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Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder

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Executive Summary

People living with an opioid use disorder in Canada should have access to comprehensive treatment options that meet all their needs. *Best Practices across the Continuum of Care for the Treatment of Opioid Use Disorder* presents services that should be available to individuals experiencing or at risk of experiencing harms from opioid use.

This report, developed to inform Health Canada's Federal, Provincial and Territorial Treatment Task Group, outlines the standard of service that should be implemented to provide person-centred care to all people experiencing harms from opioids. The report includes a summary of actions taking place across Canada at multiple levels of government to help people experiencing harms from opioids and to stop the deaths occurring from opioid poisonings.

The Continuum of Care

Every person's pathway through the continuum of care may look different. The components can overlap and are most effective when used together. Some people may use all services in the continuum of care whereas others might not. There are also people who might revisit different components as needed. Detailed descriptions of each element are in the full report.

Continuum of Care								
Harm Reduction								
Screening	Assess-ment	Brief Interven-tions	Rapid Access Clinics	Community Outreach	Withdrawal Manage-ment	Pharmaco-logical Interven-tions	Psychosocial Interven-tions	Recovery, Sustaining Wellness & Ongoing Care

Key Findings

Throughout the treatment process, there are fundamental principles and best practices to take into consideration. The first principle is that the person living with an opioid use disorder should determine the goals of their treatment with support from an experienced care provider. Other principles include:

- Customize a treatment plan to meet the individual's' needs and goals.
- Continually assess the person's well being for any issues that could prevent successful outcomes, including physical and mental health, stress, housing concerns, financial barriers and so on.
- Provide services that are culturally competent and safe.
- Provide services that are trauma and gender informed.
- All efforts should be made to reduce stigma, which is a major barrier to seeking treatment and maintaining recovery.
- Peer-engaged and led services establish trust and help people sustain positive changes in their substance use.
- Make recovery the focus of policies and practices, which can enhance outcomes for people seeking treatment.

Introduction

Evidence-informed comprehensive treatment is known to improve the lives of those living with an opioid use disorder. This inventory was developed in response to a commitment to the Health Canada's Treatment Task Group to "develop a document that defines the continuum of outreach, interventions and treatment supports for opioid use disorder, including rapid access to addictions medicine and mild to moderate social supports (i.e., brief intervention and counselling), [and] make recommendations on best practices and drive policy development to improve quality care across the country."

Identification of best practices[i] across the continuum of care can provide a benchmark to ensure effective services are available in Canada to prevent and minimize the experience of harms.[ii] Responding to these harms requires a combination of both available services and quality implementation. This inventory includes best practices for certain services, but also overarching principles that should guide the way in which these services are delivered (i.e., in a patient-centred manner).

The continuum of care outlined below was developed to inform Health Canada's Treatment Task Group of the services to be considered for availability in all jurisdictions. It should be recognized that the settings and providers for the services outlined in the continuum might differ across and within jurisdictions. For example, a range of practitioners from nurses to pharmacists to community outreach and peer support workers can implement harm reduction services, whereas pharmacological interventions might require a specialized addiction physician. Additionally, pharmacological interventions might take place in a primary care provider's office or in a specialized opioid agonist treatment clinic. System planning is required to ensure that quality services are available and competent providers are engaged to meet the needs and intensity levels of those seeking help.

While reviewing the findings, the reader should consider that the evidence base related to substance use treatment is an evolving area of inquiry. Many components of practice are guided by expert opinion and even best practices are established based on varying strengths of evidence.

Method

Best practices for care and treatment of opioid use disorder among the general population were identified from peer-reviewed and grey literature. Peer-reviewed articles were found through searches using PubMed, PsycNet, Health Evidence and the Cochrane Library. Grey literature was retrieved by searching the Centre for Addiction and Mental Health's Google Custom page as well as individual websites such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Best Practices Portal, HealthEvidence.org, Public Health England and Portico. A search using Google was also performed to ensure that valid resources were not omitted. A limitation of this methodology is that 1) the quality assessment of the peer-reviewed literature was not within scope for this project and 2) that grey literature is not necessarily peer reviewed and can have varying levels of quality. Retrieving resources from only reputable, well-established organizations minimized this risk.

i Best practices are defined as initiatives, projects, policies, programs or procedures that are recognized or accepted, and have proven effective in achieving the desired outcomes or results.

ii Throughout this documents the term "harm" can refer to a variety of outcomes, including injury, contraction of illnesses such as hepatitis C or HIV, functional impairments, polysubstance use, dependency, overdose, poisoning, or risk of overdose with relapse following a period of abstinence.

To focus on best practices, as opposed to emerging ideas, only review papers, systematic reviews, meta-analysis and grey literature produced between 2007 and 2018 were included. Primary research and preclinical studies were excluded. The release by the Canadian Research Initiative in Substance Misuse of guidelines coincided with the development of this inventory. To avoid duplication of efforts, in-depth reviews of pharmacological or psychosocial interventions were not conducted. A detailed search strategy is available upon request.

Best practices that speak to specific populations (i.e., youth, women who are pregnant, First Nations, individuals living with chronic pain and individuals convicted of an offense) are highlighted in Appendix A, where studies with these populations appeared in general searches. Studies examining individuals living with cancer pain were excluded. While it is critical to tailor treatment to the needs of specific groups, a comprehensive search for each population was out of scope for this project. Additionally, interventions for individuals who use drugs occasionally requires a separate, in-depth review as the strategies that are effective for this population could differ from those that are best practices to treat individuals living with an opioid use disorder.

Best practices were synthesized in the inventory to highlight critical services across the continuum of care. External partners with expertise in addiction medicine, harm reduction, substance use, psychology and psychiatry reviewed and provided input to the inventory. (See Appendix B for details.)

