

CRISM



Environmental Scan of Withdrawal Management Practices and Services in Canada: Response to Opioid Use Disorder

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Executive Summary

Background

A withdrawal management service (WMS) is a comprehensive service offered to individuals who are experiencing the effects of cessation of prolonged use of alcohol and/or other drugs. A WMS has three significant functions – (1) to safely manage any acute medical, psychological, and/or behavioural complications arising from ceasing to use one or more psychoactive substances which may involve gradually tapering off the substance in a safe and effective manner or substituting it with a cross-tolerant pharmacological agent, and then gradually tapering that agent; (2) to provide a period of rest and stabilization in a supportive and humane environment that is respectful and protective of the person's dignity; and (3) to prepare for and assist with accessing a range of substance use/addiction treatment and other services (e.g., medical, mental health, social, and/or spiritual) that will support recovery. While, from a treatment system planning perspective, each of these three aspects of a WMS must be considered, they may be given differential weight by different stakeholders and for different sub-populations. Further, experts generally agree that a WMS, on its own, is not effective in maintaining recovery.

With respect to opioid use disorders (OUD), the medical management of opioid withdrawal syndrome involves the provision of gradually tapering doses of either opioid or alpha2-adrenergic agonists, along with other non-narcotic medications, to reduce withdrawal symptoms. While these approaches have been shown to be more effective than placebo in reducing the severity of withdrawal symptoms and drop-out rates, most clients relapse to opioid use if treatment is not linked to long-term substance use treatment. The Canadian Research Initiative on Substance Misuse (CRISM) has developed guidelines for the treatment of OUD¹, including withdrawal management, including informing clients of the risks of tapering without close and ongoing follow-up with a service provider and provision of naloxone kits and overdose prevention and rescue education. Treatment interventions for opioid use disorder consist mainly of long-term treatment (e.g., opioid pharmacotherapy) as 'first-line response' options. However, for a variety of reasons, including client choice, withdrawal management may be provided without ongoing treatment, and may include considerable risk for harms to the patient (e.g., overdose due to lowered tolerance). As a first step in improving evidence-based guidance on approaches for WMS for opioid use disorder, more information on current practices across Canada is needed, and in the broader context of the provision of WMS more generally.

Aim

The aim of the present study was to conduct an environmental scan to identify and describe current organizational practices and context with respect to withdrawal management for individuals with OUD in private and public Canadian substance use treatment systems. The

¹ Canadian Research Initiative in Substance Misuse (CRISM). (2018). *CRISM national guideline for the clinical management of opioid use disorder*.

results will contribute to subsequent development and dissemination of evidence-based guidelines for opioid withdrawal management services in Canada, in order to minimize risk and harm to those seeking such services.

Methods

Sampling procedures: The project developed an organizational-level national survey of public and private substance use treatment services that provide either WMS on a residential or non-residential basis. A nominated planning/policy representative from each province and territory, and several sub-regions, supported the development and validation of the list of service providers, as well as communications with the providers regarding survey completion. A total of 147 organizations offering WMS services were identified.

Data collection and analysis: An online survey questionnaire was developed through consultation with a Project Working Group and in collaboration with another CRISM project team located in Alberta (Prairie CRISM Node). The questionnaire comprised both quantitative and qualitative items covering background information about the organization; demographic characteristics of clientele; the nature and extent of withdrawal management services in *general* (e.g., residential/non-residential; nature of services provided) and *specific* to clients with OUD (e.g., staffing model, specific protocol, policies, barriers); and in-house provision, or access to, Opioid Agonist Treatment (OAT). The questionnaire was completed by a program representative, often in collaboration with one or more colleagues. Data were downloaded from the online survey management tool (REDCap) into Excel for analysis. Open-ended data were analysed for key themes relevant to the project objectives.

Results and Implications

Eighty-six programs completed the survey: an overall return rate of 58.5%. Summarized across four regions, the Atlantic region had the highest level of participation (84.2 percent; n=16), followed by Quebec (64.4 percent; n=18), Ontario (61.7 percent; n=29), and a large geographic grouping of the Western provinces and three Northern territories (46.8%; n=22).

Canada's WMS services

With the exception of Nunavut and the NWT, every province and territory had a specialized WMS at the time of the survey, open to a diverse profile of clients and, in many cases, providing gender-specific and age-specific alternatives. A mix of both residential and non-residential WMS were reported by just over half of the programs providing bed-based services only, a third providing both bed-based and non-bed-based services, and the remainder providing only non-residential services. Private facilities also offer WMS services as a part of their treatment offerings, although they are not well-represented in the survey results.

The overall number of admissions admitted into active WMS programs per year (n=52,860) signals the importance of these services within the national substance use treatment continuum.

Estimates of the number of these clients accessing WMS treatment for various substances highlight the importance of opioids (e.g., heroin, morphine, fentanyl) as well as the widespread involvement of multiple substances. Aside from opioids, which accounted for an average of 30.4 % of the WMS caseload, stimulants accounted for 32.7% on average (e.g., cocaine, crack, methamphetamine) and alcohol topped the chart at 62.2%.

A diverse staff mix was also reported including but not limited to a range of medical supports most frequently on site (60%), or offered through various formal arrangements within other parts of a larger organization (e.g., an affiliated emergency department), or through an arrangement with one or more external partners. A wide range of clinical and psychosocial interventions were reported as being offered, including information about services available, medication management, a range of harm reduction services and resources, support for basic needs, and counselling. While results were too varied to identify a “common staffing profile” or “a core service mix” for Canada’s WMS services, medical supports offered by physicians, a range of nursing professionals and other health-care workers were common and often intermixed with many other types of professionals in order to deliver a range of services beyond immediate substance detoxication and stabilization (e.g., social worker, case manager, pharmacist).

Overall, the data suggest a strong national capacity for WMS services in general, including a publicly funded mix of residential and non-residential WMS options, and available matching criteria from the research literature so as to support client placement in a stepped care approach. While the results do not allow for an accurate assessment of provincial/territorial capacity in relation to population size and level of need, or of important factors such as availability by sex/gender or other important factors related to service accessibility, there is clearly a strong foundation within which to strengthen evidence-based capacity for safe withdrawal from opioids.

Involvement of WMS with OUD

Strengths: The current national capacity for WMS provides a strong foundation for supporting people with OUD, including medical supports within a multi-disciplinary staffing model and their positioning within the regional/local treatment continuum so as to facilitate client transitions after the withdrawal phase. They are also significantly involved with clients using opioids, and not infrequently have been touched directly by the tragedy of one or more drug overdoses among the people they serve. These and other factors have prompted significant engagement in community prevention and harm reduction initiatives, as well as playing an important role in the community response to the overdose crisis.

With respect to their current involvement with opioid dependence specifically, the WMS client-centred approach is noteworthy, respecting client choice but also generally focused on safety and risk management protocols. There is also a basic familiarity with opioid-related treatment guidelines as well as a general openness to clients seeking help with other substances while remaining on OAT. Programs are generally open to supporting clients to withdraw from opioids when longer-term treatment resources are in place and/or other medical and follow-up services

are needed. The staffing complement of medical and psychosocial professionals supports this level of service delivery. Their provision of longer-term opioid agonist treatment and close relationship to other medical supports are particularly noteworthy, as is their close relationship with other community partners for other medical and psychosocial needs, including for the next stage of focused substance use treatment.

Challenges and opportunities for capacity building: These many strengths in the national WMS system notwithstanding, it is important to note that they reflect general patterns observed in the study but not should be taken to obscure the considerable variability that is also evident in many features of the national system. Further, the results come from only about 60% of the WMS program nationally, although there is no reason to believe the study sample is biased in any specific direction with the exception perhaps of the under-representation of private for-profit organizations which may be more open to practices that are not normative in the publicly funded system.

