CADTH

ENVIRONMENTAL SCAN

Programs for the Treatment of Opioid Addiction: An Environmental Scan

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Abbreviations

AFM	Addictions Foundation Manitoba
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DTC	drug treatment courts
ED	emergency department
HMP	Her Majesty's Penitentiary
ISKM	Information Services and Knowledge Mobilization
LHIN	Local Health Integration Networks
MAT	medication-assisted treatment
MATICCE	MAT Implementation in Community Correctional Environments
MMT	methadone maintenance treatment
NL	Newfoundland and Labrador
OAT	opioid agonist therapy
OTC	opioid treatment centre
OTP	opioid treatment program
RAAM	Rapid Access to Addictions Medicine
SAMHSA	Substance Abuse and Mental Health Services Administration
WMS	Withdrawal Management Services

Summary

- A literature search and a survey informed this Environmental Scan. Survey respondents were comprised of stakeholders involved in health care for patients with opioid addiction.
- There are numerous types of opioid programs both in Canada and internationally, including residential treatment, community treatment, primary care, pharmacy treatment, therapeutic communities, and programs within correctional settings.
- Ideally, patients would be seen with no wait times and be accepted into treatment immediately. According to survey results, wait times in Canada vary from immediate service to about three months.
- Facilitators to timely access include walk-in style programming, transportation initiatives, increased staffing, lowered stigma, flexible appointment times, and integrated treatment services. Telehealth programs are also successful in facilitating access to opioid programming across Canada, especially in rural and remote regions.
- Most services appear to accept patients who have a *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V)-diagnosed substance use disorder, with not many other restrictions. Common prioritization criteria for services include patients who are at high risk, such as pregnant patients, adolescents, and individuals with HIV.
- Communication and integration of services was noted as key to improving transitions between settings, including from the emergency department (ED) to primary care, primary care to specialized clinics, and from correctional settings to the community.

Context

Opioids are a class of drugs that provide pain-relieving properties and often a sense of euphoria. Opioids can be obtained through a prescription (such as codeine, fentanyl, morphine, oxycodone, and hydromorphone) or illegally (such as heroin).[1] Substance abuse and opioid addiction occur when an individual misuses opioids in a problematic way, such as when incorrect dosages of opioids are taken or prescriptions are misused.[2] Often, this is accompanied by the four "C's" of addiction:

- cravings
- a loss of control of amount or frequency of use
- compulsion to continue using
- use despite negative consequences.[2]

Canada consumes the second-highest number of opioid products per capita, with only the US consuming more.[3] Over-prescribing and consumption of opioids, paired with the addictive nature of the drug, has led to high rates of opioid misuse, addiction, and overdose. Between January 2016 and September 2018, more than 10,300 apparent opioid-related deaths occurred in Canada, with a large percentage (more than 90%) of these deaths being accidental.[4]

Treatments for opioid addiction include pharmacological treatments and non-pharmacological treatments. Pharmacological treatments include opioid agonist therapy (OAT) — a prescribed treatment of an opioid agonist such as methadone or buprenorphine/naloxone. These agonists must be taken daily; they prevent withdrawal but do not produce the euphoric high of other opioids.[5] Non-pharmacological treatments include counselling, psychological therapies (such as cognitive behavioural therapy), and psychosocial support.[6]

Other harms reduction strategies can be used to lessen the negative consequences of opioid use, such as safe injection sites and naloxone kits.[7] However, in Canada, limited availability of specialized treatment services and the rising demand for intervention limits accessibility.[8] While guidance and inventories of programs are available, there is interest in understanding the front-line practices and approaches to providing care for individuals with opioid addiction. Some of these practices may influence policies or programs that jurisdictions choose to implement, or practices within existing programs. There is specific interest in program availability and wait times, as well as best practices for supporting patients in receiving OAT through care setting transitions. There is a need to gain perspective on the current context of use of different programs and practices for opioid addiction, and a better understanding of the movement of patients through the system.

To support these needs, CADTH conducted an Environmental Scan to gain direct stakeholder perspectives on the current context surrounding opioid addiction programs (including both OADs and other non-pharmacological programming) and care setting transitions. For the purposes of this report, opioid substitution therapy is referred to as OAT. OAT includes methadone and Suboxone (buprenorphine/naloxone) therapies. Suboxone is buprenorphine combined with naloxone (equivalent to buprenorphine/naloxone). Opioid addiction refers to an addiction to any form of opioids, including illicit opioids such as heroin, and prescription opioids such as oxycodone. For the purposes of this report, opioid addiction also encompasses opioid use disorder and substance use disorder related to opioids. In this report, OAT includes both pharmacological treatment and non-pharmacological treatment.

Objectives

The key objectives of this Environmental Scan are as follows:

- Describe the opioid addiction treatment programs that are currently available for use in Canada and internationally.
- Identify the recommended wait times for opioid addiction treatment programs in Canada.
- Summarize the factors influencing wait times for opioid addiction treatment programs in Canada.
- Identify the patient characteristics or prioritization criteria in use for determining entry to opioid addiction treatment programs in Canada.
- Describe current practice as it relates to supporting patients receiving opioid agonist therapy through care setting transitions.

This Environmental Scan does not include an assessment of the clinical or cost-effectiveness of opioid addiction treatment programs. Thus, conclusions or recommendations about the value of these programs are outside the scope of this report. For more information on intervention effectiveness, the Canadian Research Initiative in Substance Misuse published a national guideline concerning the clinical management of opioid addiction, including a review of pharmacological and non-pharmacological treatments.[9] CADTH has also published an Evidence Bundle with information on prescription opioid abuse prevention and treatment.[10]

This Environmental Scan does not endorse one form of OAT over others, nor is it a comprehensive list of all available types of addiction programming, forms of treatment, or settings of treatment.

Methods

This Environmental Scan is based on a limited literature search combined with a survey (Appendix 1) distributed to identified relevant stakeholders across Canada.

Literature Search

This Environmental Scan is based on a limited literature search. Relevant published literature was identified primarily through a targeted MEDLINE search; grey literature was retrieved through a focused Internet search. The literature search was limited to English-language documents published between January 01, 2013, and November 29, 2018. Citations retrieved before May 9, 2019 were incorporated into the report. Table 1 outlines the criteria used for information gathering and screening.

Research Questions

The literature review attempted to address the following questions through the literature search:

1. What opioid addiction treatment programs are currently available for use in Canada for individuals with substance abuse problems?
2. What opioid addiction treatment programs are currently available for use internationally for individuals with substance abuse problems?
3. What are the recommended wait times for individuals entering opioid addition treatment centres or programs?
4. What are the facilitators and barriers to timely access to opioid treatment centres or programs?
5. What are the prioritization and patient selection criteria used to determine entry of individuals into opioid treatment centres or programs in Canada?
6. For patients receiving opioid addiction treatment and are transitioning through different care settings, what are the current policies, practices, and guidelines?

Screening and Study Selection

One author independently screened titles and abstracts for eligibility according to the inclusion criteria outlined in Table 1. Articles that were published in a language other than English or French, or were published prior to January 1, 2013, were excluded. For research questions 1 and 2, the following types of publications were excluded: reports that were not a review or summary (i.e., were randomized controlled trials, cohort studies, etc.) or were not inventories or summaries of opioid addiction programs (i.e., focused on one addiction program or focused on non-opioid substance abuse).

For research questions 3, 4, 5, and 6, there were no limitations on publication type, except conference abstracts, which were ineligible.

Table 1: Components for Literature Screening and Information Gathering

	Inclusion
Population	Patients with opioid use disorder (other names: opioid addiction, substance use disorder, opioid abuse disorder)
Intervention	Opioid addiction treatment programs including: • OAT or pharmacological (e.g., methadone [Methadose] or buprenorphine [Suboxone] therapy, clonidine) treatment programs • other opioid addiction/disorder treatment programs (e.g., psychological, risk-reduction, multimodal approaches)
Settings	Any setting (community, in-patient, acute care) Settings of interest: • correctional settings (e.g., probationary settings, prison settings, bail supervisory settings, parole settings, alternative measures programs, etc.) • transitionary settings (i.e., supporting patients on OAT who are transitioning between care settings such as from an emergency department or correctional facility to a specialty OAT clinic or primary care, etc.)
Types of Information	RQ1: Inventories of opioid addiction treatment programs within Canada RQ2: Inventories of opioid addiction treatment programs internationally (countries) RQ3: Recommended wait times for entry into opioid addiction treatment program RQ4: Facilitators and barriers to timely access and availability of opioid addiction programs RQ5: Criteria for entry into opioid addiction treatment programs; prioritization structure and criteria for patients entering or on wait lists for opioid addiction treatment RQ6: Policies, practices, or guidelines for transitioning clients between care settings (see Settings in this table).

OAT = opioid agonist therapy; RQ = research question.

Survey

A survey was conducted to address the objectives of this Environmental Scan. The survey was distributed electronically using SurveyMonkey (www.surveymonkey.com) to key jurisdictional informants and stakeholders involved in research, planning, management, and service provision related to opioid addiction treatment in Canada. Survey respondents were identified through CADTH's Implementation Support and Knowledge Mobilization (ISKM) team networks, and other available networks via stakeholder and expert suggestions.

The electronic surveys were distributed to stakeholders in March of 2019 via email invitation. The survey targeted the following categories of respondents:

- health care providers, in various care settings, involved in OAT including providers of direct front-line care to patients with opioid addiction
- policy-makers involved in policy development for the care of patients with opioid addiction
- clinical decision-makers involved in program or practice development for the care of patients with opioid addiction; Subgroups of interest were respondents with a Correctional Service perspective.