The Continuum of Care for the Treatment of Opioid Use Disorder

The continuum of care represents a range of services that should be available to individuals experiencing or at risk for experiencing harms from opioid use. Although presented as discrete categories, many of the continuum components overlap in practice (e.g., screening and assessment) and are most effective when used together. Pathways through the continuum are not necessarily meant to be linear. Some individuals might use all components of the continuum whereas others might not, and some might revisit different components as needed.[1,2,3,4,5]

Continuum of Care								
Harm Reduction								
Screening	Assess-ment	Brief Interven-tions	*Rapid Access Clinics	*Community Outreach	Withdrawal Manage-ment	Pharmaco-logical Interven-tions	Psychosocial Interven-tions	Recovery, Sustaining Wellness & Ongoing Care

*Although there is insufficient evidence (i.e., no review papers) to categorize rapid access clinics or community outreach as best practices in the continuum of care, details about these components were included as a) these resources have shown promise in Ontario,[6] and b) to address the request from Health Canada to identify services that might be of value to individuals who use drugs occasionally or are not identified in health surveillance activities.

Best Practices for the Continuum of Care

This inventory outlines best practices for each component of the continuum; however, there are overarching principles to be considered in implementing any of the services in the continuum.

1. The individual experiencing harm from opioid use should determine the ultimate goal of treatment (i.e., safer use, abstinence, opioid maintenance, obtaining certain functional outcomes, etc.) with input from a care provider who is experienced in substance use management.[1]
2. The treatment plan and services used can be determined together with the individual, and customized to meet their needs and goals.[1,2,7,8,9,10,11] Stepped care, wherein the least intensive services are offered first, should be used.[5,12,13]
3. The continuum of care should assess and address in a coordinated manner all components of a person's wellbeing that might prevent successful outcomes, including physical and mental health, personal vulnerabilities, stressors, housing, recovery capital[iii] and so on.[1,2,3,4,7,9,11,12,13,14,15,16,17,18,19,20,21,22,23] Family of choice can also be included in treatment activities where desired by the individual seeking treatment.[2,9]
4. Services should be culturally competent and safe, and trauma and gender informed.[1,10,12,20,21]
5. Stigma is a major barrier to seeking treatment and maintaining recovery. All efforts to reduce stigma should be undertaken.[2,20]
6. Peer-engaged and peer-led services help establish trust[20,24] and help individuals sustain positive changes in substance use.[2]
7. A recovery-oriented system of care, wherein policies and practices that reflect recovery principles are integrated into treatment, can enhance outcomes for individuals seeking treatment.[2]

Harm Reduction

Efforts to minimize the negative outcomes experienced while an individual is using opioids and to prevent accidental death or poisoning should be integrated along the continuum of care.[5,12]

- Education and training on recognizing and responding to overdose, along with take-home naloxone, decreases mortality related to opioid overdose.[10,25,26,27,28,29] Take-home naloxone should be widely available,[7,8,16,19] particularly to individuals being treated for an opioid use disorder, as well as to those who frequently spend time with them as they may be present if an individual overdoses.[5,7,12,30]
- Supervised consumption services help prevent multiple harms, including overdose,[20,31,32] and provide an opportunity to connect with health and other support services, including primary care[32] and treatment.[31,33]
- Needle distribution and exchange programs are related to decreased incidences of HIV;[34,35,36] results related to incidences of hepatitis C have been mixed as sharing of other drug use

[iii] Recovery capital refers to the resources an individual can rely on to support them through their journey along the continuum. It may include personal, interpersonal and community resources.[2]

equipment such as swabs, cookers, water and filters, is also a factor of particular importance in the transmission of HCV.[34,37]

Resources

A Public Health Guide to Developing a Community Overdose Response Plan[20]

Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are At Risk for HIV, HCV, and Other Harms: Part 1[38]

Community Management of Opioid Overdose[26]

Supervised Consumption Services: Operational Guidance[31]

Screening

Identifying if an individual is currently at risk for experiencing harms from opioid use allows for the identification of those who may benefit from additional services and supports.[4]

- General dialogue for initial screening should be used with all individuals,[4] not just those at risk;[1,10] positive screens should be followed with an assessment.[4]
- Screening should address polysubstance use, and mental and physical health concerns.[7,9]
- Multiple screening tools are available, as listed below, but are general to all substances and do not provide comprehensive assessment (i.e., do not address mental health, physical concerns, etc.). There is no consensus on best practice.[39,40]
    - *Alcohol, Smoking and Substance Involvement Screening Test* (ASSIST): eight-item measure that can be used in primary care settings to identify risk related to the use of 10 different substances across all levels of severity[41]
    - *CAGE-Adapted to Include Drug*s (CAGE-AID): four-item measure to predict substance use disorders in primary care context[42]
    - *Drug Abuse Screening Test* (DAST): 10-, 20- and 28-item versions assess problematic drug use among multiple populations[43]
    - *Global Appraisal of Individual Needs—Short Screener* (GAIN-SS): 20-item measure that examines internalizing and externalizing disorders, substance abuse and criminal behaviour[44]
    - *Kreek-McHugh-Schluger-Kellogg Scale*: 28-item measure that considers the frequency, amount and duration of use of opiates, cocaine, alcohol and tobacco[45]
    - *Two-Item Conjoint Screen*: two-item measure that can be used in primary care to evaluate using substances more than intended to and feeling the need to cut down on substance use in the past year[46]

Assessment

Assessment allows for the identification of an opioid use disorder and co-occurring conditions, determines the severity and indicates the intensity of treatment to be considered.[4]

- The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) is the most recognized criteria to establish a diagnosis of opioid use disorder.[47]

- Assessment should include:
  - concurrent disorders and physical health concerns,[1,3,7,9] and
  - an examination of recovery capital, which are the resources an individual has to support them through their journey. Treatment should then be designed to build and strengthen recovery capital.[2]
- Assessment should also include collaborative care planning with the individual seeking treatment[4] repeated throughout treatment to ensure services are meeting individuals changing needs.[3,9]
- There are multiple assessment tools, including the *Addiction Severity Index* (ASI), a structured interview that assesses an individual's functioning or the severity of problems an individual with an opioid use disorder is experiencing in the medical, employment, legal, social, psychological and substance use components of their lives.[48]