Particularly noteworthy is the variability across the national WMS system on key features of high relevance to adherence to the current opioid treatment guidelines, including variability in:

- whether or not programs accept clients who are maintained on OAT but are also seeking WMS services for other substances (a significant minority of programs currently do so);
- their familiarity and adherence to guidelines, including policies related to client education on risks of tapering without transition to OAT and/or a concrete follow up plan;
- the availability of medical supports (in some cases a clearly identified gap) and other reported barriers to transitioning clients from WMS to longer-term treatment;
- their provision of client education regarding the risks of opioid withdrawal;
- staff knowledge of specific WMS procedures for opioid dependence, including treatment protocols for withdrawal without supporting medication, and corresponding need for more specific guidelines;
- in the availability of follow-up supports; and.
- organization-level harm-reduction-based protocols for prevention of overdose and inclusion of overdose-related quality indicators in system-level surveillance processes.

Implications: In citing these summary points of strengths and opportunities for capacity development, it is important to also note that there are no doubt considerable provincial/territorial variations in WMS for OUD beyond the scope of this project to assess, as well as significant variation within and across local health planning areas. Health system planning authorities are encouraged to use the present findings and key items from the national survey questionnaire to explore the strengths and challenges in their jurisdiction through more

focused needs assessment. More focused regional or community-level needs assessment of WMS for OUD must also take into account the impact of the COVID-19 pandemic on the nature and extent of substance use in the population, and the required health system response through more telemedicine and other virtual care options. In many respects, the key question for planners and policy-makers is how to design an appropriate **combination** of WMS options within a broader continuum of services and supports and tailor it to the specific communities they serve. The next phase of the project will involve the development of best practice guidelines for treatment of withdrawal from opioids and the results of that work will require careful review and consideration for maximizing adherence to these guidelines within the organizational and community context.

1.0 Introduction and background

1.1 What are withdrawal management services?

A withdrawal management service (WMS) is a comprehensive service offered to individuals who are experiencing the effects of cessation of prolonged use of alcohol and/or other drugs². While precise definitions of withdrawal management vary in the literature, seminal documents and practice guidelines have agreed for some time that there are three aspects or objectives of service delivery (e.g., Centre for Substance Abuse Treatment, 2006):

1. To safely manage any acute medical, psychological and/or behavioural complications arising from ceasing to use one or more psychoactive substances (commonly referred to as “detoxification”). This may involve gradually tapering off the substance in a safe and effective manner or substituting it with a cross-tolerant pharmacological agent, and then gradually tapering that agent.
2. To provide a period of rest and stabilization in a supportive and humane environment that is respectful and protective of the person’s dignity.
3. To prepare for and assist with accessing a range of substance use/addiction treatment and other services (e.g., medical, mental health, social, and/or spiritual) that will support recovery.

While, from a treatment system planning perspective, each of these three aspects of WMS must be considered, they may be given differential weight by different stakeholders and for different sub-populations. For example, for some individuals with chronic challenges related to substance use disorders and low or no motivation for treatment, service goals may focus more on the management of (public) intoxication. For others, the stabilization and preparation for a subsequent phase of treatment and support will be more salient. As well, some patients are not interested in longer term treatment and just want to detox. This variability is reflected in different WMS service delivery models and the interventions they offer.

Notably, experts generally agree that WMS is distinct from treatment and other support services that are designed to facilitate the longer-term recovery from substance use/addiction (Centre for Substance Abuse Treatment, 2006), and that, on its own, is not effective in maintaining recovery (Meister et al., 2018). Further, there is accumulating neurobiological evidence that withdrawal drives the maintenance of repeated, compulsive substance use through a mechanism of reward dysfunction and negative reinforcement (Schlienz & Vandrey, 2019). In other words, the avoidance of the negative symptoms of withdrawal is a critically important reason for continued use of the substance, a factor particularly salient for substances such as opioids (Fishman et al., 2019).

² The term “withdrawal management” has gradually replaced the term “detoxification” in much of the relevant published literature, as well as in provincial and territorial strategic plans and priorities for substance and mental health services

Regionally and nationally, the provision of WMS is extremely resource-intensive. While the overall cost of WMS in Canada is not known, according to data reported in 2015-2016 by six Canadian provinces (Meister et al., 2018) WMS accounted for a quarter (24.6%) of all service events³ related to substance use treatment services (26.9% for males and 20.8% for females). They also reported that, in that same year, hospitalizations for withdrawal management accounted for 30% of all hospitalizations for substance-related disorders. Many factors determine the rates of service use, including not only the level of need in the community but also the awareness, availability and accessibility of services. Also, as noted above, sex and gender differences prevail, with males accounting for more use of WMS. These differences no doubt reflect underlying variation in patterns of substance use as well as barriers to accessing services for women, such as childcare responsibilities.

1.2 Evidence base for WMS

The research literature highlights various models of WMS, models which vary in terms of the mix of objectives cited above; the variation in medical and psychosocial interventions offered and corresponding mix of professionals engaged in their delivery; and the many alternative ways in which services can be offered, particularly on a non-residential basis. Research syntheses, guidelines and standards also vary with respect to their level of focus, with some focused on particular substances, most commonly alcohol and opioids, and others being more “substance-neutral”. Relevant literature is also drawn from different countries—in particular, Australia, the UK, and Canada—each of which has its own traditions and program taxonomy to describe the treatment system and its components.

In summarizing literature on the effectiveness of WMS, it is important to keep in mind that key findings and recommendations are typically summarized at the level of the WMS “model” and not specifically for the effectiveness of specific types of interventions that may be incorporated into these models. Importantly, the effectiveness of any WMS will be influenced by the relative emphasis on pharmacological strategies (using medications to help manage withdrawal), psychosocial strategies (using cognitive, counselling and/or psychosocial supports); or a combination of pharmacological and psychosocial strategies. Any approach used should be tailored to the needs of the individual and the type of substance or substances involved. A number of studies recommend combining pharmacological and psychosocial strategies that can jointly address the chemical dependence and psychological factors contributing to the substance use/addiction (Diaper, Law, & Melichar, 2014; Merkx et al., 2014).

Rush, Tremblay & Brown (2019) defined three WMS models in the Canadian context to assist in needs-based planning and gap analysis: (1) the Home-based/Mobile model, which

³ A service event includes new admissions to a WMS as well as transitions from one type of service to another.

encompasses a range of non-residential options; (2) the Community Residential model which is typically described in the literature as a “social detox model”, but which operationally also includes varying levels of access to medical supports; and (3) the Hospital/Complexity Enhanced model which essentially involves hospitalization and immediate access to a comprehensive range of medical and psychiatric supports. This classification system is similar to that used in Australia (e.g., Grigg et al., 2018). Some jurisdictions in Canada, and British Columbia and Manitoba in particular, include a fourth model, namely **Acute Intoxication Services**. This category recognizes a small but growing sub-sector of WMS that focuses solely on the immediate and safe withdrawal from alcohol or other drugs (typically a short stay of less than 24 hours) and which include few medical or psychosocial supports or emphasis on transitions to subsequent treatment and support. Various provisions may be made, however, for responding to acute medical emergencies (e.g., close proximity to a hospital emergency department; access provided to emergency medical services (EMS) for brief medical assessment). The term “sobering centre” has been used in some jurisdictions for this type of WMS, particularly in BC. Telemedicine, or, more broadly speaking, virtual or internet-based service, also has a role to play in withdrawal management (Ghodsian et al., 2018), including in the provision of aftercare support which may reduce repeat admissions (Timko et al., 2019). The available literature on WMS is also not confined to the question of community *versus* hospital inpatient WMS, that is, as either/or options, and mixed models have also been evaluated with good results (Quelch et al., 2018). Lastly, it is important to note that an organization or facility may offer WMS services as one phase or component of more extended treatment options. In some Canadian jurisdictions, a small number of such organizations are privately owned and operate on either a for-profit or not-for profit basis⁴.