The survey consisted of 22 questions, including questions regarding demographics, wait times, barriers, and facilitators to timely access, prioritization of patients, and support of patients across care settings. A full list of questions is provided in Appendix 1.

The survey questions were reviewed by external stakeholders and piloted within SurveyMonkey by independent CADTH researchers who were not involved with the project.

Synthesis Approach

Feedback from respondents who gave consent to use their survey and consultation information were included in the report. Survey responses were excluded if all answers (other than demographics) were blank, the respondent refused participation, or if consent to use information was not provided.

Responses were analyzed by the objectives of this Environmental Scan, then by organization and jurisdiction. In the case of multiple responses from one organization, all responses were included. Quantitative and multiple choice answers were summarized through tables by organization and presented narratively. Qualitative (or open-ended) answers were categorized using thematic analysis and were also presented narratively and in tables.

Findings from the literature search were presented separately from survey results and were summarized narratively. When summarizing the available addiction programs internationally, countries were chosen based on similarities to the Canadian context (e.g., prevalence of opioid misuse, type of health care system, population characteristics, and gross domestic product [GDP], and on the depth of information available).

Findings

The findings presented are based on survey and literature results. The survey was distributed to 72 stakeholders representing all Canadian provinces and territories. Nineteen total survey responses were received and 10 jurisdictions responded to the survey, including Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador (NL), the Northwest Territories, Nova Scotia, Ontario, Prince Edward Island, and Yukon. Appendix 2 describes survey respondents and the organizations represented.

The literature searches yielded 1,119 citations, of which 36 studies were determined to be eligible to address the research questions. Fifteen articles were published in Canada, seven articles were published in the US, five articles were published in Australia, one was published in New Zealand, two articles were published in France, one was published in Spain, one was published in Sweden, one was published in Switzerland, and one was published in the UK. Two articles focused on European countries in general. For additional information, grey literature — including government websites and program websites — were also included.

Objective 1: Opioid addiction treatment programs currently available for use in Canada and internationally

This objective was addressed by research questions 1 and 2 based on findings from the literature. More information on specific programs can be found in Appendix 3, Appendix 4, and Appendix 5.

The most commonly cited type of opioid addiction treatment program was OAT. This includes methadone and Suboxone (buprenorphine/naloxone). The following programs are not an exhaustive list of all possible opioid programming available in each province or country.

Some provinces include a directory of programming available in their jurisdictions. For example, The Government of Saskatchewan publishes a *Directory of Mental Health and Addictions Services in Saskatchewan*.[11] The Regional Health Authorities of New Brunswick publish a list of addictions and mental health services on their health networks Horizon and Vitalité.

Canada

Each province and territory has individual OAT programs that have different policies and practices.[12] The biggest expansion in opioid treatment has occurred in British Columbia and Ontario, although other provinces are starting to expand programs to meet the increasing demand.[12]

In Canada, treatment is generally provided at a clinic, a physician's office, or at a pharmacy. Family physicians and psychiatrists provide the majority of OAT and previously could prescribe methadone if they obtained an exemption under Section 56 of the *Controlled Drugs and Substances Act*. As of May 19, 2018, physicians no longer require this exemption.[13] In a primary care setting, OAT is generally provided in:

- provincially funded addiction programming clinics, with comprehensive services over a variety of disciplines
- a physician's office, subsidized by a provincial funding stream
- in federal or provincial correctional facilities.

Indigenous Services Canada provides methadone for First Nation, Métis, and Inuit patients.

Multidisciplinary Treatment (Pharmacotherapies and Psychosocial Therapies)

Programs in Canada are usually multidisciplinary in nature, often combing both pharmacotherapies and psychosocial therapy. In British Columbia, the College of Physicians and Surgeons of British Columbia requires simultaneous treatment of mental health and addictions.[12] In Saskatchewan, physicians supplying methadone maintenance treatment (MMT) must also refer patients to addiction counsellors. [11] The *Methadone Maintenance Treatment Handbook* from the College of Physicians and Surgeons of Nova Scotia suggests that all MMT programs should include collaborative treatment, including counselling and case management.[14]

One of the major providers of addiction services in Manitoba, Addictions Foundation of Manitoba (AFM), runs the Manitoba Opioid Support and Treatment program in Winnipeg and Brandon. This program combines counselling, education, needle exchanges, and linkages with other community supports. AFM also runs a program called the Methadone Intervention and Needle Exchange Program, based on a harms reduction strategy. The program has a team-based approach with a physician and nurse, as well as a needle exchange program, an on-site dispensary, group meetings, traditional healing, and psychosocial supports. In St. John's, NL, there is the Opioid Treatment Centre, which serves the Eastern Region of NL.[15] It is a multidisciplinary outpatient program that has no set length of treatment but encourages treatment for at least one year.[16]

Pharmacotherapies

In British Columbia, methadone historically has been the standard of care and in 2016, 80% of individuals in medication-assisted treatment (MAT) were using methadone as their form of OAT.[17] All four Atlantic provinces have provincially funded methadone programs.[12] To prescribe methadone, many physicians require special approval or exemptions. For example, in Alberta, the College of Physicians & Surgeons of Alberta (CPSA) oversees the guidelines surrounding OAT and approves physician prescribing of OAT.[12,18] In Ontario, methadone is dispensed in a liquid formulation and patients initiating treatment will often receive their medication at a specialized addiction clinic, under observation. After stabilization, patients will then receive their treatment through a family physician or community pharmacy.[19] Ontario and NL also allow nurse practitioners to administer treatment, in addition to physicians, [7,15] to combat the lack of physicians available to prescribe treatment.[15] NL has had an established methadone program since 2005 but currently only has seven physicians for more than 1,000 patients (with 14 physicians in total with an exemption to prescribe methadone and/or Suboxone).[12,15]

Buprenorphine/naloxone is also used as a pharmacotherapy in Canada. British Columbia introduced the treatment in 2010 and added it to the regular health care benefits (removing the requirement to "fail" treatment on methadone).[17] The number of individuals on this treatment has subsequently increased.[17] British Columbia is also experimenting with greater access to hydromorphone (dihydromorphinone) for patients with opioid addiction.[7]

Rapid Access to Addiction Medicine Clinics

Some jurisdictions run Rapid Access to Addictions Medicine (RAAM) clinics. These are low-barrier, walk-in clinics that can help guide a patient though substance abuse treatment and connect them with other services.[20] They do not provide emergency services. RAAM clinics are available in Manitoba, Winnipeg, Thompson, Brandon, and Selkirk.[21] In Toronto, there are RAAM clinics at the St. Joseph's Health Centre, Women's College Hospital, and St. Michael's Hospital. These clinics serve patients requiring non-urgent care and increase access to OAT medications but do not manage acute withdrawal (especially in poly-substance use), so a large portion of withdrawal management still occurs in emergency departments (EDs).[22]

First Nations and Inuit Programs

In Sioux Lookout, Northwestern Ontario, there are 32 remote First Nations communities, with 22 of these communities having their own buprenorphine/naloxone programs. Initiation is performed by a community physician, who is present one week each month, or by urban-based physicians who fly in as a locum tenens (temporary doctors), with follow-up performed through telemedicine.[23] As of 2017, these programs were treating 1,399 patients.[23] Most programs are held in an unused or refurbished community building and have a service delivery team of program coordinators, medication dispensers, consultant counsellors, nurses, and physicians. The physician assists with the induction of buprenorphine-naloxone, and the community nurse or addictions worker dispenses the daily dosages. After induction, patients receive four weeks of intensive day treatment, with some programs providing an aftercare program consisting of trips of fishing, gardening, hunting, or traditional walks.[23]

Various pilot programs are also in use in remote First Nations communities. For example, in one Nishnawbe Aski Nation, a Suboxone low-dose program was piloted, with 30% remaining abstinent after six months. In Thunder Bay, the Dennis Franklin Cromarty High School piloted a drug program with clinical, cultural, and psychoeducational aspects for students.[24]

Despite relatively fewer opioid issues than other provinces and territories, Nunavut does have plans for three "healing camps" for addictions treatment providing "on the land" care that were proposed in August of 2018.[25] These are Cambridge Bay in Kitikmeot (Cambridge Bay Wellness Centre), Rankin Inlet in Kivalliq (Pulaarvik Kablu Friendship Centre), and the Qikiqtaaluk Region (formerly the Baffin region), location not decided.[25] These camps would provide 28-day substance use recovery three to four times a year and potentially a 28-day outpatient treatment two times a year. Additionally, a Nunavut Recovery Centre with 32 beds to operate year-round was proposed.

Overdose Response and Supervised Injection Sites

Currently, British Columbia has an established Overdose Emergency Response Centre, with a strategic mandate of working to invest in and improve mental health and addiction services to combat the growing opioid crisis.[26] One essential health sector intervention — "treatment and recovery" — is tasked with ensuring access to evidence-based medications and treatment, and ensuring the delivery of a continuum of treatments that combine both pharmacological and psychosocial aspects.

Many other provinces have naloxone kit or naloxone distribution services, such as Manitoba (started in 2017), the Northwest Territories,[27] NL,[28] and Ontario (Ontario Naloxone Program). [7] Nunavut has a focus on naloxone availability and education, as this jurisdiction does not have the same extent of opioid-related harms as other jurisdictions.[7] In 2016, it was announced that the Government of NL will provide funding to the AIDS committee of NL (ACNL) and to the NL health authorities to create a harms reduction-based naloxone program.

