CADTH

Appendix 1: Environmental Scan Survey — Programs for the Treatment of Opioid Addiction

Thank you for your interest in contributing to a CADTH report. Your highly valuable input is needed to inform decision-making on the management of health technologies in Canada. The purpose of this survey is to gather information that will be used to prepare a CADTH Environmental Scan report, which will be published on CADTH's website. Your participation in this survey is voluntary. You may choose not to participate, or you may exit the survey at any time. It should take approximatively 30 minutes to complete. Your identifiable private information will be kept confidential. This consent form does not give CADTH permission to disclose your name. If any direct quotes from the survey results are required, respondents will be contacted separately for a signed personal communication form before publishing. CADTH will summarize your responses in the published report and your organization may be identified as a source. However, you and (if applicable) the organization you represent are not responsible for the analyses, conclusions, opinions, and statements expressed by CADTH.

For detailed information on the purpose of this Environmental Scan entitled Programs for the Treatment of Opioid Addiction in Canada, please see the invitation email or contact charlottew@cadth.ca.

ELECTRONIC CONSENT: Please select your choice below.

Clicking on the "Agree" button below indicates that: you have read the aforementioned information you voluntarily agree to participate you authorize CADTH to use the information provided by you for the purpose as stated in this form.

If you do not wish to participate in the survey, please decline participation by clicking on the "Disagree" button. **Do you consent to participating in this survey?**

☐ Agree ☐ Disagree

1. Are you currently involved in any capacity with providing care and treatment for opioid addiction?

☐ Yes ☐ No

2. Which jurisdiction do you work in? * (select one option)

☐ Alberta
☐ British Columbia
☐ Manitoba
☐ New Brunswick
☐ Newfoundland and Labrador
☐ Northwest Territories
☐ Nova Scotia
☐ Nunavut
☐ Ontario
☐ Prince Edward Island
☐ Quebec
☐ Saskatchewan

☐ Yukon

☐ Federal

3. For which organization do you work?

4. Do you provide care to patients in one or more of these geographical settings? (select all that apply)

☐ Urban (i.e., area with no fewer than 400 persons per square kilometre and an overall population of at least 1,000 inhabitants)

☐ Rural (i.e., not fitting definition of "urban" or "remote")

☐ Remote (see below)

(Please self-identify based on your local understanding of the criteria for remote. As an example, Health Canada defines various levels of remote, ranging from remote isolated = no scheduled flights or road access and minimal telephone or radio service, through to non-isolated remote = road access and less than 90 km away from physician services.)

5. What is your profession, occupation, or title? In addition, please describe your role as it relates to opioid addiction treatment

6. Do you work in one or more of these health care settings? (select all that apply)

☐ Primary care

☐ Secondary or tertiary care

☐ Community care

☐ Correctional setting (either prison-based or community-based [e.g., probationary or parole based])

☐ Detoxification settings

☐ Other (please specify)

7. Do you work in one or more of these types of facilities?

☐ Hospital

☐ Private clinic

☐ Addiction treatment facility

☐ Ambulatory care facility

☐ Community health care facility (e.g., nursing station, public health clinic, family health team)

☐ Correctional centre or prison-setting

☐ Detoxification settings

☐ Pharmacy Services (e.g., community pharmacy, hospital pharmacy)

☐ Other (please specify)

8. Are there any standards, guidelines, or policies in effect in your jurisdiction or facility about wait times for patients seeking opioid addiction treatment services?

☐ Yes ☐ No ☐ Unsure

9. If yes, please specify which program you are referring to. Please attempt to fill out as many programs as you currently offer in your facility or setting, to the best of your knowledge. If there are greater than three programs, please fill in as many as possible and email charlottew@cadth.ca to provide additional details.

    Name of Program #1*:

    Wait Times:

    ☐ 0 to 2 weeks

    ☐ 2 weeks to 1 month

    ☐ 1 month to 3 months

    ☐ 3 months to 6 months

    ☐ 6 months to 12 months

    ☐ 12 months +

    ☐ Other, not specified

    *There were additional spaces for additional programs, if needed.

10. In general, what is the actual wait time for accessing opioid addiction treatment in your jurisdiction or facility? Please attempt to fill out as many programs as you currently offer in your facility or setting, to the best of your knowledge. If there are greater than three programs, please fill in as many as possible and email charlottew@cadth.ca to provide additional details.

    Name of Program #1*:

    Wait Times:

    ☐ 0 to 2 weeks

    ☐ 2 weeks to 1 month

    ☐ 1 month to 3 months

    ☐ 3 months to 6 months

    ☐ 6 months to 12 months

    ☐ 12 months +

    ☐ Other, not specified

    *There were additional spaces for additional programs, if needed.

11. What strategies or initiatives are in place at your facility/setting to improve wait times for patients entering opioid addiction treatment?

12. What are the barriers to timely access (i.e., meeting recommended wait times) to opioid addiction treatment that you currently encounter in your jurisdiction?

13. What are the facilitators to timely access (i.e., meeting recommended wait times) to opioid addiction treatment that you currently encounter in your jurisdiction?

14. Are there specific criteria that a patient must meet to gain access to opioid addiction treatment in your jurisdiction or facility?

15. Are there specific criteria used to prioritize eligible patients in the provision of opioid addiction treatment in your jurisdiction or facility?

16. What barriers or challenges do patients receiving opioid addiction treatment face when they are transitioning between care settings in your jurisdiction or facility? Care setting transitions can include (but are not limited to) transitions from:

    - emergency departments to a specialty OAT clinic
    - detoxification settings to specialty OAT clinics
    - specialty OAT clinics to primary care
    - correctional settings to community settings
    - emergency departments to primary care.