Reflecting these various WMS models, and related criteria for client matching, the literature focuses considerable attention on the effectiveness and appropriateness of non-residential compared to residential options. By and large, the literature on non-residential WMS refers to home-based services with support provided by a primary care physician and/or nurse practitioner, and often includes other professionals in a multi-disciplinary team. Residential options are often grouped under a broad category of “inpatient services”, and typically refer to hospital-based or “complexity-enhanced” WMS. Generally speaking, the evidence and expert opinion expressed in the literature suggests that “severe addiction” may be better addressed in highly controlled environments such as inpatient withdrawal management settings, whereas in other less severe instances, outcomes may be more successful and cost-effective in non-residential withdrawal management settings (Diaper et al., 2014; European Monitoring Centre

⁴ A not-for-profit is an organization that is engaged in some activity of public benefit without any intention of earning income for its owners. All the profits and donations of a not-for-profit organization are used in operating the organization as per its objectives (i.e., charity or public service). On the other hand, the primary objective of a for-profit organization is to earn profits for its owners. Regulations vary across Canada in terms of the certification of private providers of substance use treatment services, including withdrawal management.

for Drugs and Drug Addiction, 2014; Muncie, Yasinian & Oge, 2013). This summative view is expressed, for example, in United Nations/WHO treatment guidelines (United Nations Office on Drugs and Crime & World Health Organization, 2017) whereby inpatient WMS settings are recommended for individuals at risk of severe withdrawal, who have concurrent serious physical or psychiatric disorders, and/or who lack adequate social support. Importantly, while the strength of this recommendation was “strong”, the quality of evidence behind it was rated as “low”.

Underlying the recommendation for differential use of inpatient versus community WMS, based broadly on “moderate” or “severe” addiction, is the need to assess the severity of withdrawal symptoms, ideally with a validated tool and severity-rating process such as the CIWA in the case of alcohol (Sullivan et al., 1989) or the COWS for opioids (Wesson & Ling, 2003). In this regard, a mild to moderate level of withdrawal severity, as determined by the scoring results, is seen as a level appropriate for a community/ambulatory WMS, whereas a level of severity in the moderate to severe range signals the need for inpatient WMS.

The importance of measuring withdrawal severity is clearly embedded in the criteria for community versus inpatient WMS advanced by the American Society of Addiction Medicine (ASAM; American Society of Addiction Medicine, 2015; Gastfriend & Mee-Lee, 2004). These commonly used criteria encompass six dimensions of the person’s past and present situation, of which the first dimension is Acute Intoxication and/or Withdrawal Potential. The other five dimensions are: Biomedical Conditions/Complications; Emotional/Behavioral/Cognitive Conditions and Complications; Readiness to Change; Relapse/Continued Use/Continued Problem Potential; and Recovery Environment. Importantly, the rating of withdrawal severity is not a stand-alone factor in determining the appropriate course of treatment and support but rather is combined with information on these other dimensions to determine the overall recommendation for the level of care for substance use treatment and support, including WMS.

Importantly, while many criteria are consistently identified in this literature, no reports specify which among the range of indications are essential to ensuring patient safety and a positive outcome. Thus, considerable emphasis is also placed on flexibility in applying the matching criteria, with a strong focus on individualized, client-centred decision-making, including a role for well-informed client choice. The literature is also sparse with respect to considerations for many minority and marginalized groups, or those with special needs—for example, Indigenous peoples, LGBTQ+ communities, older adults, those living with unstable housing, individuals with co-occurring acute or chronic conditions, and individuals who are pregnant. These are all important sub-populations for which a patient-centered, age- and sex/gender-appropriate, and culturally sensitive approach will be needed.

All this being said, the overall weight of research evidence, as reflected in the most recent guidelines and standards, points to the important and growing role for non-residential WMS

options for the large majority of individuals in need of WMS, and a corresponding trend away from exclusive reliance on bed-based options. In Canada, this is perhaps best reflected in the recent British Columbia guidelines (B.C. Ministry of Health, 2017), whereby only a minority of people seeking support for withdrawal from alcohol and/or other drugs are said to require intensive bed-based medically monitored or medically managed services. A recent systematic review of community-based WMS options (Nadkarani et al., 2017) also noted that despite the need for residential WMS options for selected individuals experiencing withdrawal from alcohol and/or other drugs, interest remains high in non-residential options, given the evidence regarding their increased accessibility and effectiveness, comparatively lower cost, and perceived acceptability of these options for many individuals (e.g., those working). Interest is especially high for models that involve collaborative care between community, hospital and primary care. It is noteworthy, however, that despite these and other benefits, the authors noted ongoing skepticism among general practitioners for engaging in community-based WMS.

In conclusion, a range of community and hospital-based WMS options are required and supported by research. In many respects, the key question for planners and policy-makers is not whether to support certain evidence-based options over others, but rather to emphasize the appropriate **combination** of these options within a continuum of services and tailored to the specific communities they serve.

1.3 WMS for Opioid Use Disorder

As noted above, much of the literature on WMS, including textbooks on treatment and management of substance use disorders (e.g., el-Guebaly et al, 2020), is focused on WMS and protocols for specific substances. With respect to OUD, the medical management of opioid withdrawal syndrome involves the provision of gradually tapering doses of either opioid or alpha2-adrenergic agonists, along with other non-narcotic medications, to reduce withdrawal symptoms (Comer et al., 2015). While these approaches have been shown to be more effective than placebo in reducing the severity of withdrawal symptoms and drop-out rates, most clients relapse to opioid use if treatment is not linked to long-term substance use/addiction treatment.

The literature on withdrawal from opioids also emphasizes the role of outpatient service delivery models unless strongly indicated otherwise, for example in the BC guidelines on opioid use disorders (British Columbia Centre on Substance Use and B.C. Ministry of Health, 2017). This literature is complicated, however, by the strong evidence concerning the risks associated with opioid withdrawal in general, given decreased tolerance after tapering, and the risk of overdose upon relapse. National guidelines from the Canadian Research Initiative on Substance Misuse (CRISM: 2018) recommend that “*offering withdrawal management alone (i.e., detoxification without immediate transition to long-term substance use/addiction treatment) should be avoided, since this approach has been associated with increased rates of relapse, morbidity, and mortality.*” (p. 21). Similarly, these guidelines state that “*withdrawal management alone is not*

an effective nor safe treatment for OUD and offering this as a standalone option to patients is neither sufficient nor appropriate” (p.36).

Existing guidelines do note that individuals who wish to avoid long-term opioid agonist treatment can be slowly tapered in a supervised fashion on an outpatient basis rather than rapid inpatient opioid-agonist taper. UK guidelines on opioid detoxification (National Institute for Healthcare Excellence (NICE), 2007) suggest a community-based program as the first-line option for opioid withdrawal with the following as potential exceptions for individuals who :

- Have had no or limited benefit from previous formal community-based detoxification
- Need medical and/or nursing care because of significant comorbid physical or mental health problems
- Need for complex poly-drug detoxification, for example concurrent detoxification from alcohol or benzodiazepines
- Experience significant social problems that will limit the benefit of community-based detoxification.

The CRISM guidelines further suggest, “Clients should be clearly informed of risks associated with tapering and encouraged to consider other treatment options. For those that still choose withdrawal management, it is recommended that a slow taper (> 1 mo.) be conducted in an outpatient or residential treatment setting, rather than a rapid (< 1 wk.) taper, and with close and ongoing follow-up with the outpatient provider, when feasible, to ensure that longer-term opioid agonist treatment (OAT) is offered. For pregnant women, gradual withdrawal management is recommended that takes place between 14- and 32-weeks’ gestation and is followed by intensive long-term monitoring and support (Canadian Research Initiative on Substance Misuse, 2018). To reduce the risk of overdose, clients and families should also be provided naloxone kits and overdose prevention and rescue education (Canadian Research Initiative on Substance Misuse, 2018).”