Brief Interventions

Brief interventions provide non-judgmental information regarding the harms of substance use, and explore motivation to change opioid use.[49,50] The Screening, Brief Intervention and Referral to Treatment (SBIRT) framework allows for the identification of individuals who may be experiencing harms from substance use. Those who are not experiencing harms receive education and reinforcement for their behaviours. Those who are at moderate to high risk of harms receive a brief intervention, and those with severe risk or who are currently experiencing harms are referred to treatment.[50]

- Using motivational interviewing can encourage change towards healthier behaviours[1] and reduce substance use.[10]
- SBIRT typically involves two sessions that are 10–45 minutes in duration[49]

Rapid Access Addiction Medicine and Clinics

Rapid access clinics allow individuals experiencing harms from opioids to receive treatment from an addiction specialist (typically within a few days of referral) until they are stabilized. Individuals then receive ongoing treatment from community services and/or a primary care provider who may receive support, resources and training about addiction management from the addiction clinic staff.[6]

- Rapid access to addiction medicine services have resulted in reduced emergency department visits, reduced wait times and lessened stigma,[6] as well as greater retention in treatment.[51] However, there is insufficient data to determine if this is a best practice to be included in the continuum of care.

Community Outreach

These supports can take different forms, but are typically services provided in the community to individuals who use drugs. Activities can include education, harm reduction resources and referrals to services.[24]

- Examination of assertive community treatment[iv] revealed improvements in mental health, quality of life, housing stability[52] and treatment enrollment, but there is a need for further evaluation to determine long-term outcomes.[10]
- Best practices for substance use outreach programs: gain the trust of individuals who use drugs, go to where these individuals are, conduct outreach in evening and early morning (when risk is greatest), provide multiple means for behaviour change (e.g., information, equipment, referrals, etc.), provide training and supervision for employees, and supports to address burnout, relapse and other health issues.[24]

Withdrawal Management

Withdrawal management without subsequent treatment is strongly advised against and can put an individual at risk of serious harms, including death, if substance use resumes.[3,5,7,10,12,22,23] However, pharmacological and psychological supports can help an individual cope with the symptoms experienced when they stop using opioids.[4]

- If used, an agonist taper should occur slowly over a time period greater than one month.[5]
- Methadone,[16,23] buprenorphine,[5,16,23] and clonidine[7,12,23] are recommended to reduce physical symptoms of withdrawal.
- Clinical opiate withdrawal scale (COWS) is used to measure and monitor symptoms.[7,53]
- Contingency management and cognitive behavioural therapy were related to greater abstinence rates than control conditions over the short term.[54]

Resources

A Guideline for the Clinical Management of Opioid Use Disorder[12]

CRISM National Guideline for the Clinical Management of Opioid Use Disorder[5]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

Medications for Opioid Use Disorder (Treatment Improvement Protocol 63)[4]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

The World Federation of Societies of Biological Psychiatry Guidelines for the Biological Treatment of Substance Use and Related Disorders. Part 2: Opioid Dependence[22]

Pharmacological Interventions

Medications, particularly opioid agonists, are effective in helping an individual achieve their desired recovery outcome.[4,5,12,23]

- Internationally, buprenorphine or methadone are the recommended opioid agonist treatments.[23]

[iv] Assertive community treatment is define as 'a service delivery framework characterized by service provision in the community, assertive engagement, high intensity of services, small caseloads, 24 h responsibility, team approach, multidisciplinary team, close work with support system, and staffing continuity'.[53]

- Within Canada, the Canadian Research Initiative in Substance Misuse developed *National Guidelines for the Clinical Management of Opioid Use Disorder*, which recommend:
  - Buprenorphine/naloxone (bup/nal)[v] is the recommended first-line medication for most individuals in Canada.[5,12]
  - Methadone can be used as a second-line treatment if bup/nal is not appropriate, or if treatment has limitations or is ineffective.[5,12]
  - Agonist treatment with slow-release oral morphine[vi] prescribed by an experienced addiction physician should be used if first- and second-line treatments are not successful or if there are contraindications.[5,12]
- For individuals who do not respond well to other pharmacological treatment, diacetylmorphine-assisted treatment (with or without flexible methadone doses) resulted in greater treatment retention and reductions in illicit drug use compared to methadone treatment or baseline substance use.[16,17,55,56,57,58,59,60] There is a risk of serious events, however, so this treatment should only be considered for individuals for whom other treatment options have not been successful, and with careful medical supervision.[55,59]
- Naltrexone (antagonist) should be considered for those wanting to abstain from opioids.[9,23]
- Injected or implanted extended release formulations (naltrexone and buprenorphine) can provide improvements to treatment adherence and continuation of care.[7,9,15]
- If individuals wish to discontinue medication after prolonged period of successful response to treatment (i.e., more than one year), use a slow taper,[5] and/or possible use of oral naltrexone.[12]

Resources

A Guideline for the Clinical Management of Opioid Use Disorder[12]

CRISM National Guideline for the Clinical Management of Opioid Use Disorder[5]

Federal Guidelines for Opioid Treatment Programs[9]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

Psychosocial Interventions

Therapies that can take place in individual, family or group formats can be provided alongside pharmacological therapy to help an individual achieve their desired recovery outcome.[4,23,49]

- Psychosocial interventions provided together with pharmacological treatment are effective approaches to treating opioid use disorder,[3,7,23,47,61,62] though it is unclear if certain psychosocial therapies are more effective than others,[62,63] and if certain modalities correspond better to particular medical-treatments.[62,64,65]

v The buprenorphine/naloxone formulation is commonly referred to by its brand name: Suboxone.

vi One external reviewer strongly recommends against this approach and believes there is an insufficient evidence base to support the use of oral morphine.