Vancouver is home to the first safe injection site in the country (together with other harms reduction strategies),[17] as well as low-threshold addiction treatment programs.[7] As of 2018, Alberta runs four supervised consumption sites (with another five expected to open), with one providing supervised inhalation services.[7] Quebec has four supervised injection sites, all located in Montreal.[29] The AIDS committee of NL also runs the ACNL Safe Works Access Program (SWAP)[30] — a needle distribution service in Corner Brook (with arrangements for delivery of supplies to outside of Corner Brook).

Hub-and-Spoke Models of Care

In Nova Scotia, the "hub-and-spoke" model is often used for MAT. In this model, a centralized "hub" is a specialized clinic that carries out induction and stabilization and manages complex cases. Nova Scotia currently manages approximately five such hubs.[31] After stabilization, patients are then referred to primary care clinics — the "spokes" — to continue treatment. In this model, complex or difficult cases are managed by specialized providers, and allows for patients to transfer between the levels of care based on individual needs. Although the hub-and-spoke model allows for varying levels of specialized care, it requires strong communication between each level and, if demand for services increases past what the hub can provide, then a bottleneck effect may occur. [31]

Yukon has a Referred Care Clinic in Whitehorse for providing opioid treatment. In 2018, Yukon released a 2018-2020 opioid action plan, which includes commitments to providing naloxone kits, increasing public awareness about opioids, surveillance of opioid-related deaths, and working on pain management across the province. Yukon is committed to consolidating opioid treatment to the Referred Care Clinic and building it as a hub of opioid treatment and expertise.[32]

Telehealth

Telehealth (also known as telemedicine) is the use of technology to provide health care services to patients.[33] Telehealth can help lower barriers to care for patients with opioid addiction, as it facilitates connections between either providers and patients, or providers and other providers, for opioid treatment programs. This can eliminate obstacles to treatment such as distance to a facility or prescriber, strict surveillance of patients (requirements to come into the clinic daily), and assist with transitions between settings.[33] Ontario has capitalized on the use of telehealth through the Ontario Telemedicine Network.[12] In Stephenville and Springdale, NL, telehealth has helped doctors treat patients remotely instead of patients having to drive 250 kilometres to the clinic.[34]

Alberta also runs a program called the Virtual Opioid Dependency Program (originally Rural Opioid Dependency Program). This is provided through Alberta Health Services and is available for individuals living in areas without an established opioid dependency program. Appointments for initiation and maintenance of treatment are done via teleconference, with an individualized treatment plan. Medication is received at a pharmacy in the patients' communities.[35] Alberta also has an opioid dependency advice line for physicians to consult with specialists for advice on treatment.[7]

Correctional Setting

Canada

Federally, harms reduction strategies are available for prisoners, including OAT (methadone). However, needle exchange programs and clean needle provision are not common in prisons.[36] A phased gradual pilot of two needle exchange programs (one at a men's prison, one at a women's prison) began in June of 2018 and is expected to expand in 2019.[37] Appendix 4 details some non-pharmacological-based programs available for inmates in Canada. These include the Integrated Correctional Program Model and various national substance abuse programs. Access to OAT within the correctional setting is currently available in British Columbia. In that particular province, in both federal and provincial prisons, OAT can be either continued or initiated, using either methadone or buprenorphine/naloxone. In provincial settings, OAT was provided privately until September of 2017, when it was transferred to the publicly funded Provincial Health Services Authority.

In Alberta, within four hours of admission to a provincial correctional setting, an assessment is performed to determine which prisoners require additional addiction support and mental health services.[33] Many facilities do not have policies that are specific to the management of withdrawal and addiction.[33]

There are 26 provincial adult prisons in Ontario. In a survey of physicians within these settings, there was representation from 15 of these prisons, with all participants stating that there was at least one physician who prescribed OAT. The majority of these participants indicated that they continued both buprenorphine (77% of physicians indicated that they prescribe buprenorphine) and methadone (100% of physicians indicated that they prescribe methadone) in their correctional setting if already prescribed it in their communities, with fewer participants initiating treatment in the correctional setting.

In NL, within Her Majesty's Penitentiary (HMP) in St. John's, MMT is supplied and a physician works with patients who were on MMT prior to incarceration.[15] The health care unit at HMP includes a general practitioner, a nurse practitioner, an addictions coordinator, and staff nurses. They also have psychiatrists and psychologists available for the inmates.[15] HMP

houses all male inmates who were on MMT prior to incarceration, and these inmates attend mandatory weekly group sessions. Outside of St. John's, the other four correctional centres have part-time contract nurse practitioners and monthly access to a psychiatrist. In the NL correctional centre, women have access to services from Stella's Circle, and access its services continues in St. John's post-release. HMP, West Coast Correctional Centre, and the Labrador Correctional Centre also offer the Integrated Correctional Program Model as previously detailed.[15]

Drug Treatment Courts

In Canada, federal drug treatment courts (DTCs) exist as a drug reform method, modelled after the US drug treatment court system. Since 2006, six DTCs have existed across Canada (located in Edmonton, Ottawa, Regina, Toronto, Vancouver, and Winnipeg).[38] These DTCs provide intermediate supervision, substance use treatment, and behavioural treatments as an alternative to incarceration.[39] DTCs are only available for offenders who meet specified criteria, including active addiction to "hard drugs" such as cocaine, crack cocaine, heroin (and other opiates), and methamphetamines.[40] Appendix 5 contains a list of internationally recognized principles used in Canadian DTCs (Table 10) and a list of current DTCs in Canada (Table 9).[38]

Internationally

United States

In 2011, in the US, there were 1,103 programs that offered outpatient opioid services. Of these, 58.0% were for-profit businesses, 33.5% were non-profit organizations, and 8.5% were public programs. In 2002, the office-based administration of buprenorphine was approved by the FDA and, in 2012, 51% of opioid treatment programs (OTPs) offered it as a service.[41] Federal law requires OTPs to provide medical, vocational, educational, counselling, and other assessment and treatment services, together with medication. OTPs must also be accredited and certified by Substance Abuse and Mental Health Services Administration (SAMHSA) or SAMHSA accrediting bodies.[42,43] Providers are allowed to treat up to 100 patients with MAT (changed from 30 in 2006[43]) if they hold a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology, and provide MAT in a qualified practice setting. [44] MAT in the US often follows a "high threshold, low tolerance" model, referring to a high number of structural barriers to service and a low tolerance for negative behaviours such as using or tardiness. These services often have forced tapering of OAT, high travel distances to programs, high financial costs to patients, a "not in my back yard" stigma, punishments for missed appointments, and high supervision and control over a patients' daily life.[43] Access to methadone programs is also restricted to patients who have had opioid addiction for more than one year.[42,43]

SAMHSA operates a buprenorphine practitioner locator[45] and an OTP directory[46] on its website. The OTP directory is sorted by state. OTPs were located in every US state (as well as the District of Columbia and the territories of Puerto Rico and the Virgin Islands) except North Dakota and Wyoming in 2015. As of 2019, North Dakota appears to have three available OTPs. Some states have specialized treatment centres in which methadone initiation, stabilization, and maintenance occur in one setting.[31]

Legislation for treatments for prescription opioid addiction vary state by state in the US, but they have state-run prescription drug-monitoring programs, extended naloxone access in law enforcement and paramedics, immunity from law enforcement for individuals seeking

overdose treatment, expansion of screening and treatment for substance abuse, and prescription drug take-back programs.[41]

Vermont also runs a system similar to Nova Scotia, using a public health response to addiction through a hub-and-spoke model of care.[47] However, some states are very strict with regulations surrounding OTPs and this limits the number available to patients (e.g., Mississippi, where only one OTP is available). This means that many patients will cross state borders to receive the care they need.[47] Some states have various opioid-related projects occurring. In North Carolina, for example, the North Carolina Harm Reduction Coalition runs a grassroots advocacy initiative implementing harms reduction and public health interventions such as overdose prevention projects. There is also Project Lazarus — an overdose prevention program that provides training.[48]

Telehealth in the US is also used similarly to Canada. emocha, a mobile health technology company specializing in patient engagement and medication adherence,[49] created an application to be used by patients in OAT, where they can film themselves on a smartphone camera taking medications that requires direct observation therapy and record doses and side effects. This allows clinicians to monitor patients' adherence to medication, communicate with patients, and review progress.[50] SAMHSA also has a smartphone app called MATx for health care practitioners providing care for opioid addiction.[51]

Australia

There are more than 46,000 patients using OAT in Australia.[52] At public clinics in Australia, OAT is provided free of charge. In the community pharmacy, State Health Departments provide methadone free of charge and the patient pays a dispensing fee. General practitioners' visits are covered under Medicare.[53] Methadone is dispensed under direct supervision and after some time may be taken as two take-home doses per week.[53] Australia has an opt-in OAT program in which 60% of pharmacies do not provide OAT.[52] Approximately 43% of OAT is provided in community pharmacies.[52] OAT is also delivered in Australia through specialized clinics, general practice, correctional settings, and through public hospitals, with abstinence-based therapies only supported by the government for alcohol dependence and not for opioid dependence.[53] In New South Wales, there is a network of specialized OAT clinics within public hospitals, but in other parts of the country OAT is provided through community pharmacies. [53]

New Zealand

OAT started in New Zealand in the early 1970s[54] and buprenorphine was subsidized by Pharmac in 2012. In 2012, there were 5,018 patients in OAT. The Ministry of Health proposed an integrated model with general practitioner and specialist care at a ratio of 80% to 20% for New Zealand in 1992, but this ratio was eventually revised to 50/50. Currently, the percentage of patients continuing OAT in primary care is 29%. In 2014, New Zealand published practice guidelines for opioid substitution treatment. [55] These guidelines emphasized that treatment in New Zealand has a standardized method of person-, recovery-, family-, and whānau-centred[a] care.[55]