Treatment interventions for opioid use disorder consist mainly of long-term interventions (e.g., opioid pharmacotherapy/treatment) as ‘first-line response’ options. There are, however, other therapeutic interventions which exist for various reasons (e.g., community contexts where capacity or skills for OAT do not exist; patient requests for detoxication without follow-up OAT), and are known anecdotally and through formal provincial treatment systems reviews to be offered or practiced in Canada. This includes services which are often referred to as ‘detoxification/withdrawal management’ approaches, which, as noted above, rest on a limited evidence base and include considerable risk for harms to the patient (e.g., overdose due to lowered tolerance and limited follow-up support). For other approaches, such as opioid tapering or provision of naltrexone, evidence is only slowly emerging.

1.4 Objective of this report

Individual client, service provider, and community context and infrastructure may challenge adherence to the CRISM guidelines for WMS for OUD in all circumstances. This speaks to the need for evidence-based guidance and support for opioid withdrawal management approach, including facilitators and barriers to implementation in the Canadian context. As a first step in improving evidence-based guidance on approaches for WMS for opioid use disorder, the present environmental scan was undertaken to provide more information on current practices across Canada. This national picture will be incorporated into a second phase of the work which will develop more detailed guidance for opioid withdrawal management services in Canadian substance use services, and related knowledge-exchange activities.

The aim of the present study was, therefore, to conduct an environmental scan to identify and **describe current organizational practices and context with respect to withdrawal management for individuals with OUD in private and public Canadian substance use treatment systems.**

2.0 Methods

2.1 Ethics approval

The research protocol was approved by the CAMH ethics review board, followed by secondary reviews at relevant academic or health care services in Alberta, Quebec, and BC. In some regions, including Quebec, Alberta, and Nova Scotia, there were additional administrative reviews completed as well.

2.2 Sampling procedures: The focus of the project is an organizational-level national survey of public and private substance use treatment and support programs that offer residential or non-residential WM services. Withdrawal management is variously defined in clinical guidelines and supportive research. For the purpose of this project, the following definition was used:

“Withdrawal management service (WMS) refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.”⁵

⁵ *Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings, WHO.*

To operationalize this general definition, selection of programs for the study was based on an iterative process. See a subsequent section for survey procedures for the Province of Quebec.

Step 1: An initial search was made of government websites or available program directories for each Canadian province and territory aimed at identifying organizations, or specific sub-programs within larger organizations, specialized in delivery of services to people with substance use-related challenges. Colleagues of the first author (BR) from previous national and provincial projects were also consulted and, in snowball fashion, these colleagues and other stakeholders nominated specific programs or data sources, including potential participants from the private sector. This process led to the development of a list for each province and territory of the full range of substance use-specific, residential, and non-residential services, including but not limited to WMS. This initial, broader list was developed in support of another survey-based project led by the CRISM Prairie Node targeting substance use services offering a broader range of psychosocial treatment and support services, that is, exclusive of WMS. This broader and somewhat parallel project is referred to as the TOPP survey (Treatment of Opioids in Psychosocial and Recovery-based Programs) and is the topic of a separate report developed by the CRISM Prairie Node team.

This first stage explicitly excluded self-help recovery services as well collaborative care arrangements that may have a substance use worker or team located within a more generic health, social, or correctional service. Also, a separate CRISM project was in the planning stages regarding opioid-specific services offered by First Nations Inuit and Metis (FNIM) programs, and, as such, these FNIM programs were not included. Services focused specifically on provision of OAT was also excluded, although questions were included in the survey regarding the relationship between any WMS services being offered and the provision of OAT, either in the same organization or through collaborative arrangements. While Rapid Access to Addiction Medicine (RAAM) clinics were included at this stage of survey sampling design, this was more in support of the parallel TOPP survey than the present project, which focused on WMS specifically. It was recognized, however, that these RAAM clinics may be frequently involved in linking people to community WM services as well as in providing OAT specifically.

Step 2: The next step involved a formal review and validation of this initial program list by key provincial or territorial representatives responsible for substance-related program and policy-related work in their respective jurisdiction (see Appendix A for list of representatives). In those provinces with clearly defined regional health planning bodies (e.g., Regional Health Authorities or the Local Integration Health Networks in Ontario), the task of validation and further refining the program list was delegated to a nominated planning/policy representative in each sub-region. In a small number of instances, these communications with regional representatives were handled by the central authority (e.g., Alberta). In the case of the province of Quebec, due to fieldwork previously undertaken for a SUAP-funded project focused on that province's WMS services and opioid use disorder, a collaborative arrangement was developed with the Quebec-

based members of the CRISM Atlantic Node to identify the province's public and private substance use services offering WMS. The Quebec collaborators also subsequently supported data collection in that province.

In this step of engagement at the provincial/territorial level, an email contact was made with the key representative to inform them of the project, its goals and requirements, including eligibility criteria, and to explore interest in participation of that respective jurisdiction. A brief project description was also forwarded (see Appendix B). Expressed interest in participation, sometimes to be confirmed by a more senior official, was then followed by a specific request for an inventory of WMS services for their jurisdiction. This initial engagement process also discussed the relationship between this WMS project and TOPP being implemented by the Prairie CRISM Node. In ensuing communications, the potential value-add of the two CRISM surveys was discussed jointly, as well as the relationship to past or planned work in the respective jurisdiction relevant to the goals of the two inter-connected projects. As a result of this collaborative process between the two CRISM Nodes, the specific request made to the jurisdictional representative was for the provision and/or validation of a listing of ALL public and private substance use treatment programs, both for those offering withdrawal management services and those providing other substance use treatment services. The inventory requested information on public versus private status, address and contact information, including the name and address of the person best positioned to receive the email invitation to participate, and some basic information about the WMS services (e. g., residential versus non-residential; number of beds if residential, and provision of services for youth and adults, and gender-specific detail on this information).

From the outset, it was recognized that, in some instances, the focus of the overall organization would be on the provision of WMS services and, in other instances, WMS would be one of several programs that might be offered. Since the survey was aimed at the WMS program level, instructions for survey administration requested that the questionnaire be completed by a senior administrator or program manager with responsibility with the WMS program. Previous experience of the investigators with this type of organizational survey also recognized that the designated respondent may well seek assistance with completion of some aspects of the survey (e.g., caseload information, wait times). Thus, in the end, "key informants" can be defined as both the targeted organizations and their specific WMS program(s), and the subsequent key informant(s) for that program.

Within these processes, several challenges were identified in compiling the final list which required several clarifying conversations with the identified provincial or regional representatives. Examples included the fact that, as noted above, a given organization may offer several sub-programs (e.g., both residential and non-residential, and/or both youth and adult). They may also have one central program location but one or more satellite offices with varying levels of accessibility and provision of services. The question of inclusion or exclusion of

sobering centres in the sampling frame often came up in these clarifying discussions—that is, whether or not they qualified as WMS services specifically. Some were included in the sampling frame at the request of the regional or provincial representative, but were subsequently excluded after the determination of response rate and analysis, given inconsistencies in the WMS definition, and the fact that, in the end, only one survey return was forthcoming from this small group of prospective programs for inclusion (estimated as less than 10 nationally). Another common question at this stage of the sampling process was whether OAT programs were to be included or not, a challenge in some organizations that reported a close relationship between their WMS service and the OAT service. As per the initial survey guidelines, the OAT service specifically was to be excluded. These and many other questions were often sorted out by phone during actual data collection. In some instances, for example, questions about multiple program sites were left to the respondent to decide if separate survey questionnaires were warranted based on the availability of data for reporting purposes and actual differences in service provision across various sub-programs or sites. This was tracked closely and if the respondent reported in one survey questionnaire that two or more sub-programs had been combined for reporting purposes, it was then counted as one program and one response for the purpose of calculating the survey response rate. Also, withdrawal management services for patients admitted to general or specialized hospitals that offer this service to patients as part of their provision of more general health-care services were also excluded. That is to say, the focus of the survey and sampling process was on specialized, designated WMS services.