- Although some studies have shown psychosocial therapies to have no additional benefit over pharmacological therapies, authors have rationalized that this occurs because the control groups are often receiving some degree of management or support, and thus the question that should be examined is if extensive therapies provide benefit over minimal supports.[63,66]
    - Reviews of cognitive behavioural therapy (CBT; helping individuals reframe their thinking and actions[10]) have revealed mixed results.[54] Some mildly support the use of cognitive behavioural therapy among those on methadone maintenance treatment;[62] others do not reveal any reductions in substance use among those in methadone maintenance therapy;[49] and still others show no effect of CBT as compared to those receiving physician management of buprenorphine treatment.[62]
    - Contingency management (CM), where goods or services are provided for negative drug tests among those on methadone or naltrexone maintenance treatment,[49] have consistently demonstrated positive outcomes, including drug-free urine tests, longer involvement in treatment and greater functional improvements, as compared to control groups or treatment as usual.[10,16,23,49,54,62,66]
    - Behavioural couples therapy and family training have been associated with opioid abstinence and/or reduced illicit drug use.[49,62]
    - Motivational interviewing and relapse prevention counselling enhance effectiveness of pharmacological treatments[9] and has been related to decreased self-reported substance use as compared to those solely receiving methadone maintenance therapy.[62]
- At a minimum, psychosocial needs assessment, supportive counselling, links to existing family supports and referrals to community services should be provided to individuals seeking treatment.[7]
- Concurrent disorders (where an individual experiences both substance use and mental health disorders) are very common and evidence-based treatment should address both concerns.[3]

Resources

Federal Guidelines for Opioid Treatment Programs[9]

Drug Misuse: Psychosocial Interventions (National Clinical Practice Guideline Number 51)[49]

Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence[23]

National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use[7]

Recovery, Sustaining Wellness and Ongoing Care

Recovery can be defined differently by each individual, but generally includes changes to lifestyle and behaviours by accessing formal (e.g., treatment programs) and/or informal (e.g., meditation) supports to manage or eliminate opioid use and improve multiple aspects of quality of life.[2]

- Participation in recovery support services leads to better outcomes than standard treatment alone.[10]
- The treatment system should be recovery oriented,[2,9] which includes recognizing and supporting that each individual's recovery journey might look different and is a personal venture.[2]

- Connections to support services following acute treatment increases recovery capital.[2,9] Assess recovery capital and aid individuals in strengthening it.[2]

Resources

Federal Guidelines for Opioid Treatment Programs[9]

Moving Toward a Recovery-Oriented System of Care: A Resource for Service Providers and Decision Makers[2]

Actions across Canada[vii]

The federal government has instituted a number of policy changes to ensure Canada is able to respond to the needs of those experiencing harms from opioid use. These actions include changes to Bill C-37, *An Act to Amend the Controlled Drugs and Substances Act and to Make Related Amendments to Other Acts*, permitting a significant reduction in the number of criteria required to apply for an exemption under section 56 of the *Act* to establish safe consumption sites. Bill C-37 also amends the *Customs Act* to allow border security agents to inspect packages less than 30 grams. Whereas previously the focus was on larger packages, the potency of fentanyl allows small volumes in transit to be of concern. It is also illegal now to bring unregistered pill presses into Canada, which will make it more difficult for illicit substances to be processed. Finally, amendments made by Bill C-37 allow new psychoactive substances to be scheduled and controlled quickly and also enables law enforcement to dispose of drugs expediently.

In the spring of 2017, the parliament of Canada passed the Good Samaritan Drug Overdose Act. This act protects individuals experiencing an overdose or present at the scene of an overdose from some charges related to the possession of controlled substances. The act is intended to encourage people to call emergency services if an overdose is occurring without fear of legal repercussion. Another measure to address opioid overdoses is the coverage of injectable and nasal forms of naloxone as open benefits for First Nations and Inuit people under the non-insured health benefits program. Correctional Services of Canada has developed a national project to provide individuals being released from incarceration with access to a take-home naloxone kit. Across Canada, naloxone can be obtained at pharmacies without a prescription (without a fee in some areas) for anyone concerned about the risk of overdose for themselves or others.

The Honourable Ginette Petitpas Taylor, Minister of Health, has announced additional actions to support an evidence-based response to the opioid crisis. These actions include streamlining the processes to set up temporary overdose prevention sites, allowing drug checking to occur at supervised consumption sites and researching drug checking further in pilot projects. Projects are also examining alternatives to pharmaceutical opioids, such as hydromorphone, to be provided as an uncontaminated source to individuals using illicit opioids.

Significant funding investments have been made in the 2018 budget to address border security, law enforcement and stigma, and to support advancements in the evidence base related to the opioid crisis, as well as the evaluation of actions taken in response to the crisis.

The Government of Canada has also amended regulations focusing on treatment for opioid use disorder which allow healthcare practitioners to prescribe methadone without a section 56 exemption and to increase access to diacetylmorphine (prescription-grade heroin) for prescription to individuals dependent on opioids. While the federal government is able to make policy changes to regulations and has provided $150 million to the provinces and territories to enhance evidence-based treatment, the individual jurisdictions are responsible for service delivery.

As the impact of opioid harms is being experienced differently across Canada,[67] responses vary in each province and territory. The jurisdictions represented on the Treatment Task Group have made efforts to prevent the loss of more lives to the opioid crisis. Many jurisdictions are increasing access to naloxone. British Columbia, Alberta and Ontario are opening more safe consumption and overdose

vii During the March 12, 2018, Treatment Task Group teleconference it was decided that a summary highlighting the actions taking place in each jurisdiction would comprise the second phase contract requirements as opposed to policy analysis.

prevention sites. British Columbia is expanding the use of fentanyl test strips to determine the contamination of substances and prevent harm to users.

Efforts have also been made to improve or expand treatment and service options. Almost all jurisdictions are working to improve physicians' knowledge of appropriate opioid prescribing, as well as their knowledge of treatments for opioid use disorder. British Columbia and Ontario have established clinics that provide rapid access to addiction treatment. Manitoba has made changes to its formulary to make access to bup/nal easier, and nurse practitioners in Ontario can now prescribe bup/nal. British Columbia and Alberta are initiating the use of hydromorphone as an agonist treatment option.

