and Therapeutic Community (the Centre) was originated by Lorne Mayencourt (former MLA) and has been in operation since December 2007. The Centre, located 27 km southwest of Prince George, British Columbia is operated by the New Hope Recovery Society and provides residential addiction treatment to British Columbians.

In July 2010, the Ministry of Health Services (MoHS) provided Baldy Hughes with one-time capital funding of $500,000 to support renovations. In December 2010, the Provincial Rental Housing Corporation of BC Housing invested $3 million to purchase Baldy Hughes and the 65 acre property. Under the Operator Agreement, BC Housing will provide the New Hope Recovery Society with an annual operating subsidy of over $277,000 to assist in providing programs. The Society also receives operating funds of $100,000 through provincial gaming grants and a maximim of $676,000 in support recovery per diem funding from the Ministry of Social Development. The Centre receives ongoing financial support through the Ministries of Public Safety and Solicitor General (Housing), Social Development, BC Housing, and through private donations. Baldy Hughes does not receive operational funding from health authorities (HAs) and is not required to adhere to MoHS' standards and policies for residential treatment services. Though the HAs do not refer clients directly to Baldy Hughes, they can assist clients in completing the application form to access the resource.

Recently, a copy of "Transformative Change: A Benchmarking Report for the Baldy Hughes Addiction Treatment Centre and Therapeutic Community" (the Report) was made available to the Ministry. An analysis of this report follows.

DISCUSSION:
The Report is authored by William J. Owen, Ph.D., an Associate Professor of Psychology at the University of Northern British Columbia. The report is based on data files containing treatment status information, which were prepared by a Baldy Hughes staff member. The executive summary of the report states that the Centre has a 58 percent successful completion rate based on 107 clients who were admitted and left the treatment program within certain time frames. "Success" was not clearly defined within the report. The report states that 63 individuals completed all the phases of the program (58 percent);

however, elsewhere in the document it is stated that clients are not necessarily required to complete all phases to be considered to have "successfully completed". Such inconsistencies in parameters and definitions call into question the validity of the claim of a 58 percent completion rate. Additionally, stakeholders have suggested to Ministry staff that there were admissions of short duration during the time period under review that were not counted, thereby potentially skewing the results in a more favourable direction.

In terms of abstinence rates, Owen states that "former residents were abstaining after 3, 6, or 12 months" but he does not clearly provide the number of persons abstinent for each time period. Therefore, it can only be claimed that of the 58 percent (63/107) that successfully completed the program, 76 percent of those were abstinent for at least three months following treatment. When viewing the data from the perspective of the whole sample, the abstinence rate three months after successfully completing treatment drops to 45 percent (48/107). A brief review of the literature on abstinence rates after residential treatment of at least six months indicates abstinence rates as high as 71 percent six to 12 months after treatment. [1] Data are also provided in the report concerning the abstinence rates of those who did not complete the program: 36 percent (16/44) were abstaining at "3, 6, or 12 months". Therefore, the overall abstinence rate of 45 percent three months after successful completion of the program is only somewhat larger than the three month abstinence rate after not successfully completing the program (36 percent).

A section in the report on cost effectiveness provides a table of beds-to-staff ratios at other residential treatment programs in BC compared to the ratio at the Centre. The Centre clearly has the highest ratio (70/10), which is due to the fact that clients perform much of the work in running the Centre. Comparable effectiveness data are not provided, and no case is presented correlating cost effectiveness with treatment effectiveness. In the conclusion, the author claims that the Centre's "therapeutic community approach" is effective. However, there is scant information provided that illuminates the Centre's therapeutic community approach and how that approach might relate to effectiveness outcomes. Overall, the report contains significant gaps, inconsistencies and numerous typographical errors. As well, the study has a number of methodological flaws that obscure what may be solid effectiveness evidence. The tone of the report is not objective; it reads as a promotional document rather than a third-party evaluation. The report does not refer to client mental health issues or concurrent disorders.

ACTION:
Given the weaknesses of the report, caution is urged in accepting the reported evaluation results as benchmarks of the effectiveness of this residential treatment program.

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Date:	February 11, 2011

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[1] Greenfield, L. Effectiveness of long-term residential substance abuse treatment for women: findings from three national studies. AM J Drug Alcohol Abuse/Aug. 30, 2004