    Please specify which settings and transitions you are referring to in your answer.

17. What practices and approaches* are applied in your jurisdiction or facility to ensure continuity of care as patients who are receiving opioid addiction treatment transition between care settings? Care setting transitions can include (but are not limited to) transitions from:

    - emergency departments to a specialty OAT clinic
    - detoxification settings to specialty OAT clinics
    - specialty OAT clinics to primary care
    - correctional settings to community settings
    - emergency departments to primary care.

    Please specify which settings and transitions you are referring to in your answer.

    * This can include other practices used if “best practices” are not feasible or available.

18. What supports are available to patients who are receiving opioid addiction treatment in your jurisdiction or facility when they are transitioning between care settings? Care setting transitions can include (but are not limited to) transitions from:

    - emergency departments to a specialty OAT clinic
    - detoxification settings to specialty OAT clinics
    - specialty OAT clinics to primary care
    - correctional settings to community settings
    - emergency departments to primary care.

    Please specify which settings and transitions you are referring to in your answer.

19. Are you aware of any guidelines, tools, guidance, or practice standards regarding the support of patients with opioid addiction during their transitions between care settings? If yes, please provide details, or provide their titles below provide their URLs.

20. Are you aware of documents or other sources that compile opioid addiction treatment programs in use in Canada or internationally (e.g., inventories of available programming)? If you have a URL or title of the document or source, please provide below. If you have any documents or files you would be willing to share with us, please upload them below.

21. Are you aware of any colleagues or other groups that should receive this survey or should be contacted directly for stakeholder feedback?

22. If required, would you be willing to participate in a follow-up email or phone interview regarding this survey and its content?

☐ Yes ☐ No

Appendix 2: Information on Survey Respondents

Province/Territory	Organization Represented by Survey Respondents
Alberta	Alberta Health Services
British Columbia	Fraser Health Authority Adult Custody Division — Ministry of Public Safety & Solicitor General
Manitoba	Addictions Foundation of Manitoba[a]
New Brunswick	Elsipogtog Health & Wellness Centre
Newfoundland and Labrador	Government of Newfoundland and Labrador
Nova Scotia	Nova Scotia Health Authority
Northwest Territories	Northwest Territories Health and Social Services Authority
Ontario	Dilico Anishinabek Family Care The Royal Ottawa Mental Health Centre Department of National Defence
Prince Edward Island	Health PEI Mental Health and Addictions Services
Yukon	Referred Care Clinic Yukon Government of Yukon — Department of Justice

[a] Four separate responses were received from this organization.

Appendix 3: Opioid Programs in Canada

Table 4: Programs for Opioid Addiction in Alberta[78]

Style of Program	Program Name
In-patient/Residential	Action North Recovery Centre
	Aventa Centre of Excellence for Women with Addictions (for women, only)
	Business & Industry Clinic
	Fresh Start Recovery Centre
	Grace House (abstinence only, no OAT, men only)
	Henwood Treatment Centre
	Kapown Rehabilitation Centre
	Lander Treatment Centre
	Mark Amy Treatment Centre
	McDougall House (female only)
	Northern Addictions Centre (also has a detoxification centre)
	Our House Addiction Recovery Centre (provides a housing program)
	Poundmaker's Lodge Treatment Centres (Indigenous treatment centre)
	Recovery Acres (for men, only)
	Salvation Army's Transformations Addictions Recovery Program
	South Country Treatment Centre
	Southern Alcare Manor
Detoxification	George Spady Centre Shelter and Detox Programs (overnight shelter and detox)
	Medicine Hat Recovery Centre
Holistic in-patient Care	Bonnyville Indian-Métis Rehabilitation Centre (abstinence-based)
Transitional Housing Facility	Cunningham Place (for youth aged 18 to 30)
	Jellinek Society Recovery House (for men, only)
Homelessness Support and Addictions	McCullough Centre (men, only)

Table 5: Programs for Opioid Addiction in Manitoba[21]

Style of Program		Program
Detoxification		Addictions Unit (Health Sciences Centre)
		Main Street Project
		Aurora Recovery Centre
Abstinence-based	Residential	Addictions Foundation of Manitoba (men's and women's)
		Salvation Army Booth Centre Anchorage Addiction Treatment Program
		Behavioural Health Foundation
		Tamarack Recovery Centre
		Native Addictions Council of Manitoba
		Rosaire House Addiction Centre
	Community	Addictions Foundation Manitoba
		Native Addictions Council of Manitoba
		The Laurel Centre
		SRWC—St. Raphael Wellness Centre
Post-treatment		Esther House
		Addictions Recovery Inc.
		Two Ten Recovery
Opioid Agonist Treatment		CARI—Clearview Addictions Rehabilitation Institute
		OATS—Opiate Addiction Treatment Services
		Manitoba Addiction Treatment Centres (MBATC)
		Private clinics and community physicians

Table 6: Programs for Opioid Addiction in Newfoundland and Labrador

Style of Program	Program
Outpatient Services	Opioid Treatment Centre (OTC) in St. John's
Detoxification Services	Recovery Centre on St. John's
In-patient Services	Humberwood Centre The Grace Centre Hope Valley Centre (for youth)

Table 7: Programs for Opioid Addiction in Prince Edward Island

Style of Program	Program
Opioid Replacement Treatment Programs	Located in Montague, Mount Herbert, Summerside, and Charlottetown[90]
Residential Programs	Talbot House
	St. Eleanor's House
	Deacon House
	Lacey House
Detoxification	Withdrawal management programs