Public education campaigns are being conducted across the country to combat stigma, to increase awareness of the dangers of fentanyl and other opioids, and to educate individuals on how to avoid or respond to an overdose. Peer services and supports are being used in British Columbia and being considered for implementation in Newfoundland and Labrador. Provinces are also responding to the social determinants of health by increasing support for housing.

Together, these efforts will establish a comprehensive response that addresses the complexities and contextual differences of the opioid crisis across Canada. Additional details on the initiatives each jurisdiction represented on the Treatment Task Group is taking can be found in Appendix C.

Appendix A: Best Practices for Specific Populations

A literature review was not conducted on the populations identified below. This appendix highlights only that information encountered as part of a general search. To determine best practices for these populations, an in-depth, targeted literature search and synthesis would need to be completed.

Screening

Youth[viii]

- Multiple tools are available, but there is no consensus on best practice.
  - *Adolescent Alcohol and Drug Involvement Scale* (AADIS): interview to determine if assessment of alcohol or other drug use is needed[68]
  - *CRAFFT*: six-item measure to screen for substance use disorders and related problems[69]
  - *Drug Abuse Screen Test* (DAST)—*Adolescent*: 27-item scale that determines the presence and severity of problematic substance use among adolescents[43]
  - GAIN-SS: 20-item measure that examines internalizing and externalizing disorders, substance abuse and criminal behavior[44]
- Violence, abuse and risk of suicide should be considered.[11]

Individuals living with chronic pain

- Multiple scales exist to determine risk before initiating or during opioid therapy for chronic pain, but there is no consensus on best practice.[39,40,70,71,72,73,74]
  - *Addiction Behaviors Checklist (ABC)*: 20-item measure to track behaviours related to prescription drug addiction[75]
  - *Atluri Screening Tool*: 20-item checklist to determine which patients with chronic pain are at risk of prescription opioid misuse[76]
  - *Brief Risk Interview (BRI)*: questions about "past medication use, past discharge from treatment, concurrent mental health disorders, current and past substance abuse, family history of substance abuse and educational level" can be used by pain clinicians to determine risk of aberrant opioid use[77]
  - *Current Opioid Misuse Measure (COMM)*: 17-item self-report instrument used to measure possible opioid misuse among individuals receiving opioid treatment for chronic pain[78]
  - *Diagnosis, Intractability, Risk, Efficacy (DIRE) score*: rating scale developed for a primary care physician to predict effectiveness of pain medication and appropriate use of long-term opioid treatment[79]
  - *Opioid Risk Tool (ORT)*: self-administered instrument examining individual and family history of substance use disorders, personal history of preadolescent sexual abuse, and

viii The definition of youth varied across the studies included in this appendix. It should be noted that recommendations differ based on the chronological age and developmental stage of youth (i.e., youth, adolescents, transitional-aged youth, young adults, emerging adults, etc.).[11]

particular psychological illnesses to determine the level of risk a pain patient has for aberrant opioid use[80]

- *Prescription Drug Use Questionnaire (PDUQ)*: 42-item interview to be used by clinician to evaluate pain, opioid use, social and relationship factors, family and personal history of pain, substance use and mental health concerns. Results from the measure should be considered in conjunction with input from physicians and family members, and past medical charts.[81]
- *Prescription Opioid Misuse Index (POMI)*: six-item interview that identifies the risk misuse among of individuals using prescription opioids to treat pain[82]
- *Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)*: 24-item self-report questionnaire "to predict aberrant medication-related behaviors among chronic pain patient considered for long-term opioid therapy"[83]
- *Screening Instrument for Substance Abuse Potential (SISAP)*: five-item instrument to identify individuals at risk of opioid abuse among individuals living with chronic pain to be used in conjunction with clinical judgement[84]
- *Screening Tool for Addiction Risk (STAR)*: 14 self-administered true or false questions that identifies chronic pain patients at risk of problematic opioid use during treatment[85]

- Urine screening should be administered to individuals at high risk or who exhibit unexpected drug related behaviours.[13]

Assessment

Youth

- Assessment should be ongoing with movement across the continuum of care as needed.[21]

Individuals living with chronic pain

- Assessment should begin with a detailed history of prior pain and problematic substance use, provide weekly urine testing, and encourage reports of opioids prescribed by other practitioners.[13]
- *Pain Assessment and Documentation Tool* (PADT): assesses "analgesia, activities of daily living, adverse effects and aberrant drug related behaviours"[13]

Community Outreach

Youth

- Assertive community treatment resulted in improvements in psychiatric symptoms, general functioning and reduced duration and frequency of hospital admissions.[86]

Withdrawal Management

Women who are pregnant

- Detoxification should be avoided; methadone and buprenorphine are safe for treatment during pregnancy.[7,22]

Pharmacological Interventions

Youth

- Bup/nal should be the first-line opioid therapy for youth, and only opioid therapy for youth that live or frequently travel to communities where methadone is not available.[87,88]
- Buprenorphine, methadone and naltrexone can be considered for youth.[7]

Women who are pregnant

- Opioid agonist therapy should be initiated or maintained during pregnancy,[7,16,87] labour and post-natal care.[87]

First Nations

- Bup/nal should be the first line treatment.[87]
- Transition from methadone to bup/nal when clinically or geographically indicated.[87]

Individuals living with chronic pain

- Non-narcotic treatment should be considered first.[7] Opioid therapy can be considered if the benefits of treatment outweigh the potential risks. Treatment should be structured with check points to validate progress, and agreed upon actions in the event of non-compliance should be endorsed by the individual receiving treatment and all healthcare providers to ensure clarity of goals and the course of treatment.[13,89]
- Treatment must be comprehensive to address both opioid use disorder and chronic pain concerns.[13]