European Countries

Opioids are the principal drug in 36% of drug treatment cases in Europe, and 628,000 individuals received OAT during 2016.[56] The *European Drug Report 2018* summarizes

[a] A Māori word for extended family.

developments in drug-related treatment and prevention for 30 European countries and includes individualized Country Drug Reports for each country. These reports can be found on the European Monitoring Centre for Drugs and Drug Addiction website.[57] In general, most drug treatment is provided on an outpatient basis and in specialized outpatient clinics, followed by "low-threshold" agencies. Drug treatment is also provided by primary care (including family physicians) and general mental health centres.[56] In-patient services are provided in European countries in hospitals, therapeutic communities, and specialized residential treatment centres, but the extent of in-patient treatment varies between countries. [56]

The primary intervention for opioid-specific drug treatment is OAT (provided in specialized outpatient settings, in-patient settings, and prisons), followed by psychosocial interventions such as counselling, therapies, and intervention support groups.[58] In-patient treatment is not common but often includes prerequisites for entry, individually structured treatment, and psychosocial rehabilitation with the intent to reintegrate those addicted to opioids into society. National provision of OAT varies, with methadone being the most commonly prescribed OAT overall, followed by buprenorphine. In eight countries — Croatia, France, Sweden, Cyprus, Norway, Greece, the Czech Republic, and Finland — buprenorphine is more commonly prescribed than methadone. Buprenorphine is not prescribed in Ireland, Estonia, the Netherlands, or Romania.[56]

Similarly to Canada, European countries are also experimenting with e-health services and "m-health" (e-health provided through mobile phones) using virtual or digital technology to provide specialized care for individuals with opioid addiction.[58] Examples of these programs include MijnJellinek — a Dutch program combining e-health and face-to-face therapy — and ORION (Overdose Risk InfOrmatioN tool), which calculates an overdose risk score for the patient, with the intention of starting a dialogue for health care providers and increasing awareness of overdose risk.[58] According to a report by the European Monitoring Centre for Drugs and Drug Addiction, there are 67 smartphone-based apps for drug-related health services. These include apps that provide drug-related information and advice, apps that provide interventions for drug users, and apps that provide capacity building initiatives for health workers.[50]

United Kingdom

The drug treatment system in the UK is assigned to different local authorities in each country. These include local authorities in England, local health boards in Scotland, community safety partnerships in Wales, and drug and alcohol coordination teams in Northern Ireland.[59]

In the UK, services include community-based prescribing, one-on-one and group psychosocial interventions, in-patient treatments, partial and full-time residential treatment programs, and day programs. Outpatient, community-based, specialized drug treatment centres are the most common providers of drug treatments, including specialized OAT treatment centres. Methadone and buprenorphine (and infrequently, prescribed injectable methadone and diamorphine) are available from general practitioners and specialized doctors. [59]

France

France has a unique system in which buprenorphine is prescribed by general practitioners and dispensed by retail pharmacies,[60] but methadone is only available in specialist centres.[61] Buprenorphine is prescribed more frequently (59%) than methadone (41%).[62] There are about 100 sub-regions of France, with the majority of these areas having a specialized drug treatment and prevention centre, the CSAPA. However, many opioid users are treated in

hospitals as part of the general health care system, not in CSAPAs, and their information is not collected in the French data collection system.[62]

Spain

In Spain, the policies for drug treatment is overseen by the National Strategy on Addictions, but the autonomous communities are in charge of implementation and the provision of care.[63] The *Country Drug Report 2018* for Spain states that a specific drug dependence care network is distributed across the country, and care consists of both in-patient and outpatient services.[63] OAT therapy has a coverage (a ratio of interventions provided to interventions needed) of approximately 60% (as of 2010).[64] Currently, OAT is provided at 2,000 in-patient, outpatient, or other health centres.[63] Physicians in private practice can be licensed to prescribe and dispense methadone at no cost to the patient.[64] Buprenorphine/naloxone can be purchased by patients from all pharmacies, for a cost, but methadone must be collected from a dispensing centre.

In-patient services include: detoxification units, apartments for reintegration and treatment, and therapeutic communities. Outpatient services are generally low-threshold services working at a first-care level, screening patients and providing mental health treatment, or specialized drug treatment centres working at a secondary level. Specialized treatment centres are usually multidisciplinary and provide psychosocial treatments in addition to OAT.[63]

Greece

OAT in Greece is provided by the Organization against Drugs (OKANA), who manage "prevention centres, treatment units and social and professional reintegration centres."[65,66] Other drug treatment programs are fully or partially funded by the government and include psychosocial interventions, outpatient treatment for both adults and adolescents, and specialized drug treatment centres.[57] In-patient services are based on a 21-day detoxification treatment program in prisons, therapeutic communities, and residential drug treatment centres.[57] As of 2016, 66.4% clients were entering specialized treatment centres for opioid use.

Other organizations provide support and treatment for addictions, including the Therapy Center for Dependent Individuals (KETHEA). These organizational programs are established in various areas of Greece and are generally abstinence-based, counselling-based treatment centres or programs. [67]

Ireland

Harms reduction in Ireland has broad support through drug policies and practices. Needle and syringe programs are provided in 24 permanent sites, 14 outreach sites, and in 129 community-based pharmacies.[65] OAT has been available since 1992, and is provided by treatment centres, general practitioners, and within the correctional setting.

Italy

In Italy, the drug treatment focus is more commonly on prevention and abstinence, or reduction of drug use, and not on harms reduction strategies. Despite this, OAT — both methadone and buprenorphine — services are available in the community, most commonly in the northern and central urbanized regions of Italy.[65,68] These services include fixed sites, mobile dispensing units, outreach, and needle disposal and dispensing services.[65] Drug treatment is split into two subsystems — the public drug dependency service units providing

outpatient services and the social-rehabilitative facilities providing mostly in-patient and semi-outpatient services. Interventions available include psychosocial supports, psychotherapy, detoxification, and vocational training.[68] OAT is available through general practitioners and specialized treatment centres, but it is most commonly initiated in public drug dependency service units.[68]

Sweden

Health care and social services have joint responsibility for addiction services in Sweden.[69] In Sweden, the general view of opioid treatment is that it should be used as social rehabilitation and "normalization" — i.e., getting patients back to a "normal" life and integrating them into mainstream society.[69] The national regulations are issued by Socialstyrelsen (the National Board of Health and Welfare), and these tend to be fairly restrictive relative to other countries.[69] Opioid programs can only give OAT to individuals over the age of 20 who have been opioid-dependent for at least one year. To be eligible, dependence must be on heroin, morphine, or opium and not methadone, buprenorphine, or fentanyl, and no poly-substance use is tolerated. Medication is administered with daily supervision for at least six months.[69]

Objective 2: Standard and recommended wait times for opioid addiction treatment programs in Canada

Literature findings and survey results from research question 3 are addressed in this objective.

Survey Results

Wait times for opioid treatment can vary substantially and standard or recommended wait times for opioid addiction are dependent on the location and the type of and demand for a service or program. Wait times can be heavily influenced by the prevalence of opioid use in the region, the style of service model implemented, and staff vacancies.[70] Eight respondents stated the standard wait time policy was 0 to 2 weeks of waiting time, and actual wait times appeared to not deviate substantially from the standards or policies in effect for each program. In some regions of Northern Ontario, standard wait times were reported to vary from one to three months in outpatient settings, to three to six months for in-patient and post-treatment. However, in the Opioid Maintenance Therapy Initiative in the Northwest Territories, standard and actual wait times were reported to be zero to two weeks for treatment. New Brunswick (Elsipogtog Health & Wellness Centre) also had longer-than-average wait times of one to three months.

Some programs run a cancellation wait-list policy within their system. This wait-list approach is similar to a regular chronological wait list, but upon each intake cycle more patients than the number of available beds are processed and prepared. The additional patients are available to take the place of individuals who may cancel, be incarcerated, or not show up for treatment. If the prepared patients do not take a cancellation, they are guaranteed to be accepted into the next cycle of patients. This is to ensure that the program is at maximum capacity and that beds are always full.

Appendix 7 details the standard and actual wait times experienced by various programs in Canada, as provided by survey results.

Table 2: Strategies to Improve Timely Access to Opioid Treatment — Survey Results

What strategies or initiatives are in place at your facility/setting to improve wait times for patients entering opioid addiction treatment?	
Walk-Ins and Fast-Tracking	Allowing walk-in intakes; providing a cancellation wait-list process and "sit and waits" (replacing "no-shows"); next walk-ins coming straight from EDs
	Extremely high-risk patients fast-tracked (e.g., pregnancy, injection users)
	Rapid access walk-in models of care; streamlining intake and assessment processes
Updating and Providing Wait-Time Data	Regularly updating wait lists; regular wait-list and wait time reporting
	Using electronic wait lists for program areas; providing real-time data
Specific Local Strategies	With high-concern areas, following up and creating specific and local strategies
	Making local areas accountable for their wait lists
Adding Staff and Prescribers	Getting more individuals able to prescribe (including adding nurses who can prescribe); higher caseload capacities; additional staffing; having nurses provide intake and assessments; adding OAT case managers for patients outside of urban area; adding a dedicated NP to streamline processes
	More physician education
	Using private clinics in addition to staff at program
Pursuing Alternative Care Options	Pursuing telehealth
	Transportation initiatives to improve access
Having Integrated or Seamless Treatment	Integrated treatment for mental health and addiction problems
	Seamless care between EDs and other services
Other	Strong support from the Chief Medical Officer

ED = emergency department; NP = nurse practitioner; OAT = opioid agonist therapy.