Appendix 4: Correctional Service Canada Programs

Correctional Service Canada (CSC) offers a correctional program called the Integrated Correctional Program Model, targeting multiple risk factors including but not limited to addictions. There are four components that complement the main program: an introductory phase, where inmates are given general direction; the motivational component, where inmates are encouraged to stay in correctional programs; the community programs, where inmates who have not completed the required programs while incarcerated do complete the programs; and the maintenance program, where inmates (or released prisoners) are taught how to apply skills in real-life situations. This program is also offered at varying intensities.[91]

Table 8: Correctional Service Canada Substance Abuse Programs[92]

High-Intensity National Substance Abuse Program	• Men with substance abuse and high risk to reoffend • 89 group sessions plus individual sessions • 2 hours in length • Helps explore behaviour changes and identify risks, to avoid relapse
Moderate-Intensity National Substance Abuse Program	• Men with substance abuse and moderate risk to reoffend • 26 group sessions plus 1 individual session • 2 hours in length • Helps explore behaviour changes and identify risks, to avoid relapse
High-Intensity Aboriginal Offender Substance Abuse Program	• Aboriginal men with substance abuse and high risk to reoffend • 62 group sessions, 4 individual sessions, 3 ceremonial group sessions • 2 hours in length • Reduce the risk of relapse; modern treatment techniques with care to spiritual, emotional, mental, and physical needs
Moderate-Intensity Aboriginal Offender Substance Abuse Program	• Aboriginal men with substance abuse and moderate risk to reoffend • 35 group sessions, 2 individual sessions, 2 ceremonial group sessions • 2 hours in length • Reduce the risk of relapse, modern treatment techniques with care to spiritual, emotional, mental, and physical needs
National Pre-release Substance Abuse Program	• Men who have already completed a national substance abuse program • 4 sessions, either group or individual • 2 hours in length • For preparing for release, promotes awareness of harmful situations in the community; learns how to build a healthy lifestyle and relationships
National Substance Abuse Maintenance Program	• Men who have already completed a national substance abuse program • Variable number of sessions • 2 hours in length • Refresh skills learned in original program

Appendix 5: Drug Treatment Courts in Canada

Table 9: Drug Treatment Court Profiles

	Date Opened	Length of Treatment	Staffing and Programs/Activities	Provider	Capacity
Edmonton Drug Treatment and Community Restoration Court	Dec. 2005	8 to 18 months	7 staff members: • executive director • executive assistant/program support • 2 case managers • probation officer • peer support • transition coordination • casual substance analysis worker Activities: • court appearances • random drug testing • meetings with case managers for supportive counselling and supervision • referrals to community support • education or employment training	Pre-existing day or residential programs	Minimum 30
Ottawa Drug Treatment Court	Feb. 2006	9+ months	Directed by Rideauwood Addiction and Family Services staff and includes: • program manager • probation officer • 3 case managers • administrative assistant • nurse practitioner Activities: • assessment activities • formal addiction group sessions • individual therapy sessions • residential and outpatient treatment programs • case management services • health and social services • random drug testing • education or employment training	Rideauwood Addiction and Family Services, with additional treatment by the John Howard Society of Ottawa and the Somerset West Community Health Centre	35

	Date Opened	Length of Treatment	Staffing and Programs/Activities	Provider	Capacity
Regina Drug Treatment Court	Oct. 2006	NR	Staff includes: • program manager • addictions psychiatric nurse • 3 addictions counsellors • income assistance worker • administrative assistant • probation officer Activities: • individual counselling • group therapy • AA/NA/12-Step meetings • aboriginal-centred programming • detox and treatment facilities	Provided by Program	30
Toronto Drug Treatment Court	Dec. 1998	3+ months[93]	Staff includes: • court liaison • 3 case managers or therapists • peer support worker • program manager • program assistant • administrative secretary Activities: • assessments and evaluative follow-up • individual treatment planning • individual counselling sessions • psychoeducational group sessions • process (therapy) groups • recreational groups	CAMH—Centre for Addiction and Mental Health	48 (usually operates with 50)
Drug Treatment Court of Vancouver	Dec. 2001	NR	Staff includes: • program manager • clinical supervisor • psychologist • doctor • nurse • case management team Activities: • individual counselling • group counselling • detoxification • residential recovery • residential treatment	Vancouver Coastal Health Regional Authority	100

	Date Opened	Length of Treatment	Staffing and Programs/Activities	Provider	Capacity
Winnipeg Drug Treatment Court	Jan. 2006	NR	Staff includes: • unit supervisor • 4 counsellors • administrative support • part-time probation officer Activities: • individual counselling sessions • group counselling sessions • AA/NA/CA meetings • residential treatment • continuing care (for alumni, up to one year after graduation)	Behaviour Health Foundation and staff members	30

AA = Alcoholics Anonymous; CA = Cocaine Anonymous; NA = Narcotics Anonymous; NR = not reported.