With respect to private substance use services, the provincial and territorial representatives supporting the development of the program list for their jurisdiction also provided names and locations of the services they were familiar with. This was then supplemented by additional Google-based searches conducted by the first author (BR) and personal contacts with important providers of for-profit substance use treatment services across the country. Other privately owned and operated substance use services were contacted via phone or through their “contact us” function on their website. In the end, since the availability of specific withdrawal management services could not be ascertained among the majority of the private providers contacted in this manner, only a small number were included in the final survey distribution⁶. Private organizations that appeared to be focused more broadly on “wellness” than substance use treatment specifically were excluded from the outset (e.g., Wellness Retreat Centres), although some may have mentioned substance use among the range of health and wellness challenges for which they offer services and support.

Step 3: The third and final step determining eligibility for the WMS survey was based on the initial item in the survey questionnaire which asked about the provision of WMS services based

⁶ These private providers may however have been included in the parallel survey of broader psychosocial treatment services conducted by the CRISM Prairie Node research team

on the above definition. If the response was no, then the survey respondent was prompted to exit the questionnaire.

2.3 Data collection approach:

The primary design and data collection methodology was a self-administered online survey using an online platform called Research Electronic Data Capture (REDCap). An email containing an invitation to participate (Appendix C) and a link to the survey invitation was sent to the designated contact person identified for those eligible programs offering WMS. As noted above, this typically involved a senior administrator or program manager who may then have enlisted support of program staff in the survey's completion. The email invitation directed participants to a landing page which explained the purpose of the study, the confidentiality of their responses within the project team, and individual respondent-level anonymity of their responses in all reporting, in addition to the informed consent details. Importantly, in the case of the province of Alberta, the policies of Alberta Health Services, and their respective health administration zones, required that the invitation to participate come directly from a senior zone representative and not the research project team. In this instance, the same email invitation was attached to the ensuing communications and containing the same assurances of confidentiality and anonymity as within the other provinces and territories.

With respect to consent to participate, prospective respondents were first directed to a landing page at the start of the survey that briefly outlined the study and objectives and informed them that by completing the survey they were consenting to participate. At the end of the consent page there was also an optional checkbox that indicated their acknowledgement that they were consenting to participate.

Non-respondents within three weeks of survey launch were sent a reminder email via REDCap and, if no response was obtained by 5 weeks later, a final reminder was sent.

2.4 Survey Questionnaire:

The questionnaire itself was developed through close consultation with the Project Working Group and in collaboration with the TOPP project team. This collaborative process standardized some items that contained common program descriptors, such as funding source and demographics of clients served. Items were also drawn or adapted from a questionnaire used previously in a related Quebec survey. The questionnaire, email invitation, and reminders were available in English and French.

The questionnaire (see Appendix D) identified background information regarding:

- The organization, funding source, and demographic characteristics of its clientele;

- The nature and extent of its withdrawal management services in *general* (e.g., medical or non-medical, nature of services provided) and *specific* to patients with OUD (e.g., staffing model, specific protocol, policies, barriers);
- The in-house provision of, or access to, Opioid Agonist Treatment (OAT); and
- Availability of overdose prevention kits.

The length of time required for completion of the study questionnaire was initially estimated at 15-30 minutes depending on the nature and extent of opioid-related services provided. Calculating the actual time for completion was compromised, however, because REDCap offered a feature that allowed starts and stops before final submission.

2.5 Quebec survey procedures

Following a separate REB process and other administrative requirements specific to the Quebec substance use treatment system, the invitation to participate in the survey was sent to the identified WMS programs in the province by a research staff member. Upon agreement to participate and consents being obtained, the questionnaire was completed by way of personal interview (in-person, phone, or virtual) of approximately 60 minutes with survey responses entered directly into the survey database by a research staff member conducting the interview. While a French translation of the survey questionnaire was used via REDCap, the same survey platform was used for entry and analysis of English- and French-speaking responses.

2.6 Response rate:

Table 2 shows the level of participation in the national survey. Counting the small number of private program surveys (n=4), an overall response rate of 58.5% was obtained (86/147). The various nuances identified above in the sampling and data collection procedures—for example, whether or not satellite offices were included or reported on separately—must be considered. Grouping the programs by four regions of the country indicates the highest participation from the Atlantic region (84.2%; n=16), followed by Quebec (64.4%; n=18), Ontario (61.7%; n=29) and then a large geographic grouping of the Western provinces and the three Northern Territories (46.8%; n=22). With respect to the latter grouping (West/North), Table 2 shows that the response rate is attenuated substantially by the results for Alberta. In Alberta, the required administrative and communication processes extended data collection into the COVID-19 pandemic period, thus augmenting data collection challenges. In the end, a response rate of almost 60% was achieved for Canada's publicly funded WMS programs. While it is not possible to state this as a representative sample, especially given variation across the regions and provinces, the level of participation is quite good when contrasted with similar institutional-level surveys and is sufficient to paint a broad picture of the WMS services in the country, including their work with

respect to OUD. Related to this, since there was only one response from a private service provider in the national sample, we elected to omit this one participant from the analysis so as to limit our description and conclusions to publicly funded WMS with the exception of a small number of private programs surveyed separately in Quebec (8 of the 18 respondents).

Table 2. Response rate by region and individual provinces and territories

Prov/Territory	Targeted	Returned	Percent
Atlantic Region	19	16	84.2
N.L./Labrador	3	3	100.0
PEI	1	1	100.0
New Brunswick	7	6	85.7
Nova Scotia	8	6	75.0
Quebec	32	18	56.2
Ontario	45	29	64.4
West/North	47	22	46.8
Manitoba	3	3	100
BC	17	12	70.5
Saskatchewan	10	6	60.0
Alberta	15	1	.07
Yukon	2	0	-
NWT	0	0	-
Nunavut	0	0	-
Sub-total	143	85	59.4
(public)			
Private WMS ⁷	4	1	25.0
Total	147	86	58.5

2.7 Analysis and reporting

Data were downloaded into an Excel database from the online survey management tool (REDCap). Frequency distributions for each survey item were reviewed for potential recoding of infrequently checked response categories and specification of missing values for purposes of calculating percentages (e.g., “not applicable” responses excluded). The main analysis was based on frequency distributions and cross-tabulations for Canada as a whole. Future reporting maybe

⁷ A small number of private resources (n=8) are included in the Quebec sample of 32 targeted programs and the 18 respondents)

be possible within specific sub-regions but potentially compromised by jurisdiction-specific sample size.

A separate REDCap database held the results from the Quebec survey and were subsequently merged with the data from the remainder of the country after being translated.

3.0 Results

3.1 Program description and selected operating characteristics

Among survey respondents indicating the source of their funding (n=77) about one-third of the participating programs were funded **and** operated directly by the provincial/territorial health authority or a government department/entity (Table 3) . A further 22% were funded in that manner but operated independently. Of the seven programs receiving funding from other sources, five were supported wholly or in part by client fees and the remainder by a mix of other sources including private donation.