Table 2 details strategies and initiatives used in facilities to improve wait times for clients. Initiatives included allowing walk-ins, providing wait time data, adding more staff, integrating care, and using alternative health options, such as Telehealth.

Literature Results

Ideally, patients requiring opioid addictions treatment would be accepted into treatment immediately. However, general barriers exist in all jurisdictions in Canada. Patients are more likely to attend initial appointments when randomized to a rapid access treatment (seen within one to three days) versus a regular clinic (seen within two to four weeks). In one study, delay in treatment was a strong predictor of treatment drop out, stronger than individual patient characteristics or readiness to change.[22]

Health Quality Ontario published quality statements for improving the quality of care for patients with opioid use disorder (in all settings). These quality statements recommended that individuals diagnosed with opioid addiction should have access to OAT within a maximum of 3 days. They also state that treatment of moderate to severe withdrawal with buprenorphine/naloxone should occur within 2 hours.[71,72]

Health Quality Ontario reported wait times for general addiction programming in Ontario, in 2012-2013, as 42 days for residential treatment programs, 16 days for community treatment programs, and nine days for community day or evening programs. This was reported to be an improvement of seven, 10, and three days, respectively, over the 2008-2009 reports.[73] In the Toronto Central Local Health Integration Network (LHIN), wait times were a week, 25 days, and up to 17 to 34 weeks for community day or evening treatment, residential supportive housing, and residential treatment, respectively.[22] In Winnipeg, Manitoba, the

Opioid Assessment Clinic at the Health Sciences Centre had a waiting time for assessment of approximately three months, and the Addictions Foundation Manitoba methadone intervention & needle exchange (m.i.n.e.) program had a wait time ranging from a couple of days to a year.[21,74] In Alberta, times to access adult outpatient addiction services for 90% of patients ranged from 0 days in the Calgary and Edmonton Zone to 21 days and 24 days in the South Zone and in the North Zone, respectively (both of these zones are rural areas). These are compared to the provincial 2017-2018 targets of 12 days.[70] In one study,[75] incarcerated patients continuing OAT in Vancouver, British Columbia waited a median number of two days to receive their first dose, and incarcerated patients initiating OAT waited a median number of two to three days.

The Canadian Mental Health Association reported wait times for addiction treatment as ranging from two weeks to one year, with public services having longer wait lists than private. In 2013, 65% of 203 surveyed public programs maintained a wait list, and 56% of these were "overburdened" with this waiting time.[76]

Objective 3: Factors influencing wait times for opioid addiction treatment programs in Canada

Literature findings and survey results from research question 4 addressed this objective.

Survey Results

Barriers

Themes that emerged from the survey included transportation and rural and remote locations, no-shows and scheduling difficulties, staffing and spacing, funding and demand of services, lack of training, lack of integration of care, and stigma. These themes are summarized in Appendix 8, Table 12.

In many areas, there is limited public transit or no infrastructure for supporting travel. In remote and rural locations, it can be worse —there may be long travel distances to and from pharmacies and treatment. Canada is a large country, with many rural and remote communities that may not receive the care they need. With methadone treatment often requiring daily attendance at a pharmacy, this is a major barrier for patients who wish to start OAT. This, combined with treatment only being available in specific places (e.g., urban centres), creates an inequity of access and a barrier to the timely access of treatment.

Treatment can be delayed by both client issues (including no-shows or missed appointments, a recent use of opioids, or schedule issues), and facility issues (including limited opening hours or no options for weekend appointments). Running an opioid program also requires space — the demand for opioid treatment has increased and is constant. This overwhelming need for opioid services creates programs that are often at capacity because of limited space and support, which limits access for new clients. Insufficient staffing was another major barrier for timely access — limited nursing staff, prescribers, physicians, and pharmacies and pharmacists to dispense medication were cited as reasons for not meeting recommended wait times. Together with limited staff, it was noted that limited training of staff also creates barriers for timely access to opioid treatment, and limited funding and remuneration also creates barriers.

It was noted that often clinics work in silos and are often not connected well to one another.

This lack of integration of services was mentioned as a barrier to timely access — specifically, a lack of providers in the community to discharge patients to from the correctional setting was cited as a major barrier. This barrier is also discussed in Objective 5 for continuity of care.

Facilitators

Themes that emerged from the survey as facilitators to timely access of opioid treatment included staffing and appointment times, collaboration, alternative care options and technology, support from government, guidelines and education, and having integrated or seamless treatment. These themes are summarized in Appendix 8, Table 13.

While staffing and appointment times can be a barrier to timely access, it was also mentioned as a facilitator to access, as well. Some respondents noted that their programs had flexible appointment times and multiple bookings per day, as well as staff members who went above and beyond the call of duty to assist with the program. These "champions" dedicate time outside clinic hours and were noted as being particularly skilled at providing care for patients. It was also noted that having nurse practitioners be allowed to prescribe OAT was particularly helpful, as they could dedicate a nurse practitioner to do this task.

Another factor that also serves as a facilitator for service was having integrated treatment services for patients. Respondents mentioned that streamlined paperwork and triaging for patients, as well as having specific case management at the territorial level , helped with care. One respondent mentioned having developed functional, seamless care pathways between services and EDs, detox and withdrawal management settings, OAT clinics, and primary care. Similarly, collaboration between services was also noted as a facilitator — including collaborations between the EDs and the community; collaboration with the Royal College of Physicians and Surgeons of Canada, the Newfoundland and Labrador Pharmacy Board, and the Association of Registered Nurses (of Newfoundland and Labrador); and collaboration with and access to private clinics.

Additional facilitators to timely care were alternative care options and the use of new technologies to assist in patient care, including telehealth and electronic medical records.

Literature Results

Table 3: General Barriers to Timely Access to Addiction Services

Barriers to Opioid Treatment	
Resource Barriers	
Lack of remuneration	OAT clients are often more time-consuming than other types of patients and may be a more challenging patient group. Fee-for-service physicians may not want to risk no-show appointments, as they result in a loss of money for the physician, so they do not open clinics .[31] Salaried physicians in collaborative teams may be more likely to provide OAT and benefit from the support and access to resources, but fee-for service physicians and physicians early in their career may be more cautious to offer OAT (especially when new to medicine and trying to establish their own practices).[31]
Limited number of providers and training	Many areas do not have enough prescribers of OAT. The ability to prescribe methadone is quite limited and requires a special exemption (as of 2018, no longer required[13]).[77] Some physicians do not feel they have enough knowledge or training to provide these services.[17,31] Primary care physicians are often not taught about substance use disorders in medical school.[31]

Barriers to Opioid Treatment	
Private services are too expensive for some patients	If a patient decides to use private services, these can be quite expensive. Many patients cannot afford this type of treatment. Patient-paid programs range in Alberta from approximately C$20 to C$200 per day, most commonly at C$40 per day. [78]
Client is a youth or adolescent	Services that can cater to clients who are adolescents are limited. A younger age is associated with less likelihood of receiving treatment or pharmacotherapy for addiction.[79] Some programs have strict minimum ages.
Services are strict in entry criteria	Some services are strict in entry criteria (e.g., no poly-substance use), which limits the available services for people with poly-substance addiction. Many programs require a certain number of days of drug abstinence before admittance. [78]
System Barriers	
Transportation not available or clinic too far away	Some patients must travel hours to receive dosages of OAT.[12] In remote, rural, and northern regions, this can be very difficult. Take-home doses can require daily travel to the clinic for about eight months, but the federal Non-Insured Health Benefits funding only subsidizes four months of travel to the clinic.[12] Some patients do not have access to transport.[31] Some clinics are highly isolated from other clinics (therefore, physicians are isolated from one another and are unable to provide support or advice). This isolation also makes it difficult for specialized methadone clinics to assist with patient care if they are not located nearby.[31] There is geographic variability in provider number — it can range from zero providers per 1,000 patients in rural areas to 20 per 1,000 in urban areas.[17]
Addiction services do not exist	Addiction services may simply not exist for patients in their communities or areas.[80]
Unaware of services	If they do exist, patients may simply be unaware that services exist for them or unaware of how they work. [80]
Wait times are too long for provincial services	Subsidized and provincial services often have very long waiting lists for clients because of volume, staffing, and other factors.[76] Long waiting lists may deter patients from starting treatment.[54]
Services are often not provided in a language other than English or French	It is important to provide services that can be understood by the client. If a client is not fluent in English or French, it may be difficult for them to understand the services provided and so they may not seek treatment.[80]
Altitudinal/Rational-Emotive Barriers	
Concerns about diversion	Patients may not receive OAT if providers are concerned about diversion of the medication.[77,81]
Physicians are reluctant to provide OAT, or worried about their careers	Some physicians do not want to incorporate OAT in their practices.[31] It has been reported that some physicians may be worried about the clientele they will attract, stigma around their practices, or bring the attention of governing bodies to their practices.[31] Physicians also dislike the "supervision" aspect of providing OAT, feeling as though they are surveilling the patients too closely and therefore cannot build a rapport or a trusting relationship with them.[31]

Barriers to Opioid Treatment	
Public opposition and zoning laws	The public may consider harms reduction strategies to be an endorsement of drug use and oppose their use.[82] Many municipalities enact zoning restrictions[a] and bylaws that limit the access to OAT clinics by restricting where these clinics can be located or distributed through making "methadone clinics" and "methadone dispensaries" a distinct category from health care or social services.[83] These restrictions on the use of land for purposes of harms reduction and treatment are often related to the concept of NIMBY-ism, where communities organize to oppose certain developments in their neighbourhoods.[83] As health care in Canada is a provincial responsibility, municipalities cannot technically create legislation that affects access to health care services, such as services for methadone addiction. Although methadone addiction services is a provincially funded form of health care in British Columbia, be cause of the stigma surrounding drug users and their behaviour, residents of municipalities often want to "put" drug users elsewhere.[83] Five Ontario cities (London, Windsor, Quinte West, Belleville, and Woodstock) have introduced bylaws that restrict OAT clinics and separate them from other medical services. Some cities may also look at the opening of methadone clinics on a case-by-case basis, with no predefined requirements for opening them, limiting timely access to treatment for patients who may not have a local clinic to attend.[81]

BC = British Columbia; NIMBY = not in my back yard; OAT = opioid agonist therapy.