Table 10: Programs for Opioid Addiction in Prince Edward Island

Integrated justice system case-processing and addiction treatment services
A non-adversarial approach to case problem-solving by the judge, prosecutor, and defence counsel
Eligible participants are identified early and placed in the drug treatment courts program as promptly as possible
Drug treatment courts provide access to a broad continuum of treatment and rehabilitative services
Objective monitoring of participants' compliance by frequent substance abuse testing
Coordinated strategic response to program compliance and non-compliance by all disciplines involved (including police, probation, prosecutor, treatment, social workers, and court)
Swift, certain, and consistent sanctions or rewards for non-compliance or compliance
Ongoing direct judicial interaction with participants
Monitoring and evaluation processes for the achievement of program goals and to gauge effectiveness
Continuing interdisciplinary education of the entire drug treatment courts team
Forge partnerships among courts, treatment, and rehabilitation programs, public agencies, and community-based organiza-tions to increase program effectiveness and generate local support for the program
Ongoing case management including social reintegration support
Adjustable program content, including incentives and sanctions, for groups with special needs; e.g., women, minority ethnic groups, and persons with mental disorders

Appendix 6: International Correctional Settings

United States

Different states have different opioid treatment approaches in the correctional setting. For example, in Rhode Island, inmates who were on methadone maintenance are given the same dose for seven days, then tapered off over 30 days, while in Massachusetts inmates must go "cold turkey" immediately.[94] In 2008, a survey of US prisons found that 55% of prisons provided methadone in any circumstance and 14% provided buprenorphine.[77]

Australia

In Australia, continuation of opioid agonist therapy (OAT) in prisons is available across all six states and two territories. However, initiation of OAT is only allowed in five of the states.[94] Detoxification services are available in all states and territories.[95] In four states, there were seven external Indigenous population-specific programs in 2015.[95]

United Kingdom

Services for the prison system are split into three separate administrations: England and Wales, Scotland, and Northern Ireland. Prisoners are able to access detoxification treatments, OAT therapies, psychosocial interventions, specific case management, and counselling. Drug-recovery wings in the prison system are a pilot project in England, Wales, and Northern Ireland. As an attempt to achieve continuity of care between prison and the wider community upon release, take-home naloxone is available in Scotland and Wales, and a specific focus for health care has been placed on this transitory period.[59]

Spain

MMT is available in all prisons in Spain[64] and drug treatment for prisoners is part of in-patient services.[63] One review discussed the state of opioid treatment in the autonomous community of Catalonia.[65] In November of 2014, Catalonia gave the authority over prisons to the Department of Health from the Department of Justice, and was the only community to do this. OAT is available in all Catalan prisons, and needle and syringe programs run by prison health care staff members are available in all but one Catalan prison.[65]

The other autonomous regions have their prisoner health overseen by the General Secretariat of Penitentiary Institutions of the Ministry of the Interior. Prisoner mental health is assessed upon arrival to the prison; following this, a treatment plan is created. Spanish prisons have a variety of health-related programs, including counselling, drug treatments such as OAT (primarily MMT), and harms reduction (such as needle exchange programs or prevention). To facilitate successful reintegration into the community, social reintegration programs are offered in prisons and detoxification programs are available on an outpatient basis.

Greece

Currently, there is no national harms reduction strategy for harms reduction in prisons in Greece. OAT within prisons in Greece has also suffered cutbacks due to the financial crisis, with the Ministry of Justice lowering budgets for health care staff and independent society organizations. [65] Although there are laws allowing released prisoners to apply for rehabilitation programs with assistance in transitioning to these programs, there are fewer programming options available to current prisoners. The current available programming is "therapeutic programmes, often provided by organizations such as KETHEA. These programs are abstinence-based and provide a wide range of services related to addictions. But often, they require that an individual has no history of mental illnesses and speaks fluent Greek. This strict policy can pose a problem, especially in the corrections setting, as many prisoners are non-Greek nationals.[65] An example of one such program is the KETHEA PROMITHEAS,[67] which provides counselling and treatment to individuals with addiction with northern Grecian prisons and treatment assistance upon release from prison.

Ireland

The health of prisoners is under authority of the Irish Prison Service. Although standards for the prison service attempt to emulate services available in the community, this is not always feasible or practised. DTCs exist where a convicted individual can be referred in lieu of serving the sentence, which is uncommonly used. OST is available in 14 prisons across Ireland, with varying quality. An example of high-quality OAT in an Irish prison is in the Mountjoy Prison in central Dublin. In this prison, there is a multidisciplinary clinical drug dependence team and six specialist nurses with individual duties.[65]

Italy

Similarly to Ireland, an offender can join a drug treatment court as an alternative to prison time, but the approval of this is determined by a judge. Prison health is the responsibility of the Ministry of Health, which has caused regionalization of health care services and some variation in quality and access.

Appendix 7: Wait Times in Canada — Survey Results

Table 11: Survey Results — Wait-List Times

Jurisdiction	Program	Standard Wait Times[a]	Actual Wait Times[b]
British Columbia	Fraser Health	0 to 2 weeks	0 to 2 weeks
	Health care requests from PHSA (Adult Custody Division of the Ministry of Public Safety & Solicitor General)	0 to 2 weeks	No answer provided
Yukon	Withdrawal Management Services, Department of Justice	0 to 2 weeks	No answer provided
	Whitehorse Correctional Centre	0 to 2 weeks	0 to 2 weeks
	Referred Care Clinic Yukon & Yukon Opioid Clinic	0 to 2 weeks (Referred Care Clinic) No standard wait time policies (Yukon Opioid Clinic)	0 to 2 weeks
Northwest Territories	Opioid Maintenance Therapy Initiative	0 to 2 weeks	0 to 2 weeks
Alberta	Calgary Injectable Opioid Agonist Therapy Program[c]	No standard wait time policies	0 to 2 weeks
	Calgary Opioid Dependency Program[c]	No standard wait time policies	0 to 2 weeks
Manitoba	Manitoba Opioid Support and Treatment (MOST)	Varies regionally; e.g., Winnipeg is 51 days and Brandon is 46 days[d] 3 months to 6 months	3 months to 6 months No answer provided Varies depending on triaged risk level
	RAAM, Thompson	0 to 2 weeks	0 to 2 weeks
	Community-based intake, Thompson, Addictions Foundation Manitoba	0 to 2 weeks	0 to 2 weeks
	Residential program intake, Addictions Foundation Manitoba	No standard wait time policies	1 month to 3 months
Northern Ontario (Thunder Bay area)	In-patient residential care at Dilico Anishinabek Family Care	3 months to 6 months	Depends on wait lists
	Post-treatment at Dilico Anishinabek Family Care	3 months to 6 months	Still assessing wait times
	Outpatient addictions at Dilico Anishinabek Family Care	1 month to 3 months	1 month to 3 months