Individuals convicted of an offense

- Pharmacological treatment is recommended and should be accessible.[7,23]
- Methadone maintenance therapy initiated before, during or after release was related to greater treatment engagement after release, reduced risk of death from overdose, decreased relapse and reduced HIV drug-risk behaviours.[64]
- Monthly naltrexone injections resulted in lower rates of relapse and greater time to relapse, as compared to treatment as usual (brief counselling, referral to community treatment programs). However, results were not sustained after treatment ended.[90]

Psychosocial and Behavioural Interventions

Youth

- Behavioural therapies focusing on resistance skills, coping, problem-solving and interpersonal relationships can strengthen motivation to change and thus help adolescents remain abstinent from substance use.[11]
- Family (of choice) should be involved in treatment and receive education and counselling as needed, including with transitional-aged youth.[9,11,21]

First Nations

- Programs based in community, land and culture.[87]

Individuals living with chronic pain

- Cognitive behavioural therapy and graded exercise recommended.[13]
- Education regarding how to deal with pain syndromes without misusing opioids should be prioritized.[47]

Individuals convicted of an offense

- Access to psychosocial treatment options should be equivalent to those available in the community.[49]

Recovery, Sustaining Wellness and Ongoing Care

First Nations

- Culturally appropriate aftercare that supports individual, family and community healing from post-traumatic stress disorder and historical trauma transmission.[87]

Individuals living with chronic pain

- If relapse occurs, an examination of the factors leading up to the incident should take place, followed by a focus on developing coping strategies and supports to address these factors.[13]

Appendix B: External Reviewers

We would like to thank the following external reviewers for their contributions to this document.

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Appendix C: Jurisdictional Highlights

British Columbia

- In July 2017, the Ministry of Mental Health and Addictions was established with responsibility to lead the provincial response to the opioid emergency. An Overdose Emergency Response Centre, based on emergency management best practices, was established in December 2017 to bring together provincial, health authority, municipal, Indigenous and law enforcement resources to tackle the overdose crisis at a community level.
- The provincial response focuses on four key areas:
    1. Saving lives: Services for people who continue to use drugs that help reduce the risk of overdose, reduce the severity of overdose, or provide immediate lifesaving interventions when an overdose has happened.
    2. Ending the stigma around addictions and mental illness: Activities that reduce negative attitudes about people who use drugs that may keep people from seeking and receiving help for problematic substance use.
    3. Rebuilding the network of mental health and addiction treatment services: Services that support treatment of and recovery from addiction.
    4. Addressing the full range of supports and social factors: Activities and services that address social factors related to substance use such as housing, income, employment, intergenerational trauma and community development.

Saving Lives

- The province has broadened access to no-cost naloxone with an extensive publicly funded Take-Home Naloxone program that distributes naloxone kits and community organization facility response boxes to over a thousand distribution locations in British Columbia.
- The province is focusing on drug checking as a harm reduction intervention and has expanded drug-checking services through the use of fentanyl test strips to all overdose prevention and supervised consumption service locations in the province. The City of Vancouver purchased a Fourier-Transform Infrared Spectrometer to rapidly test drug samples at supervised consumption sites at Insite and Powell Street Getaway. There is a plan to build upon the City of Vancouver's experience and purchase more mass spectrometers for other health authorities. The BC Centre on Substance Use released an evidence review on drug checking services as a harm reduction intervention. The report can be found at http://www.bccsu.ca/wp-content/uploads/2017/12/Drug-Checking-Evidence-Review-Report.pdf
- The BC Centre for Disease Control has been funded by Health Canada to initiate a pilot project to support access to safer drugs. The pilot would dispense oral hydromorphone pills to people who use opioids obtained from the illegal drug supply. The pilot is slated to begin in the summer of 2018.

Ending Stigma

- The province launched an overdose awareness campaign with the Vancouver Canucks in January 2018. The campaign encourages people to strike up honest conversations about problematic substance use with friends, family members, and co-workers.
- A new website, www.stopoverdoseBC.ca, launched and will continue to expand.
- The BC Centre for Disease Control, peers and other partners have completed a three-year research project, Peer Engagement and Evaluation Project (PEEP). The goal of PEEP is to ensure everyone across the province has equal access to harm reduction services by visiting communities across B.C. to talk to people who use drugs and providers about peer engagement and harm reduction. A number of resources have been developed including a guide for health providers that outlines peer engagement principles and best practices. Resources can be found at http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction/peer-engagement-evaluation#Resources

Building a Network of Mental health and Addiction Treatment Services

- The BC Centre on Substance Use has released provincial Guidelines for the Clinical Management of Opioid Use Disorder. It is expected that a number of supplementals focusing on the treatment of opioid use disorder in pregnancy, in youth, and in correctional settings will be released over the next few months.
- For the small proportion of people who are living with an opioid use disorder and do not respond successfully to first line treatment with oral medications (i.e., methadone, buprenorphine/naloxone and slow-release oral morphine), the province is working with health authorities to expand access to injectable hydromorphone treatment.
- Regional health authorities are scaling up rapid access to medication treatment for opioid addictions by expanding hours of operation and opening new addictions clinics.
- Increased education and training in addictions treatment has been made available to healthcare providers through interdisciplinary addictions fellowships, rural fellowships through the Rural Education Action Plan initiative, online addiction medicine and opioid agonist treatment online training programs and preceptorships, and a range of clinical guidance documents, provider tools and fact sheets available from the BC Centre on Substance Use.
    - In particular, the BC Centre on Substance Use offers a free online certificate course targeted at healthcare professionals interested in learning more about providing care to patients with substance use disorders. Details can be found at https://www.bccsu.ca/about-the-online-addiction-medicine-diploma/
    - Working in partnership with the University of BC Continuing Professional Development Program, the BC Centre on Substance Use offers a Provincial Opioid Addiction Treatment Support Program to provide education and information for physicians, nurses, allied health professionals and other care providers involved in the treatment of individuals with opioid use disorder. The course is free and provides an overview of the provincial Opioid Use Disorder Guidelines. Details can be found at https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program

Addressing the Full Range of Supports and Social Factors

- In May 2017, a Mobile Response Team was established under Health Emergency Management BC's Disaster Psychosocial Support Program. The Mobile Response Team delivers services across all regions in the province to front-line providers, including volunteers and peers. Services include formal and drop-in sessions, assessments, psychosocial education and training, information on how to deal with grief and loss, outreach and referrals, team building and trauma responses.
- The province and regional health authorities are working together to expand access to services for inadequately housed youth and for people living with mental health and substance use issues who require supportive housing.