[a] Zoning is when municipalities regulate land through bylaws and control the use of the land space for the health, safety, and general welfare of their residents.[83]

There are numerous barriers to care that a patient with addiction may face, which impact the timeliness of treatment. These barriers are well-established in the literature. An overview of common general barriers is outlined in Table 3.

Correctional Setting

While the correctional setting often has barriers similar to those in the community, there are also barriers unique to this setting. In a survey of 27 physicians working in correctional facilities in Ontario, the most common barrier to prescribing OATs was concerns about the diversion of medication.[77] There were also concerns about initiating treatment for prisoners who were not currently using opioids and whether this was appropriate, and there were concerns about a lack of access to community-based providers upon release and concerns about adherence.[77] Lack of support — whether nursing support, institutional support, or patients not being brought to the attention of the physician — were also barriers to the implementation of OAT.[77] Thirteen physicians did not prescribe methadone, with nine of these physicians stating they did not have an exemption to prescribe methadone and therefore were unable to prescribe OAT. It was stated that OAT is under-resourced and is a large burden on health care staff in the correctional setting, with one participant stating that the initiation of OAT should be only done when the ministry provides appropriate resources to facilitate it.

More than 30% of participants in the survey agreed that supports — in the form of support from health care staff and administration in the institution, additional resources for program delivery, and access to linkage with the community — would facilitate the use of OAT in the correctional setting. It was also noted by two participants that better remuneration would be a facilitator to OAT-prescribing, as the time requirement and liability potential of this opioid addiction population is quite high. This barrier was also mentioned within our survey that follows in the next section.

Physician Barriers

Some physicians question the effectiveness of OAT for prisoners in the correctional setting, believing that initiating OAT in prison is inappropriate regardless of ministry policies, and that it is not an effective treatment for opioid addiction in this environment. [77] It was mentioned by some physicians that, in this context, they believed OAT is not more effective than counselling and referral to treatment post-release. It was noted that there was a lack of optimism about the treatment for this population, especially in repeat offenders. They were unsure how the treatment was helping the population when a number of inmates continue to use regardless of treatment.[77]

Many physicians appeared disillusioned with the initiation of OAT in custody, stating that they have initiated the medication previously and had the patient divert the medication, and were concerned about OAT becoming "currency" for inmates (and the safety issues and overdose potential this has).[77] Formulations of Suboxone in sublingual tabs also makes diversion much easier. There were also complaints of inmates with factitious complaints asking for medications such as benzodiazepines and the concern that the concurrent use of methadone or Suboxone with these other medications will increase overdose potential.[77]

Objective 4: Patient characteristics or prioritization criteria in use for determining entry to opioid addiction treatment programs in Canada

Literature findings and survey results from research question 5 addressed this objective.

Survey Results

The majority of respondents (79%) answered questions regarding criteria for entry into their programs and the prioritization criteria used to select patients. Appendix 9 , Table 14 outlines survey responses to these questions. Many programs, at minimum, required a diagnosis or needed-to-meet criteria for a substance abuse disorder (as defined in the DSM-V) prior to acceptance into treatment. Some programs did not require any criteria for entry (outside of assumed "problematic opioid use"). One program required the provision of a urine sample prior to treatment.

Most programs did not have prioritization in their treatments, as they accommodated all patients, but a few programs prioritized persons who are pregnant, use injectable opioids, had a recent overdose, are adolescents, or who live with HIV.

Literature Results

The College of Physicians and Surgeons of Nova Scotia released a *Methadone Maintenance Handbook*[14] that recommended that physicians consider patients for methadone therapies after a thorough assessment and discussion about treatment. Within the assessment, the physician should consider four factors:

- an opioid use problem; this can be confirmed with a urine drug screening that is positive for opioids
- meeting the DSM-V criteria for opioid substance use disorder
- no contraindication to methadone
- patient agreement to the terms and conditions of the program.

In the US, SAMHSA released federal guidelines for the provision of OTPs.[42] The patient characteristics to determine entry into OTPs includes a determination, using accepted criteria

such as the DSM-V, that a patient is addicted to an opioid drug, has been addicted for more than a year, and is voluntarily choosing treatment. Some criteria can be waived under certain exemptions (e.g., pregnant patients can waive the year requirement).[42]

Objective 5: Current practice as it relates to supporting patients receiving opioid agonist therapy through care setting transitions

Literature findings and survey results from research question 6 addressed this objective.

Survey Results

Respondents were asked questions relating to barriers and challenges for patients transitioning between settings, and approaches and support used to assist patients with transitions. Respondents were also asked about barriers to assisting in the identification of potential challenges to the implementation of transitional policies or guidelines. Appendix 10, Table 15, Table 16, and Table 17, detail the survey answers given, organized into main themes and setting transitions.

Barriers and Challenges

Overall, respondents noted that barriers within transitional settings were similar to some barriers experienced with receiving timely opioid treatment — including stigma, a lack of knowledge from providers, a small number of available physicians, difficulties in access, and difficulties in transportation. It was noted that, overall, transitions can be difficult, as many doctors and emergency departments do not want to prescribe or start OAT therapies for patients despite the ED being one of the main contact points for patients initiating treatment.[22] EDs may also want specialist clinics to initiate OAT, but specialist clinics are unable to do so when the patient is in care of the ED. Conversely, after some ED physicians initiate OAT, some community physicians do not want to maintain patients on OAT when transitioning from the hospital setting, either from a lack of desire to prescribe OAT or from a lack of the same hospital privileges that allow them to prescribe the medication. This leads to patients leaving the ED either without a prescription entirely, or with a prescription and no way of continuing treatment or renewing the prescription after release. These breaks in medications can be detrimental to the patient, as it allows for withdrawal symptoms to appear and may prevent long-term harms reduction.

A lack of communication was noted by many respondents; communication is challenging when moving both internally and externally, and a lack of general opioid addiction oversight in primary care with no provincial policies results in recommendations which are not consistently met for transitions of care. It was mentioned that patients may be admitted to in-patient settings and discharged without having a consultation with an agonist prescriber, and this lack of communication results in the patient not receiving adequate care upon transition from the in-patient setting. In was also mentioned that electronic medical records are not always integrated, which means there is inadequate or incomplete information shared among providers. This was also mentioned in the literature as a major barrier in transitioning — clients transitioning from private to public services with no records being shared.[75] The number of doctors who fill in temporarily in some EDs can prevent transitions to primary care that can provide OAT, and the doctors on duty are unaware of who provides these services when withdrawal starts to occur. Communication was also noted as an issue in the Yukon correctional setting: prisoners can be put on remand, attend court, and be released in one day, without the clinical side of corrections being notified. Nor is the prisoner put in contact with them, so the prisoner does not get an opportunity to initiate OAT or be directed

to somewhere they can. Additionally, it was mentioned that some correctional facilities will release most prisoners on a Friday, with the addictions centres not open on weekends to take them to continue addictions supports. This issue was also present in the literature, especially for clients in pre-trial settings who may be released after court without notice, so a physician cannot assess a client and prescribe OAT.[75] This fragmentation of care in correctional settings upon discharge is a major barrier to care for prisoners.[75]

Along with a lack of communication, respondents noted a lack of pharmacies and clinics in general that contribute to difficulties in transitions between settings. This includes in the injectable OAT setting to correctional settings, correctional to community settings, and from contact with the health care system to detox settings. A lack of following guidelines in some private clinics were mentioned, with some "boutique" clinics not fully catering to the primary needs of patients and stricter rules about poly-substance use potentially leading to fragmented care for the client.

Supports, Practices, and Approaches

Communication was noted again as a theme in practices and approaches used to ensure the continuity of care. Some programs are integrated in a continuum, some programs have ongoing fax and phone calls or telephone consults between programs, and some have forms that are filled in prior to transfer. However, some programs do not have transfer plans in place, at least not formally.

Supports for patients in transitory settings include the implementation of specific case managers who facilitate and coordinate care between the OAT prescribers and the community pharmacies, telephone work with team leads that coordinate care, case management from the ED to primary care, and outreach registered nurses, or RNs, who assist with transitions. There are also outreach staff in OAT clinics who meet with patients, transport them, provide information, and connect patients in one facility and assist in their transfer to the OAT clinics. One respondent said that, in their opinion, the outreach service has been the most beneficial service to assist with transitions out of all other initiatives.

In settings that have a high percentage of First Nations patients, having culturally competent services is critical to the success of providing for this population, as First Nations peoples are more likely to respond to care from someone who they identify with. It was noted that transitions are more manageable in services that are culturally sensitive, and that transitions can be frustrating for both the patient and the organizations when agencies do not match in philosophies of service delivery.

Some programs use step-up, step-down care to assist in transitions between programs. This is the option for patients to transition between levels of intensity of services (e.g., moving from residential to outpatient care if struggling with the former). Step-up, step-down care is available for programs that have integrated care but not available for stand-alone programs. Other programs use warm transfers, or warm hand-offs for clients transitioning to other programs, including from EDs and from the correctional centres. Patients are referred before leaving the centre and intake for a community clinic is done immediately. Other programs also use electronic medical records to increase communication between OAT clients; this helps make acute care aware of proper dosing and provides a continuity of information across the health care system. Finally, some programs use specific staff to help facilitate transfers, including mental health nurses, ED doctors, and addiction counsellors.