Jurisdiction	Program	Standard Wait Times[a]	Actual Wait Times[b]
Ontario	Addiction Treatment, Department of National Defence	No standard wait time policies	2 weeks to 1 month
	Psychosocial services, Department of National Defence	No standard wait time policies	0 to 2 weeks
	Regional Opioid Intervention Service at The Royal, Ottawa	0 to 2 weeks	0 to 2 weeks
	Medical withdrawal management beds at The Royal, Ottawa	No answer provided No standards for this program	0 to 2 weeks
	RAAM clinic at The Royal, Ottawa	0 to 2 weeks	0 to 2 weeks
New Brunswick	"Opioid Replacement Treatment," Community Health Centre (Elsipogtog Health and Wellness Centre)	1 month to 3 months	1 month to 3 months
Nova Scotia	Opioid Treatment and Recovery Program, Eastern Zone of the Nova Scotia Health Authority	No standard wait-time policies	Wait times both program- and client-related (e.g., no-shows for appointments)
	Addictions Day Program, Eastern Zone of the Nova Scotia Health Authority	No standard wait-time policies	Continuous admission Clients can join a 3-week education program at any time
Prince Edward Island	ORT program, Health PEI Mental Health and Addictions Services	0 to 2 weeks	0 to 2 weeks
Newfoundland and Labrador	ODT hubs, Government of Newfoundland and Labrador	Other, not specified Just started to use a provincial model Unconfirmed standards of care	No answer provided[e]

ODT = opioid dependency treatment/therapy; ORT = opioid replacement treatment/therapy; PHSA = Provincial Health Services Authority; RAAM = Rapid Access to Addictions Medicine.

[a] Respondents were asked, "Are there any standards, guidelines, or policies in effect in your jurisdiction or facility about wait times for patients seeking opioid addiction treatment services?" and asked to provide specific details if the answer was "yes." If answer was "no," it was assumed there are no standards regarding wait times.

[b] Respondents were asked, "In general, what is the actual wait time for accessing opioid addiction treatment in your jurisdiction or facility?"

[c] There is an injectable opioid agonist therapy clinic and 11 opioid treatment program clinics located in Edmonton, in addition to the Calgary clinics.

[d] One respondent involved with these programs responded "no" to: "Are there any standards, guidelines, or policies in effect in your jurisdiction or facility about wait times for patients seeking opioid addiction treatment services?"

[e] This is assumed to be because of the relatively new nature of the program.

Appendix 8: Barriers and Facilitators to Timely Access to Opioid Treatment — Survey Results

Table 12: Survey Results — Barriers to Timely Access to Opioid Treatment

What are the barriers to timely access (i.e., meeting recommended wait times) to opioid addiction treatment that you currently encounter in your jurisdiction?	
Transportation and Rural/ Remote Locations	Limited public transit, no strong infrastructure to support travel, long travel distances, transport from rural and remote locations
	Inequity of access for patients across region, treatment only available in certain places (e.g., Whitehorse)
No-Shows/Scheduling Difficulties	Client no-shows/missed opportunities, not being open 24 hours, office hours, scheduling difficulties (work, child care, etc.), can delay access if client has used recently
	Weekend and evening options not viable
Staffing and Spacing, Funding, and Demand of Services	Insufficient staffing, lack of prescribers, physician shortages, lack of providers in the community to discharge patients to, lack of pharmacies that will dispense opioid agonist therapy, lack of physicians to oversee program
	Constant demand for services, overwhelming need, high opioid rates in region, with no providers to discharge to, not enough space
	Need for more space and support, not enough support and resources, only six withdrawal beds
	Inadequate remuneration (not equitable or at parity with rest of health system)
	Funding limitations
	Not possible to meet timelines, demand exceeds resource by 200%
Lack of Training	Need for more training
Lack of Integration of Care	Lack of integrated care, disconnection of services, services being in silos, lack of providers in community to discharge to
Stigma	Stigmatization of clinics; because of the nature of services and potential occupational or disciplinary action, may not seek treatment

Table 13: Survey Results — Facilitators to Timely Access to Opioid Treatment

What are the facilitators to timely access (i.e., meeting recommended wait times) to opioid addiction treatment that you currently encounter in your jurisdiction?	
Staffing and Appointment Times	Flexible appointment times, having multiple bookings each day
	Dedicated nurse practitioner prescriber, having a nurse practitioner prescribe
	Having skilled doctors and nurses, having "champions" who provide care, dedicated staff who provide outside clinic hours
Collaboration	Collaboration between physicians and staff, team approach and collaboration, collaboration between addictions and the health system, collaborations between the community and the hospital, working in a multidisciplinary team; working with the College of Physicians and Surgeons, the Association of Registered Nurses of Newfoundland and Labrador, and the Newfoundland and Labrador pharmacy board
	Access to private clinics
Alternative Care Options and Technology	Telehealth, improving telehealth utilization, having electronic medical records for doctors in regional centres
	Transportation initiatives
Support from Government	Rapid access treatment models and investment in them, support from the government, buy-in from care providers
Guidelines and Education	Development of guidelines for nursing staff
	Increased education regarding Suboxone for the community
Having Integrated or Seamless Treatment	Streamlined paperwork and triaging, having case management at the territorial level