Table 3. Sources of WMS funding among survey participants

Sources of funding	N	%
Primarily prov/territorial health authority or government department/entity and operated directly by same entity	51	66.2
Primarily prov/territorial health authority or government department/entity but operated independently	17	22.1
All funding comes from sources other than from prov/territorial health authority or government department/entity	7	9.1
Partial funding from prov/territorial health authority or government department/entity but operated independently	2	2.6
Missing	8	---
Total	77	100

Table 4 shows the mix of residential and non-residential WMS supported by this funding with just over half of the programs providing bed-based services only, a third providing both bed-based and non-bed-based services and the remainder non-residential only. The table also illustrates that just over half of the participating programs (54.1%) offer only bed-based services and about another third (34.1%) these were combined with non-residential services. A small but still important percentage reported offering only non-residential services (11.8%) and, when added to the combined category, note that about 45% of the programs offer some non-residential services.

Table 4. Distribution of residential and non-residential WMS among survey participants

Type of WMS	N	%
Residential only	46	54.1
Non-residential only	10	11.8
Both residential and non-residential	29	34.1
Total	85	100.0

Table 5 provides some additional details about the nature of these non-residential services showing a mix of Daytox (48.7%), home/mobile team (46.2%) and “other” options (53.9%). These other options included telephone support and follow-up (n=4), sometimes requiring a previous home visit and risk assessment; and some combination of counseling, case management and psychosocial supports (n=4). Five participants reported accessing to addiction medicine services including an affiliated RAAM clinic or direct access to proximal opioid agonist treatment. The remaining options cited as other non-residential options reflected assessment and transition supports to residential treatment or acute care beds on an as-needed basis. One non-residential program reported delivering services over the Internet, an option that may now be more common as result of treatment system changes put in place as a result of the COVID-19 pandemic.

Table 5. Type of non-residential WMS provided by the participating programs.

<i>Non-residential services</i>	N	%
Daytox	19	48.7
Mobile team	18	46.2
Internet-based support	1	2.6
Other	21	53.9

The bed capacity of the residential programs is summarized in Table 6, keeping in mind that this is the capacity of those programs participating in the survey and therefore not representative of

total national WMS capacity. Similarly, with the ratio of male to female beds (305:235). The relative balance of bed availability for men versus women is also complicated to pinpoint since a significant number of beds are also available for both genders (non-gender-based beds were not reported) and explanatory notes provided by some respondents indicated some flexibility in use of beds officially designated by gender.

The range of bed capacities is rather wide reflecting both large, dedicated facilities as well as those with only a small number of beds. Services with the smaller number of beds tended to be reported by mixed residential and non-residential programs, that is, the WMS service was primarily non-residential but with small bed capacity used for selected cases if needed, and then transitioned to the non-residential component. Average length of stay is also summarized in Table 6, indicating a mean stay of 7.8 days, and again a considerable range from 2-21. Programs reporting the longer period for withdrawal management were primarily those reporting on non-residential services, and no doubt including some aspects of their post-withdrawal continuing care services. Similarly, a precise determination of length of stay is challenged by the fact that a significant number of the participating WMS services are affiliated with a residential treatment program (42.5%; n=36), such that clients would transition from WMS directly into structured residential treatment without there necessarily being a clear demarcation of the WMS phase. In the same vein, the withdrawal phase for opioid use disorder (i.e., tapering) would typically lead to induction to OAT, again making it difficult to demarcate and calculate the average duration of each phase. In the end, the calculation of average length of stay for purposes of this environmental scan should be considered an estimate based on both administrative records and estimation by key informants.

Table 6. Bed capacity and average length of stay of the residential WMS provided by the participating programs.

Bed Capacity	N
Overall bed capacity	
# of program (reporting beds)	53
Mean # beds	25
Max beds	48
Min beds	1
Total beds	656
Beds for males only	
# programs	24
Mean # beds	14
Max. beds	32
Min. beds	2
Total beds	305
Beds for females only	

# programs	26
Mean # beds	9
Max beds	30
Min beds	2
Total beds	235
Length of stay	
X (mean days)	7.8
Max	21
Min	2

When asked if any of the WMS-designated beds shown in Table 6 are hospital beds, 14 programs indicated that all their beds are considered hospital beds, and five indicated that some were hospital beds. Clearly, the majority of the bed-based WMS programs are not located in the hospital; although a variety of medical supports may still be available (see below). Further, a small number of programs (n=4) indicated that formal arrangements are in place for back-up hospital beds for WMS purposes, for example, 1-2 dedicated beds in the emergency or other departments to facilitate an intake or transfer.

In addition to the above designated program capacity for WMS, several of the participants endorsed that other beds are also available. A wide variety of such arrangements were noted by 25 programs (31.3%).

The nature of these other arrangements for non-designated beds included access to services and supports affiliated with the WMS service and those offered through other providers in the community. With respect to affiliated services, this included a formal substance use residential treatment program (n=6) or inpatient concurrent disorder unit (n=1); hospital beds, if needed, for medical supports (n= 3); observation beds (n=2); or low threshold beds referred to as “brief detox” or “sobering beds” (n=2). One respondent mentioned “safe beds”, a specific service category used in Ontario for short-term crisis support.⁸ Options mentioned for accessing beds in the community included beds available in residential treatment services or multi-functional beds in low-barrier community settings. Three respondents noted that all beds in their residential treatment facility are available for withdrawal management as needed by incoming clients.

As noted above, a significant percentage of the WMS services (42.5%; n=36) are closely affiliated with a residential substance use treatment program. These are important arrangements that facilitate smooth transitions across the continuum of care and are summarized below. The large majority of respondents reported a direct affiliation with an in-house treatment program,

⁸ Safe Beds offers an alternative to hospitalization for individuals with an addiction or mental illness experiencing a crisis and unable to stay in their current living situation. Safe Beds is a voluntary, non-medical facility providing services 24/7 with an average length of stay of 3-5 days.

such that the WMS was essentially “Phase 1” of the overall treatment process (n=26). One respondent referred to this as “pre-treatment”. A small number also reported the duration of the program which may include or exclude the WMS component. Responses ranged from 3 weeks to 5-6 weeks. Nine respondents cited a formal arrangement with a residential treatment provider in the community or they utilized either their own residential service or one in the community depending on the individual circumstances.

Table 7 highlights the provision of medical supports among the participating WMS services. Importantly, virtually all programs make some provision, most frequently on-site or otherwise among the team (60.0%) or various formal arrangements within the organization or external partners.

Table 7. Provision and/or arrangements of medical supports for WMS clients

Provision for medical supports	N	%
Provided on-site (or in the team if home, mobile or Internet-based)	51	60.0
Formal arrangement with a hospital emergency department	16	18.8
Formal arrangement with another part of same organization	10	11.7
Informal arrangement with another organization or health care provider	5	5.9
Formal arrangement with another organization or health care provider	2	2.4
Not sure	1	1.2
None	0	0

Table 8 illustrates the nature of the professional resources involved, with the most frequently cited being physicians (78.6% of respondents) and nursing professionals, including both nurse practitioners (33.3%) and other nursing professionals (71.4%). 32 or 38.1% of the reporting programs were also staffed with other health care workers. These other health care workers were from diverse backgrounds and training.

Table 8. Provision of medical supports for WMS clients

Nature of medical supports	N	%
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Physician	66	78.6	Respondents were asked for further details on both physicians (i.e., medical specialty) and the other health care workers. For physicians, the most common response was General Practitioner (n=25), sometimes noted as “GP with Addiction Specialist”, followed by Psychiatrist (n=10), and then other (n=8), which included for example, Emergency Department Physician.
Nurse practitioner	28	33.3	
Other nursing professional	60	71.4	
Other health care professional	32	38.1	
Not sure	4	4.8	

For other health care workers, respondents often reported multiple categories, often listed together in the same open-ended response. The most frequently mentioned were various levels of nursing professionals (n=21); counsellor and social worker (n=6 respectively); paramedic (n=3) and pharmacist (n=2). Other professionals given a single mention included crisis support worker, physician assistant, occupational therapist, recreation therapist, educator, and case manager.