Alberta

- As of March 28, 2018, Alberta has opened four supervised consumption services across the province, with another five anticipated to open in 2018–2019. The Lethbridge service is the first supervised consumption service in Canada to offer supervised inhalation; the Royal Alexandra Hospital in Edmonton is the first in-patient hospital supervised consumption service model in North America.
- The Alberta naloxone program provides kits and overdose training distributed through harm reduction agencies, community-based organizations, pharmacies, emergency departments and Alberta Health Services facilities.
- Alberta is developing an overdose prevention site program for both a fixed-term and short-term basis, which may include festivals and other community events.
- Alberta has both launched a mainstream opioid awareness campaign by Alberta Health Service and provided grants to communities to increase awareness.
- The College of Physicians and Surgeons of Alberta continues to communicate with physicians and the public about appropriate prescribing of opioids.
- The College of Physicians and Surgeons of Alberta provides physicians who prescribe opioids and/or benzodiazepines with comparative prescribing pattern reports including a list of patients exceeding guidelines.
- Alberta has been expanding access by opening many new treatment spaces in areas that were previously underserved. In addition, an opioid dependency advice line is available for physicians and prescribers to consult with an opioid dependence specialist for advice regarding prescribing drugs such as Suboxone and methadone, as well as treating patients with existing opioid dependency.
- Alberta is implementing a supervised injectable opioid agonist therapy program in Edmonton and Calgary to support people with severe opioid use disorder. The program is planning to provide hydromorphone to clients.
- Health Professional colleges have been making regulatory changes and releasing standards of practice to support healthcare professionals in providing opioid agonist therapy (e.g., the removal of administrative barriers for physicians prescribing Suboxone).

- Addiction Recovery and Community Health (ARCH) Team, in the Royal Alexandra Hospital (Edmonton), provides patient-centred, evidence-based and holistic care for patients with an active substance use disorder and/or those dealing with social inequity. ARCH is being expanded to both increase supports available to Edmonton clients and be implemented in Calgary.
- A project to increase the role of primary care in the opioid response (i.e., improve access to opioid treatment in primary care) through a partnership of the College of Family Physicians, Alberta Medical Association, Alberta Health Services and the primary care networks.
- Alberta is implementing a project where patients will be able to be initiated on Suboxone in emergency departments in Edmonton and Calgary.
- Alberta is supporting Stimulus 2018, the national harm reduction and drug policy conference in Edmonton in October 2018.
- Indigenous communities and Indigenous serving organizations were supported to develop and implement interventions to address the opioid crisis.

Manitoba

- Manitoba's addiction services system offers a continuum of treatment services and support for youth and adults, including school-based intervention and prevention, medical and non-medical residential detoxification, a variety of community-based services, opiate replacement therapy clinics, short- and long-term specialized residential treatment, aftercare programming and outreach.
- To assist Manitobans with finding the right service, the Manitoba Addictions Helpline was established in November 2015 and is operated by the Addictions Foundation of Manitoba.
- Addictions services are provided by the Addictions Foundation of Manitoba, and a number of other organizations funded by Manitoba Health, Seniors and Active Living.
- The health response to opioid use and misuse in Manitoba is being coordinated through a Health System Opioid Response. Work is managed to provide a system response in an integrated, coordinated and effective manner.
- Accessibility to Suboxone has increased over the last year due to changes to the Manitoba Drug Formulary (removed coverage criteria for Suboxone to the Manitoba Pharmacare Program) and support of programs like the Manitoba Prescriber Education and Audit Program (MPEAP)
- Effective April 20, 2017, Suboxone was moved from a Part 3 (Exception Drug Status) to a Part 1 (open) listing on the Manitoba Drug Benefits Formulary making it easier for individuals to access coverage for this drug
- Funding through the MPEAP has contributed to the development of an inter-professional "Opioids 101" workshop, led by the College of Physicians and Surgeons of Manitoba.
- A provincial naloxone distribution program was launched in January 2017. People who are at risk of opioid overdose may access free take-home naloxone kits at designated distribution sites located throughout the province. In addition they can receive overdose recognition and response training at participating distribution sites.

- As of September 30, 2017, there are 64 registered naloxone distribution sites, with registered sites in all five regional health authorities and First Nations. In the first nine months of 2017, over 765 take-home naloxone kits were distributed to people at risk of opioid overdose and over 93 have been used in overdose events in the community.
- Data collection has been improved through the implementation of a robust opioid surveillance system, which collects data from a wide range of stakeholders and provides analyses on the data to inform public health programming and direct policy. The *Surveillance of Opioid Misuse and Overdose in Manitoba* report is produced on a quarterly basis. http://www.gov.mb.ca/health/publichealth/surveillance/opioid.html
- A social media awareness campaign was launched in November 2016 and a webpage created to provide information to the public and service providers about the dangers of fentanyl and how to get help. http://www.gov.mb.ca/health/mh/overdose/index.html
- Information packages were sent to all schools in Manitoba, including First Nations schools, in November 2016.
- A training manual was developed: *Overdose Prevention, Recognition and Response*. This manual provides education about the use of naloxone to address the morbidity and mortality associated with opioid overdoses. The manual is intended to prepare educators and trainers in provincial take-home naloxone distribution sites to prepare people to prevent, recognize and respond to overdose in a voluntary capacity. http://www.gov.mb.ca/health/publichealth/docs/training_manual_overdose.pdf
- Increased funding from the Public Health Agency of Canada was received to increase harm reduction efforts.