Appendix 9: Criteria for Entry and Prioritization of Patients in Opioid Programs in Canada — Survey Results

Table 14: Survey Results — Criteria for Entry and Prioritization

Jurisdiction	Organization	Criteria for Entry[a]	Prioritization[b]
British Columbia	Fraser Health	No answer	No answer
	Adult Custody Division of the Ministry of Public Safety & Solicitor General	Must provide urine sample and attend appointments	No
Yukon	Government of Yukon, Department of Justice	• Diagnosed with opioid use disorder as per DSM-IV criteria • Able to report for daily witnessed dosing • Live in Whitehorse	Provide treatment if criteria is met, so no prioritizing
	Referred Care Clinic Yukon	Anyone can receive treatment. Treatment and assessment is mainly done on Monday, Tuesday, or Wednesday. An assessment will diagnose addiction and then treatment would start.	There are no prioritization criteria. All patients are accommodated.
Northwest Territories	NTHSSA	Diagnosis of DSM-V substance use disorder	Priority if pregnant or if they had had a recent opioid overdose
Alberta	Alberta Health Services	• For oral OAT, must have diagnosis of DSM-V substance use disorder • For injectable OAT, must have diagnosis of DSM-V substance use disorder, current or previous intravenous drug use, and have tried oral OAT	Priority if pregnant or if they have HIV
Manitoba	Addictions Foundation of Manitoba	Must meet OUD criteria, assessment criteria, and have an opiate dependency	Priority if they have risk factors such as pregnancy, intravenous drug use, HIV/hepatitis C status, or multiple overdoses; but the Foundation tries to serve all who come to clinic
Northern Ontario (Thunder Bay area)	Dilico Anishinabek Family Care	Low-barrier access: assessments are done but periods of sobriety are not required	Focus on bed use optimization and not prioritizing patients

Jurisdiction	Organization	Criteria for Entry[a]	Prioritization[b]
Ontario	The Royal, Mental Health Care	16 years of age or greater	Priority by severity of disorder, risk factors, lack of access to other services to meet needs
	Department of National Defence	Must not have access to a car within the local clinic Must be approved by the local clinical authority	Unaware (of prioritization criteria)
New Brunswick	Elsipogtog Health & Wellness Centre	Prenatal, HIV	Yes
Nova Scotia	Eastern Zone of the Nova Scotia Health Authority	Diagnosis of DSM-V substance use disorder, meet the induction score criteria (e.g., COWS score)	Not a lot of need for prioritization, as most patients are treated right away, but adolescents and pregnant women are triaged immediately
Prince Edward Island	Health PEI Mental Health and Addictions Services	Must meet OUD criteria, history of OUD, treatment is patient's best interest	No answer
Newfoundland and Labrador	Opioid dependency treatment hubs, Government of Newfoundland and Labrador	No	First in, first served

COWS = Clinical Opiate Withdrawal Scale; DSM-V = Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; NTHSSA = Northwest Territories Health and Social Services Authority; OAT = opioid agonist therapy; OUD = opioid use disorder.

[a] Respondents were asked: "Are there specific criteria that a patient must meet to gain access to opioid addiction treatment in your jurisdiction or facility?"

[b] Respondents were asked: "Are there specific criteria used to prioritize eligible patients in the provision of opioid addiction treatment in your jurisdiction or facility?"

Appendix 10: Barriers, Challenges, Practices, Approaches, and Supports for Transitions between Settings — Survey Results

Table 15: Survey Results — Barriers and Challenges in Transitory Settings

Setting	Theme	What barriers or challenges do patients receiving opioid addiction treatment face when they are transitioning between care settings in your jurisdiction or facility?
Overall: "There are barriers in pretty much all transitions."	Stigma and judgment	Stigma, lack of knowledge and understanding from providers
	Medication breaks/ changes and lack of desire to prescribe agonists	Small number of trained physicians comfortable prescribing OAT; in Yukon, few physicians will initiate treatment in ED; lack of prescribers in community; ED doesn't want to start agonist therapies, want specialist clinics to, but they don't have the jurisdiction to when patient is in ED
		Breaks in medication; doctors in community settings do not want to continue medication or can't (don't have hospital privileges); lack of understanding by physicians; prescribing the wrong medications (e.g., diazepam instead of OAT); not referring them to the RAAM clinics; lack of understanding/underestimation of the lethality of street drugs
		The prescription renewal not seen as urgent or a priority
		Dosages being adjusted in correctional settings based on urine tests (whatever it is positive for at the time, regardless of impairment); doses may be stopped
		Leaving without a prescription, can't get it renewed
	Communication	Communication is challenging when moving internally or externally
		No oversight in primary care; there lacks any provincial policies or oversight, just recommendations which are not met consistently for transitions of care
		Patients admitted to in-patient settings, discharged without a consultation with agonist prescribers
		Information, basic written or verbal, regarding addiction for patients and families
		No integration of electronic health information systems, and there is incomplete information sharing
	Wait time	Waiting times are long
		Detox is overused for non-continuum support
		Availability of appointment limiting factors for transfer from ER to primary care
	Access	The only program that takes patients directly from corrections
		There is no specialty OAT clinic; OAT providers are just embedded in primary care clinics
		Difficult to access detox clinics
		Transportation to remote and rural location