Respondents were also asked to describe the availability of these medical supports for their WMS clients. Coding of the responses was challenged by the wide variability in these arrangements, no doubt reflecting the nature of their program and its affiliations, their clientele and local circumstances. Provision of medical supports on a 24/7 basis was the most frequent response (n=58), either through an ED, inpatient unit or with nursing or other staff scheduling. Nine respondents specifically mentioned availability of an on-call physician as part of this mix. A Monday-Friday arrangement was noted by 17 respondents with some variability on hours (e.g., 9-5, 8:30-4:30, 8am-10 pm) and 14 others gave very specific but highly variable responses, which was difficult to categorize (e.g., “Physician 24-7, Nurse Practitioner 8:30 to 4:30, and other nursing 24-7”; “Paramedics 24/7, Access to Doctor weekdays, Registered Nurse Monday to Friday, Nurse Practitioner weekends 24/7”).

Table 9 shows the availability of additional treatment or other support offered to clients through the withdrawal management services. Not surprisingly, information about mental health (92.9%) and addictions treatment or other services (95.3%) were most frequently cited as well as medication management, in particular, for addictions (82.3%). Importantly, support through a range of harm reduction services and resources was reported as widely available (75.3%) as well as support for basic needs, such as housing (71.8%) and counselling (77.6%).

Table 9. Provision of additional treatment and support services

Nature of additional treatment and other supports	N	%
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Information about treatment or services available for addictions	81	95.3
Information about treatment or services available for mental health issues	79	92.9
Medication to help with addictions	70	82.3
Counselling or support on a non-residential basis, including any kind of help to talk through problems	66	77.6
Help to reduce the risk of harm related to using drugs, such as needle exchanges, testing for diseases that can be passed on through drug use, etc.	64	75.3
Responding to basic needs such as housing, finances, or food security	61	71.8
Education supports (e.g., to undertake self-care, to use their time, or to meet people)	55	64.7
Residential (non-medical) treatment overnight or longer	53	62.4
Medication to help with mental health issues	50	58.8
Hospitalization overnight or longer	40	47.1
Help to improve clients' ability to work	40	47.1
Other	9	10.6

“Other” services and supports mentioned included navigation supports to connect to outreach teams or other community services (n=3); 12-step recovery supports (n=2); and provision of naloxone (n=2). Services and supports given a single mention included fitness services, recreation therapy, and linkage to medication.

3.2 Client characteristics of the participating WMS services

Table 10 summarizes the accessibility of the WMS services to different population sub-groups and, for the most part, shows a high level of formal inclusion. The difference for youth compared to adults is striking (54.2% compared to 96.1%, respectively)⁹. Incarcerated offenders were the group least likely to be included.

The data on inclusion or exclusion by male or female gender is interesting in light of the significant number of gender-designated beds reported earlier (Table 6). This implies that many organizations provide WMS for both men and women under the same organizational umbrella, although perhaps in separate facilities. Relatedly, this may also reflect survey recruitment and completion processes whereby one questionnaire was completed for the organization as whole.

⁹ Percentages are based on the number of respondents to each sub-category.

For those endorsing age-related inclusion or exclusion criteria, the youth and adult age ranges were requested. With respect to youth, the most frequent responses were 16 and over (n=14) or more broadly phrased as “youth or transitional aged youth” (n=18). A small number cited 18 and over (n=11) or did not specify an age range (n=3).

For adults, the most common response was 18 or 19 and over (n=45), and a smaller number endorsed either 16 or 17 and over (n=9). Together with the youth-specific age ranges this implies a lack of WMS service options for those in the gap-years of 16-17 compared to adults and older adults. Several other responses for adults included 21+ or 25 or 26+ and a few respondents simply reported that they had no age limit for adults (n=8).

Table 10. Client characteristics

Client groups accepted	Includes		Excludes		No response
	N	%	N	%	
Males	76	100	0	0	0
Females	76	98.7	1	1.3	8
Youth	39	54.2	33	45.8	13
Adults	74	96.1	3	3.9	8
People mandated to treatment by justice system	61	80.3	3	19.7	8
People with concurrent mental health challenges	77	100	0	0	8
Incarcerated offenders	25	35.2	46	64.8	14
First Nations, Metis or Inuit peoples	75	97.4	2	2.6	8
LGBTQ clients	77	100	0	0	8
Other cultural groups (e.g., newcomers)	71	92.2	6	7.8	8
People with developmental disabilities	64	84.2	12	15.8	9
People with physical disabilities	74	97.4	2	2.6	9
Pregnant or post-partum women	71	91.0	7	9.0	7
Seniors or older adults	75	96.2	3	3.8	7
Others	8	61.3	5	38.5	72

Participants were also asked to report the total number of admissions accepted into their WMS program - “admissions” referring to admissions to the withdrawal management service with an

associated discharge event or case closure in the past 12 months. Importantly, total admissions may count the same person more than once in the reporting period. These results are shown in Table 11 where 72 out of 85 programs were able to report on this survey item and highlight the huge variability in program capacity with a minimum of 2 clients to a maximum of 3,240. This variability no doubt reflects, at least in part, differences between non-residential and residential services, the latter being much more limited in capacity. Mean annual capacity was 656 admissions and the national total was 47,239, keeping in mind that this reflects only the total admissions among the participating programs in the survey (about 60%).

Table 11. Total past-year admissions to the WMS programs

Client admissions in past 12 months	Total programs reporting N= 72
Mean	656
Max	3240
Min	2
Estimated total clients	47239

Table 12 goes further and reports on the percentage of clients receiving WMS for specific substances, these percentages often being estimated by the survey respondents. The most frequently endorsed substance was alcohol (mean = 62.2%), followed by stimulants (mean = 32.7%) and opioids (mean=30.4%). Some caution is warranted in the interpretation of these results given the responses provided for tobacco and cannabis, for example, which showed that 24.6% and 21.3% of clients, respectively, were in WMS for these substances, with maximum percentages being 95% and 96%. It is likely that some respondents were acknowledging the multiple substance use profile of clients rather than reporting only on the one *primary* substance as the focus of the withdrawal management process. In interpreting these results it is also important to note these percentages apply to the overall caseload seeking WMS, and not necessarily reflective of the substance use profile of those seeking WMS specifically for opioids.

“Other” substances mentioned included GHB¹⁰ (n=5), and single mentions for Gabapentin, non-consumable alcohol, over-the-counter medication, multiple substances, and gambling.

Table 12. Percentage of clients receiving WMS for specific substances

Substances	# of programs	Mean %	Median %	Max %	Min %
Alcohol	71	62.2	65	100	0
Stimulants (e.g., cocaine, crack, methamphetamine, ecstasy)	69	32.7	25	95	0

¹⁰ Gamma Hydroxybutyrate (C₄H₈O₃) commonly referred to as a “club drug” or “date rape drug”

Opioids (e.g., heroin, codeine, morphine, fentanyl, opium)	67	30.4	30.2	100	0
Tobacco/nicotine	59	24.6	0	95	0
Cannabis (e.g., marijuana, hash)	622	21.3	6.9	96	0
Non-alcoholic depressants (e.g., barbiturates, benzodiazepines)	64	12.0	5.0	80	0
Hallucinogens (e.g., LSD)	62	4.2	0	50	0
Inhalants (e.g. glue, solvents)	62	2.1	0	50	0

3.3. Involvement with opioids and services for opioid use disorders

As noted in Table 12, 67 participants reported on the percentage of their caseload receiving withdrawal management services for opioids with a prompt to include heroin, codeine, morphine, fentanyl and opium as examples. The mean percentage of total caseload was 30.4 % (median 30.2) and ranging from 0% to 100%. Based on the total number of admissions reported (Table 11) and this percentage receiving withdrawal management for opioids, we estimated the total number of WMS clients that this would represent.¹¹ This yielded an estimated total of 19,785 opioid-related admissions, again acknowledging this as a substantive underestimate due to the survey participation rate hovering around 60%.