Ontario

- Ontario has a range of services and supports that align with the continuum of care for the treatment of opioid use disorder.
- The province has Assertive Community Treatment Teams that provide outreach and connections to treatment resources, and case management services that provide ongoing individual assessment and adjustment of treatment plans.
- Individuals can access short-term treatment through Rapid Access Addiction Medicine clinics, which offer opioid agonist therapy, counselling, harm reduction interventions (e.g., naloxone kits) and advice, until they can be connected to longer-term support in their community.
- Ontario has medical and non-medical withdrawal management services in residential and community-based settings, which offer additional supports such as discharge planning and early recovery education.
- Both buprenorphine/naloxone and methadone are available pharmacological interventions for treating opioid use disorder on the Ontario Drug Benefit Formulary, and in April of 2017, nurse practitioners were given the ability to prescribe buprenorphine/naloxone to improve access to treatment.
- The province offers psychosocial supports such as community-based lifestyle and personal counselling, including relapse prevention, which is available in individual, group and family formats, and individuals can access supportive housing services to aid in recovery.

- Ontario has addiction programs targeted to special populations, such as youth aged 12–24, Indigenous communities, and women, including pregnant women and mothers.
- Treatment services are supported by initiatives to improve provider treatment capacity, including targeted outreach, training, and opioid agonist therapy prescribing support to interdisciplinary care teams in communities of high need through the Centre for Addiction and Mental Health, mentorship opportunities for treating opioid use disorder through the Ontario College of Family Physicians, and quality standards on treating opioid use disorder developed by Health Quality Ontario, released March 2018.
- Ontario has various harm reduction initiatives such as needle exchange/syringe programs, naloxone distribution programs, supervised consumption services, and overdose prevention sites. Ontario's three main programs where naloxone is made available at no cost to Ontarians to prevent opioid overdoses are the Ontario Naloxone Program (ONP), the take-home naloxone program for at-risk inmates in collaboration with the Ministry of Community Safety and Correctional Services, and the Ontario Naloxone Program for Pharmacies (ONPP). The ministry maintains a list (in the form of a locator map) on its website that is available to the public and displays all of the organizations currently participating in the ONP and ONPP. This locator map can be found online at https://www.ontario.ca/page/get-naloxone-kits-free. The government has also strengthened the harm reduction workforce by providing new funding for the hiring of additional frontline harm reduction outreach workers and additional staff at public health units.
- In the fall of 2017, the Ministry of Health and Long-Term Care established the Opioid Emergency Task Force that brings together representatives from province-wide system partners, including front-line workers in harm reduction, emergency response and addiction medicine, community mental health and addiction, education, public health, municipalities, primary care, hospitals, people with lived experience, as well as other essential partners, to strengthen the province's coordinated response to the opioid crisis.
- In December of 2017, Ontario launched the first phase of a robust and targeted public education campaign to raise awareness about the risks associated with both prescribed and illicit opioid use, and how people can protect themselves and their loved ones against addiction and overdose.

New Brunswick

- New Brunswick, currently has methadone maintenance treatment programs, which are also referred to as opioid replacement therapy programs. They are offered in different forms such as publicly funded, privately operated physician offices or specialized clinics. These services are now offered in most areas of the province. Individuals receiving opioid replacement therapy are able to also participate in various programs such as individual counselling and residential rehabilitation programs.
- The accessibility to take-home naloxone kits is currently being rolled out in the province. The AIDS organizations through their needle exchange programs are able to provide take-home naloxone kits to those at risk. In addition, the residential withdrawal management programs (detox programs) will also be distributing the take-home naloxone kits to those most at risk.
- The province has also increased their capacity to report on opioid-related data to get a better understand of the New Brunswick reality. The following website offers information and tools related to opioids: http://www2.gnb.ca/content/gnb/en/corporate/promo/opioids.html

- In addition, the following link provides surveillance data for our province. Last surveillance report available on the site: http://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/MentalHealth/New-Brunswick_opioid-surveillance-report_2017-Q3.pdf

Newfoundland and Labrador

- Newfoundland and Labrador has an integrated system of delivery for mental health and addictions. The province has prevention and promotion services, a youth outreach worker program and youth case managers. The province is looking at peer-support programming.
- Under Towards Recovery Action Plan, Newfoundland and Labrador has an Action Plan for Mental Health and Addictions Services in the province. There are 54 recommendation to guide the re-design of mental health and addictions services. These recommendations cross all points of the continuum.
- In Newfoundland and Labrador, the four regional health authorities would offer mental health and addictions services. These services would differ from region to region; however, all regions would offer intake services, single-session counselling session (Doorways), and addictions counselling services (assessment and therapeutic counselling to individuals of all ages).
- There is a Provincial Navigator who provides information on services via telephone for all regions.
- There are three provincial inpatient addictions treatment programs:
    - Humberwood (Corner Brook) for 19+
    - Grace Centre (Harbour Grace) for 18+
    - Hope Valley (Grand Falls) inpatient addictions treatment for 12–18 year olds.
- Tuckamore: live in treatment program for 12–18 year olds with complex mental health needs
- Withdrawal services
    - The Recovery Centre in St. John's is open to anyone in the province who is 16+ and needs help while withdrawing from alcohol, drugs and/or gambling. This is a medical assisted withdrawal service.
- Harm reduction
    - Take-home naloxone kits: available at 91 sites in the province
    - Safe Works Access program: offered through the NL AIDS Committee
- Opioid Treatment Centre: St. John's site
- Methadone Clinic: Corner Brook
- Mental Health Crisis Line and Gambling Line

Yukon

- No update to provide at this time

Nunavut

Nunavut is currently not experiencing opioid-related harms to the same extent as other jurisdictions in Canada. As such, efforts are focused on naloxone availability and training sessions.

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