Setting	Theme	What barriers or challenges do patients receiving opioid addiction treatment face when they are transitioning between care settings in your jurisdiction or facility?
Correctional Setting to Community Setting		Discharged on a Friday, centre not open on weekends
		"There are issues with transition between correctional and community settings."
		Not allowed to increase OAT in jail; limitations on treatments
		In Yukon, inmates can be on remand, go to court, and be released that day, without clinical correction staff awareness
		Loss to follow-up of released prisoners (or remand prisoners)
		Patients on OAT treatment discharged straight from court, then return home to an area with no support or OAT treatment
Private Clinics to Health Authority/ Provincial Care		Private clinics do not follow guidelines
		Clients can be kicked out for poly-substance use with no transfer of care
		Large private agonist “boutique” clinics do not address primary care needs of patients; care then becomes fragmented
Specialty OAT clinics to primary care		Currently unable to discharge many clients from oral OAT to primary care. OAT provider does not know who in the community is willing and able to provide care to the clients.
Calgary iOAT to Correctional Settings		Lack of pharmacies that dispense OAT
Emergency Department to Primary Care		Largecoverage with temporary doctors of ED can prevent transition to OAT (OAT embedded in primary care); when detox occurs, temporary doctorsare unaware of OAT providers

ED = emergency department; iOAT = injectable opioid agonist therapy; OAT = opioid agonist therapy; RAAM = Rapid Access to Addictions Medicine.

Table 16: Survey Results — Practices and Approaches for Continuity of Care

Setting	Theme	What Practices and Approaches are Applied in Your Jurisdiction or Facility to Ensure Continuity of Care as Patients Who Are Receiving Opioid Addiction Treatment Transition Between Care Settings?
Overall		Communication
		Education; education for all doctors and nurses in our RAAM clinic and on the issues of opiates in the community; community forums on fentanyl.
Emergency departments to a specialty OAT clinic or primary care	No Transfer Plans	None; this is being looked at but nothing formally in place right now
	Communication	Telephone consults
		Currently under an integrated services continuum; transitions are facilitated internally along continuum and across disciplines
		Fax sheets with information from ED to Calgary opioid program
		Ongoing phone calls between providers when iOAT client in acute care
	Warm Transfer	"I know that our staff try to practice 'warm transfers' from AFM to transitions as much as possible;" "Warm hand-off." (Also done from correctional centres) Clients are referred before they leave the correctional centre and then intake for the community clinic is done right away.
	Opened-up Referrals	Many patients do not have a doctor — the OAT physicians are acting in this role for other problems such as diabetes or HIV; not an ideal situation. The OAT clinic is housed in the same space as referral-only primary care clinic. The plan is to open referrals up to this clinic so it can take OAT patients with no primary care provider. Also, a clinic that accommodates all OAT patients without primary care physicians and provide primary care in addition to OAT will potentially open up.
	Electronic Medical Records	Electronic medical records flag for all iOAT clients so acute care is aware of dosing. Single electronic medical records across the territory helps provide continuity of information and communication between communities, hospital, and primary care setting
	Dedicated Staff	Relatively small number of doctors who have been exposed to many teaching rounds for Suboxone, methadone provision, and management in acute care settings. Two of the ED docs are also OAT providers, one of them is also is the doctor for the correctional facility.
		A mental health nurse is attached who connects with the correctional facility and patients who are contacting clinics for more information about transitioning into the program from out of territory.
		Local addiction counsellors are very involved with patients during transition.
	Care Pathways	Improved care coordination; integrated treatment for mental health and addiction problems; seamless care pathways with EDs, community services, and primary care.
		Rapid access addiction medicine clinic facilitates linkages and transitions between ED, detoxification, OAT, primary care, public health, and system navigation services.
		Patients are followed until stabilized and connected to either their primary care provider or another service provider.

Setting	Theme	What Practices and Approaches are Applied in Your Jurisdiction or Facility to Ensure Continuity of Care as Patients Who Are Receiving Opioid Addiction Treatment Transition Between Care Settings?
Specialty OAT clinics to primary care	Communication	There is a transfer of care form that can be used, but primary care providers refuse to take stable clients back into their practices to continue OAT.
Correctional settings to community settings	No Transfer Plans	There is nothing formalized, it is hit or miss, they are looking to have some oversight or some provincial guidelines.