The Dilico Anishinabek Family Care centre also provides housing support within the continuum to assist patients. This includes assisting patients to transition to a supportive transitional living environment and rental support with case management associated with it. This housing support is realized under the *Local Health System Integration Act*.

Literature Search

Appropriate transition between settings is a key to maintaining continuity of treatment and not allowing patients to slip through the cracks. In an ideal situation, all patients would receive appropriate, timely care, with no gaps in treatment and with appropriate transitions between programs. However, some gaps in treatment can occur because of the belief that addiction is solely a psychosocial issue and is therefore not part of the greater health care system.[22] Continuing to create a separation between addiction programming and "regular" health care systems can cause patients to not receive addiction medications in EDs, primary clinics, or hospitals. This belief also can create a lack of access and a lack of opportunity for patients to be referred to the appropriate treatment after undergoing withdrawal management or discussing their addictions with their primary care providers. [22] Patients seeking withdrawal, depression, overdose, or infection help in EDs will also often leave EDs prior to being seen by the physician if their withdrawal symptoms (which can occur rapidly after the previous use of opioids) become too distressing and they are not promptly seen. This does not allow the patient access to long-term care on an appropriate OAT medication or access to referrals to other treatment centres. [22] To overcome the barrier of treatment fragmentation, multidisciplinary and collaborative approaches have been proposed, such as the rapid reintegration of buprenorphine/naloxone in the ED with a coordinated referral process to primary care.[17]

In Ontario, RAAM clinics appear to help support patients transitioning through the opioid treatment system. A patient who presents to the ED with withdrawal symptoms, either from alcohol or opioids, receives withdrawal management and is referred to an addiction-specific physician at a RAAM clinic.[22] This pathway attempts to ensure the continuity of care. An alternative pathway is through the community — community providers (e.g., detox centres, shelters) can refer patients to the RAAM clinic, where they are seen within seven days.[22] Rapid access clinics can result in fewer ED visits, reduced wait times, and higher treatment retention.[7] Ontario also published the *Methadone Treatment and Services Advisory Committee, Final Report* in 2016 that recommended and committed to providing funding for RAAM clinics and to creating a more integrated care pathway for treatment.[84] Assertive Community Treatment teams connect patients to resources, case management, and outreach services, and are also available in Ontario.[7]

In this care pathway, the addiction-specific physician prescribes OAT, refers and connects the patient to other treatment programs, and a therapist provides counselling. After stabilization, long-term care is passed to the patient's primary physician, with full transfer of care to the primary care provider . In the early stages of treatment, however, RAAM clinics can help to deter a relapse by referring patients to immediately available resources, such as Narcotics Anonymous and Withdrawal Management Services (WMS).[22]

The Canadian Centre on Substance Use and Addiction published a 2018 report, *Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder*.[7] Overarching principles for best practice included:

- The patient determines the ultimate goal of treatment.
- The treatment plan is made in collaboration with the patient.

- Treatment includes all components of well-being, including physical, mental, and social well-being.
- Treatment should be culturally competent.
- Stigma should be reduced.
- Treatment should be peer-engaged.
- Recovery-oriented systems of care are recommended.

Warm Transfers, or Warm Hand-Offs

Warm transfers or warm hand-offs are a method of transition care that attempts to introduce a patient to and between care programs gradually, as opposed to abruptly handing them off to another service with no guidance. This can include directly introducing a patient to another care provider, which helps to engage the patient in their care and prevents communication breakdowns.[85] This style of transfer is also designed to minimize no-shows at services, especially between overdose management in an ED and withdrawal care and OAT care in the community. ED transitions are one of the most vulnerable times for patients, as this is when they are often very motivated to seek treatment but may lose this motivation once discharged and not promptly seen. Currently in the US, Illinois has 12 hospitals using this system, mostly in Chicago. In these hospitals, a support worker comes directly into the hospital and encourages patients presenting with addiction issues to enter treatment prior to leaving the hospital.[86] Pennsylvania also has a warm hand-off program in which a patient presenting to the ED with concern for opioid use disorder would be warmly handed off to a drug and alcohol assessor prior to discharge, or warmly handed off to in-patient services if not safe for discharge.[87]

Warm hand-offs were also mentioned in the abovementioned survey results. This was in the context of the Yukon Department of Justice, where a client is introduced to a community care provider before leaving the correctional facility, but this warm transfer also occurs in the community care clinics. The goal of this transfer is to provide education on how the community OAT program works and to build some rapport with the patient to encourage them to stay in, or to seek treatment. Warm transfers were also noted to be used in AFM, as much as possible.

Evolving the System — Toronto Central LHIN22

In 2015, the Toronto Central LHIN prepared a report with recommendations regarding addictions treatment, including opioids and alcohol, using a community-based engagement process (focus groups, interviews, a planning summit, and working groups).[22]

The report recommended that services should become more coordinated because there is a lack of standardization and centralized assessment and referral for addiction services. The authors also noted the lack of integration of services and fragmentation of knowledge around available services, and a lack of communication between organizations, especially those with different philosophies on treatment. The overarching recommendations to "evolve the system, seamless flow, flexible options, and access to all clients"[22] included standardized intake so that a "no wrong door" philosophy is met (i.e., everyone, regardless of situation, experiences the same flow through the client pathway), reformed emergency services that require hospitals to have an addiction strategy that allows appropriate triaging and connection to services, and to improve time-to-access and flow through WMS and referral to treatment. Improvement of access time and flow included the creation of a working group within intensive treatment services to facilitate prioritization of specific client groups, a reduction

of wait times, and appropriate case management. A high-level client pathway was developed to visualize care through addiction services, detailed in Appendix 11. The model of care was designed so that clients entering the addiction care service would receive support that is standardized and meets their individual requirements.

High-level themes from the focus group and community consultations conducted by the Toronto Central LHIN included principles that ran "across" the system — e.g., services should be coordinated and seamless, services should be integrated (a coordinated addressing of physical and mental health needs), there should be access between services or programs with differing treatment goals and transitions should be fluid, and there is a need to better share information between programs (such as via electronic medical records). Within the system, it was noted that care is fragmented between the community and medically based withdrawal, and there needs to be more medical and clinical support to address this.

Recommended in this pathway is the creation of a standardized intake and matching processes. Currently, patients may connect with the services through a variety of ways, but individual providers may not be aware of places to refer patients or have relationships with other providers. Without connections to other providers, patients may not receive the appropriate care, and there may be overcrowding in one part of the system even if there is capacity to assist in another.

Currently, the ED is a common place for individuals to have first contact with the health care and addictions system. Often after stabilization, patients are referred to a central access line, but more than one-third of patients then return to the ED within 30 days. It is suggested that the ED is a critical point that can facilitate transitions to treatment and improve patient outcomes. The working group proposed an ED flow that sees the patient referred from the ED to a rapid access clinic or an addictions consult team, who then provide short-term case management and peer support, and then refers the patient to WMS and supported stabilization services. These transitions would also use warm transfers, or warm hand-offs.

One recommendation from the focus groups and community engagement process for the Toronto Central LHIN was to improve the time and flow from referral to treatment, to combat the gap in time between a referral to intensive treatment and the actual receipt of the treatment. Gaps in time between withdrawal and treatment may result in patients who go through many rounds of withdrawal, which may cause patients to become disillusioned with treatment. Improving flow can occur through a few factors, including using intensive treatment to its full capacity, increasing agent accountability for their capacity (i.e., providers should pull patients to treatment when they have capacity), and to prioritize patients for treatment who are coming from WMS. When wait times are unavoidable, short-term case management should be used including psychosocial support. This recommendation is similar to SAMHSA's recommendation of the provision of interim care in lieu of solely a wait list.[88]

Transitions From Correctional Settings

Release from prison to the community is one of the most vulnerable transitions in the care pathway. Prisoners released from correctional settings who do not seek help or have access to services (either mental health or substance abuse) are likely to reoffend.[88] In one study,[77] Ontario physicians were asked about the delivery of OAT in provincial correctional settings. Participants in the survey noted challenges to the continuity of care both in custody and upon release. One participant noted that the majority of the population they treat are in transient custody and may see multiple physicians day to day, as physician coverage may change

daily and prisoners may change units frequently. The surveyed physicians mentioned that, because a lot of prisoners are on remand, they are often not ready to have a discussion about MMT with them, as the patient may not appear for another court appearance. Participants also mentioned the challenges of ensuring community care upon release, as it is difficult to find a community care provider that would follow up with a patient and also ensure that the patient follows up.[77] With many prisoners having a lack of primary care available to them, no permanent address upon release (often a prerequisite for methadone clinics), and no health card, it can be difficult to guarantee community care. One of these survey participants noted that they had specifically developed relationships with community providers in order to support the continuity of care upon release. They noted that community providers are aware of individuals who start methadone in the correctional setting, and that they agree to take patients directly into their programs upon release, with no gap between treatments.[77] This study therefore recommended establishing linkages with community-based care to ensure the continuity of treatment. [77] However, it was noted that if patients fail to follow up with community providers and are re-arrested, they may not be able to start methadone management in prison again. [77]

In 2018, SAMHSA published *Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide*.[88] This guideline is for general behavioural issues but extends to opioid addictions as a component of substance abuse disorders.