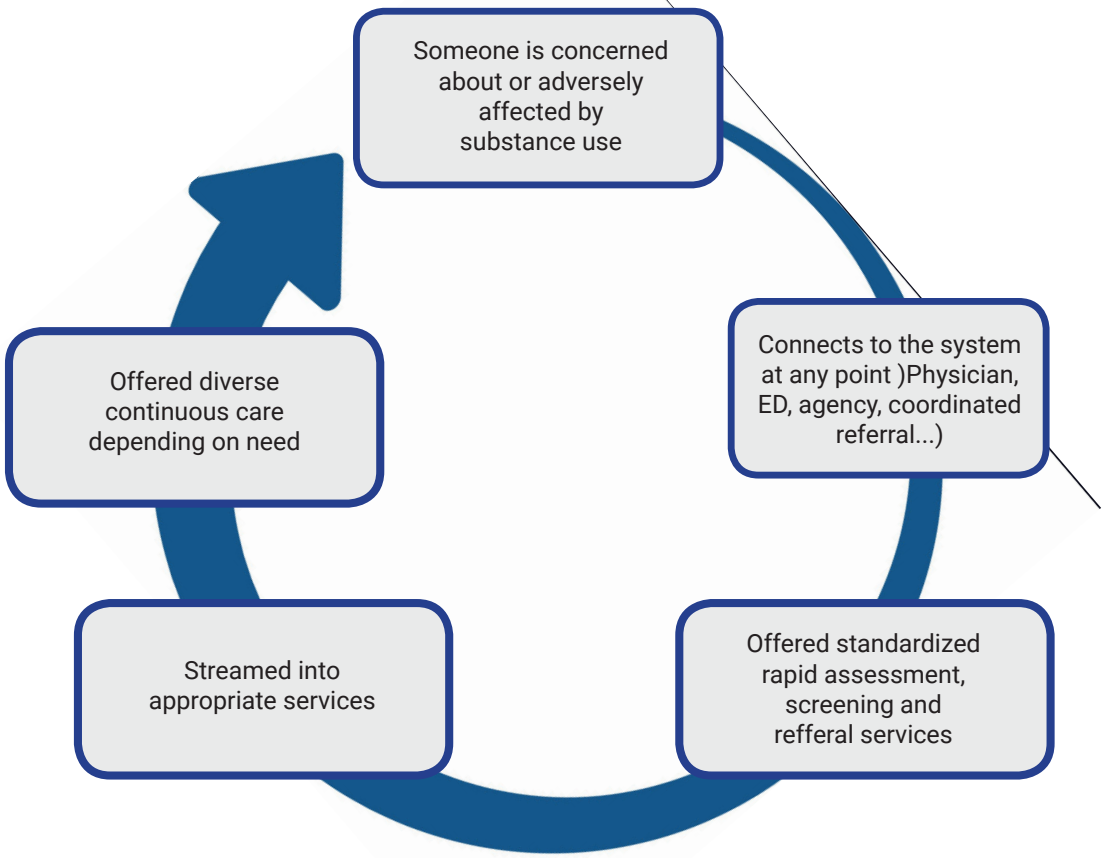
AFM = Addictions Foundation of Manitoba; ED = emergency department; iOAT = injectable opioid agonist therapy;; OAT = opioid agonist therapy; RAAM = rapid access addiction medicine.

Table 17: Survey Results — Supports for Patients in Transitory Settings

Setting	What Supports Are Available to Patients Who Are Receiving Opioid Addiction Treatment in Your Jurisdiction or Facility When They Are Transitioning Between Care Settings?
Detoxification settings to specialty OAT clinics	Case managers in OAT help facilitate this and coordinate care with the OAT prescriber and community retail pharmacy
Specialty OAT clinics to primary care	Not happening in the Eastern Zone, Nova Scotia
Correctional settings to community settings	Telephone work with team leads coordinate care, but this can be hit or miss; there is a good system in place for federal corrections; provincial is more problematic and disjointed
Emergency departments to primary care	Nothing is happening and nothing is in place
	Culturally competent care provision, with access to elders and ceremony
	Case management
	Step up, step down programs
	Housing, single mother with 0 to 6 children supported residences
	Patients in the OAT program may receive referrals to other forms of support with Health PEI or with community Organizations. These supports are available at various transitions in care. Some examples include: psychiatry primary care counselling support groups, food banks, victims services, maternal health programs, employment programs, parenting program, etc.
Outreach services	The OAT clinic has outreach staff that can assist in all of these transitions. The outreach worker can assist in meeting patients where they are at physically and bring them (by car) to OATS clinic, provide information on the clinic, and, if needed, meet the patients at the facility they are transitioning from and connect them with the OATS clinic.
Nursing services	OAT also has a registered nurse who can also help out in an outreach role to assist with transition.
	Also, information from WGH is automatically sent to the electronic medical record of OATS clinic, but only if the patient is already a patient of OATS and is listed as such at the hospital. Usually information is faxed the same day for new referrals.
	Also, providers in all settings often phone the OATS clinic with inquiries, referral information, setting up appointment times for follow-up, etc.
	Also, there is the potential to improve access to naloxone kits and training in facilities and practice settings before a patient is referred to an OAT clinic.
	Counselling
	Medical services from nurse and physician
	Bridge prescriptions when coming from a detox centre to opioid programs in Calgary
	Creating protocols for referral from ED to opioid programs Calgary; creating protocols for continuation of care from iOAT Calgary to Corrections.

ED = emergency department; iOAT = injectable opioid agonist therapy; OAT = opioid agonist therapy; RAAM = rapid access addiction medicine; WGH = Winnipeg General Hospital.

Appendix 11: High-Level Client Pathway for Transitional Care



ED = emergency department.

Source: The Potential Group for the Toronto Central LHIN. Access and integration - Transforming pathways for services for substance use and addictions: Report and recommendations from the Community Strategy Initiative October 2014 – April 2015. In: Toronto (ON): Ontario Local Health Integration Network; 2015. Accessed 2019 May 17.

- These "entry" points into the system can include self-referral, or include referral from emergency services, primary care etc.
- All patients making connection with the treatment system are assisted by friendly and knowledgeable staff members.
- All clients are offered standardized assessment and are screened rapidly.
- After assessment, patients are streamlined to the appropriate service (e.g., intensive case management, withdrawal management, harms reduction, residential treatment, etc.).
- There are no points in the system where a patient is not connected to the system and no patients are "left behind."
- Patients are offered warm transitions between agencies and organizations.
- The system has coordinated referral and access.

Appendix 12: Additional Reports of Interest

CADTH

Evidence on opioids [Evidence Bundles]. Ottawa (ON): CADTH; 2019: https://www.cadth.ca/evidence-bundles/opioid-evidence-bundle Accessed June 24 2019

Out of Date Range

A cross-Canada scan of methadone maintenance treatment policy developments. Ottawa (ON): Canadian Executive Council on Addictions; 2011:
https://ceca-cect.ca/pdf/CECA%20MMT%20Policy%20Scan%20April%202011.pdf Accessed June 24 2019