These guidelines use an acronym — APIC — which stands for "assess," "plan," "identify," and "coordinate." With this acronym, there are ten guidelines to help plan transitions for prisoners leaving the criminal justice system.[88] These guidelines include:

- universal screening upon entry to the facility, as early as the intake process, to detect substance use or behavioural issues
- if positive for substance use, perform a comprehensive assessment of the prisoner to guide program placement and decide on which services to provide; this assessment includes demographics, clinical need, what supports the prisoner has (family and community), and public safety or risk
- develop an individualized treatment plan
- develop a collaborative approach between behavioural health treatment and the criminal justice system
- anticipate the vulnerable period post-release; identify appropriate interventions as part of the transition-planning process
- develop policies that facilitate the continuity of care through direct linkages (e.g., Warm Transfers, or Warm Hand-Offs)
- support adherence to treatment through a coordinated approach; provide incentives and gradual sanctions to the prisoner as rewards to encourage compliance, with standard protocols that deal with violations of conditions of release
- develop mechanisms that support the sharing of information across programs at different places in the criminal justice system
- encourage cross-training between organizations
- evaluate program performance and identify gaps in treatment.[88]

For recommendation number six — facilitating continuity of care — one option includes appointing specialists (e.g., pre-release coordinators or specialized re-entry probation or parole officers) who work with inmates in preparing them for release, including planning for physical health care, behavioural health care, and community supports. This could be as involved as just connecting the inmate with these supports and leaving them to follow up, or as involved as personally transporting the inmate and introducing them to the supports.[88]

One study from the US[89] described implementation strategies and a project (MAT Implementation in Community Correctional Environments, or MATICCE) to improve inter-organizational relationships between the correctional setting and the community providers. One project attempting to reduce system-level fragmentation of services for homeless individuals with serious mental health issues (Access to Community Care and Effective Services and Supports) had planned strategies including building interagency coalitions and interagency teams for service delivery, cross-training staff, and developing more formal interagency agreements. The project resulted in more integration between services but not always better client outcomes.

MATICCE focused on structured communication between parole agencies and community treatment agencies using a "local change team." This local change team had eight to ten staff from the community agency and the parole agency, as well as other OAT treatment agencies. Firstly, the change team identified current policies and procedures that either prevent or facilitate the referral process of OAT clients, then developed a strategic plan with objectives from three domains: building relationships, getting buy-in from staff, and financing OAT. It then implemented the strategic plan. [89]

Strengths of the MATICCE process were noted, including how it often involved front-line staff in planning, as well as improved engagement. But other barriers were also noted, including how corrections officers and community treatment staff often have differing organizational cultures, and that many organizations are reluctant to share information among one another about clients for fear of confidentiality breaches and the US *Health Insurance Portability and Accountability Act*. [89]

Other strategies mentioned included setting mutual goals between treatment and parole agencies, implementing a recovery-oriented system of care (coordinated system of community supports based on person-centred care), using professional associations to disseminate policy statements, and providing cross-training on OAT.[89]

Limitations

The findings of this Environmental Scan aim to present a broad overview of opioid programs both across Canada and internationally and based on a survey and limited literature review. It therefore may not provide a fully comprehensive review of the topic. There may be opioid programs across Canada that are not well-documented either in the literature or online, and therefore were not captured in this report.

Methods

The quality of included studies is uncertain because of the lack of critical appraisal of the literature and the broad inclusion of publication types. In addition, the literature screening and data abstraction was not performed in duplicate. Surveys were sent to stakeholders identified by the ISKM team at CADTH. With the substantial number of opioid programs and opioid addictions within Canada, it is likely that some potential stakeholders suitable for this report were not contacted. This could potentially create a gap in valuable information regarding opioid treatment.

Survey Results

Although there was representation from numerous jurisdictions and settings captured in the survey results, not all jurisdictions responded to the survey. As well, respondents were only able to speak on behalf of their own program and may not have been able to comment on other programs. The responses to the survey also reflect personal experiences with opioid programming in Canada and may not reflect all programming within that jurisdiction. The total response rate was 26.3%, with 2.7% of asked stakeholders declining participation and the remainder not providing any responses.

Additionally, only providers of care for opioid treatment were contacted to provide survey responses. No patients or individuals with experience within the system were contacted, although these experiences and perspectives would potentially be relevant.

Literature

Specific literature and information regarding entry criteria and prioritization of recipients of opioid treatment was lacking. Given that the scope was restricted to international addiction programs in countries with similarities to the Canadian context, this report does not highlight all opioid programming in all countries. Finally, some insights from other countries may not be generalizable to the Canadian context, and some insights from some provinces and territories may not apply to other provinces and territories because of differing provincial health care systems and populations.

Conclusions and Implications for Decision- or Policy-Making

This Environmental Scan was informed by literature searches and a survey. Seventeen full responses were collected from the survey, resulting in a response rate of 26.3%. Although limited by number and type of respondents, survey responses were generally in-depth and informative.

There are numerous types of opioid programs both in Canada and internationally, including residential treatment, community treatment, primary care, pharmacy treatment, therapeutic communities, and programs within prison or jail settings. The most common type of programs use a combination of OAT, such as methadone or buprenorphine, and psychosocial treatments, such as counselling, therapy, and housing support.

Wait times for many programs in Canada were reported to average between zero and two weeks, although timing may vary between jurisdictions, urban and rural areas, and between

correctional settings and public care. Literature results did not always align with the survey results; however, some literature was published a few years earlier than the survey and may not accurately reflect current wait times. Additionally, with the limited number of programs captured by the survey, programs with varying wait times may not have been captured in this report. Timely access to treatment can be achieved through limiting barriers to treatment and providing rapid access to clinics, such as through RAAM clinics and integration of care. Streamlined assessments and screening are also potential options for enabling timely access to opioid treatments within Canada. Major barriers to opioid care include a lack of addiction services, stigma and judgment, long wait times, strict entry criteria, expensive private services, and a limited number of providers of care. Additionally, structural barriers such as public opposition to harms reduction efforts and far travel times to clinics create obstacles to care for patients with addictions.

Most services appear to accept patients who have a DSM-V diagnosed substance use disorder with not many other restrictions. Common prioritization criteria for services include patients who are high risk, such as pregnant patients, adolescents, and individuals with HIV. It was reported in the literature that, across the continuum of care, patients should determine the goal of treatment, be engaged with treatment, and collaborate in the treatment plan. The literature also reported that recovery-oriented systems of care can be used and that stigma should be reduced. To ensure the continuity of care during transitions to other settings, warm hand-offs can be used, as well as the integration of care to promote seamless transitions.

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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.

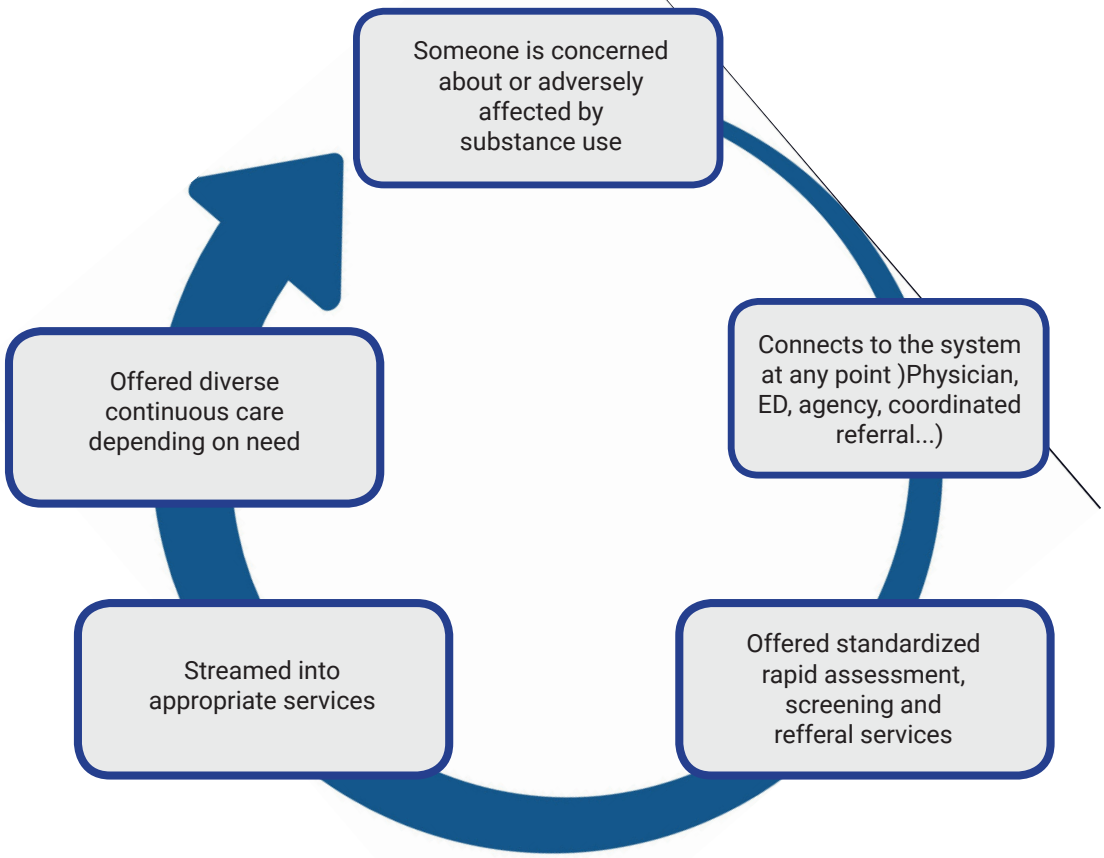
AFM = Addictions Foundation of Manitoba; ED = emergency department; iOAT = injectable opioid agonist therapy;; OAT = opioid agonist therapy; RAAM = rapid access addiction medicine.

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