When asked if the opioid crisis has impacted their program’s involvement in prevention or treatment-related work with opioids, 51 participants or 60% responded in the affirmative, both with respect to their work within the broader community and within their own program. Eight participants or 9.4% responded “no” and the same percentage “not sure”. Open-ended comments reflected a wide variety of community involvement in prevention or treatment-related activities, including joint program planning and development (n=11); community collaboration (unspecified) (n= 9); provision of training and education (n=7); and drug testing (n=6). Eleven programs mentioned “jurisdiction-wide” support but again not specified beyond the geographic coverage.

“This crisis has enabled us to increase our harm reduction measures by offering needle kits. The crisis has also created an increase in take-home naloxone kits and an increase in requests for OAT. We had better access to treatment for people who wanted to have OAT because the doctors were more interested in addiction, this probably because of the opioid crisis.”

¹¹ Missing values for total admissions and the percentage opioid admissions were imputed based on the overall group means for each variable. The number of admissions for one program providing only residential services was estimated based on reported bed capacity, length of stay and occupancy rate.

“We have increased availability of Naloxone and training. OAT clinics have expanded and we now have one , 5 days per week and are in conversation to further improve access to OAT.”

“We have set up a regional vigilance committee on opioid overdoses which is overseen by public health”

For the 51 respondents reporting an impact within their own program, 22 (43.1%) reported following the CRISM iOAT guidelines and 7 or (13.7%) indicated that these guidelines had been read by **all** staff (Table 13). A somewhat larger percentage reporting following other guidelines (52.9%), which included (in open-ended comments) guidelines from BCCSU (n=4); CAMH (n=2); other (unspecified) organization or province (n=6) or guidelines from other (unspecified) regulatory bodies (n=3) . Among the “other” comments, three mentioned the use of the “COWS instrument and opioid withdrawal protocol” although it is not clear precisely which scale or protocol this refers to. Fifteen participants (29.4%) reported having developed their own guidelines.

Table 13. Within-program impact related to use of clinical guidelines

Use of guidelines within program	N	%
Follow other guidelines	27	52.9
Follow the CRISM guidelines	22	43.1
Developed own guidelines	15	29.4
All staff have read the CRISM National Guideline for the Clinical Management of Opioid Use Disorder	7	13.7
Other	3	5.9

Participants were also queried about opioid overdoses among clients of their withdrawal management services and 40 (48.8%) indicated that this had occurred. A probe then followed as to the number of times and to comment on the circumstances. Of those reporting the number of overdoses, the number reported by each participant was most commonly 1-2 incidents (n=22), with five programs reporting 2-3 incidents, another five reporting four or more incidents and 14 not able to specify the number. In describing the circumstances, 15 participants mentioned the overdose occurred on site in their residential facility, nine reported during provision of outpatient services while living in the community and eight reported the overdose occurred while en route to the program or upon arrival to their program or the ED. For 25 overdoses for which the outcome was reported, there were 18 survivors and seven deaths. However, comments showed widespread and varied experience with overdoses among the programs and their clients.

Many participants reported several overdose experiences among clients but were often unable to provide an estimate of the actual number.

“We have had a lot of overdose cases, but I don't know the number. These overdoses have occurred in 10-15% of the OAT clientele (we have had 150 admissions to our OAT program in the past 12 months). Of the overdoses that occurred, 5 to 10 were fatal”.

“15 overdoses for patients followed externally including 2 fatal overdoses. There were also 2 other overdoses in our walls.”

“clients have used en route to the centre and have all overdosed upon arrival in entry or parking lot. Multiple overdoses have been reported on our clients in the community, but we don't track the number.”

“We have had a few cases of overdose mainly among our external services clientele. Unfortunately, we do not have the number of drug overdoses that occurred, but these were not always related to fentanyl. There would have been around 3-4 deaths among these overdoses, but that's an estimate.”

“overdose in hospital, none resulting in death, none at detox facility. OD in hospital does not include presenting to ER with OD. No overdoses have occurred onsite. We currently do not track number of overdoses reported by individuals on our caseload.”

Several made mention of very unexpected incidents on site or upon arrival.

“client urgently seeking restroom at time of presentation, allowed to use bathroom and injected opiate whilst in there.”

“in house. It's happened twice by clients sneaking in substances.”

“2 overdoses have occurred. Both of these people used fentanyl without our knowledge and required doses of naloxone and were then transferred to hospital for follow-up”.

Program-specific preventive and treatment practices were also noted.

“2 people have died of overdose in the past year. Which led us to having naloxone kits in our addiction rehabilitation centre.”

“We see many patients who report previous overdoses prior to initiating our services. All patients are provided a naloxone kit, education on overdose prevention, and supervised consumption services as appropriate. We've had 1-2 overdoses on the unit.”

“... client arrived for service but had consumed significant amounts of opiates before arriving. Given Narcan while waiting for EMS to arrive to bring to the emergency dept.”

Participants were asked directly if they provide WMS services to clients with problematic opioid use as either a primary presenting problem or a secondary/co-occurring problem¹². Of the 81 participating programs responding to this item, 45 (54.9%) reported providing WMS services to people with opioid use disorder as the primary problem and 26 (31.7%) as a secondary problem. The remaining 11 (13.4%) indicated that people with opioid use disorder were not admitted for WMS.

The survey also probed participants as to whether their program admitted clients for withdrawal management for non-opioid substances but who may be receiving OAT through another program or service. The large majority responded in the affirmative – 62 (76.5%) “always” and a further nine (11.1%) “sometimes”. Only seven participants, (8.6%), indicated this was not accommodated.

When asked if clients were asked to discontinue OAT before being initiated into their withdrawal management service for other substances, the large majority (94.3%) reported that this was not required. Only one responded “yes” with the remainder being unsure.

A final question in this thread asked if clients with problematic opioid use who are receiving OAT were asked to taper their use of opioids during withdrawal from other substances and, again, the large majority indicated that this was not expected (91%). Five (7.5%) programs endorsed that this was encouraged but not expected and one program reported that yes it was expected.

Those participants that indicated that people with opioid use disorder were not admitted for WMS (the 11 programs; 13.4%) were asked to comment on individual or structural factors behind that decision. Responses tended to fall under two broad, interconnected themes, with a small number of outliers. The two major themes that emerged were “insufficient capability” and “safety concerns”. Some comments that fell under the first theme of “insufficient capability” include:

“... there are some individuals for whom intense medical supervision is required for their withdrawal. [Our] withdrawal management unit is not sufficient to fill

¹² For the purposes of the survey, respondents were given the following instructions: “... opioids include the illicit drugs heroin and fentanyl, as well as prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, street methadone, street buprenorphine/naloxone as well as prescribed methadone and buprenorphine/naloxone and any synthetic derivatives thereof. “Problematic opioid use” is broadly defined as use of opioids that interferes with an individual’s psychosocial wellbeing or health.

this gap as [we do] not have the mandate nor sufficient medical personnel and resources to support a medically supervised withdrawal program.”

“We do not have any certification to offer opioid withdrawal. In addition, our doctor is not specialized in opioid withdrawal.”

“If someone needs more intense medical withdrawal for substances such as methadone referrals are made to appropriate services; we are not able to provide this kind of treatment unless it was related to other physical medical emergencies.”

“offer non-opioid drug withdrawal only. We do not offer opioid drug withdrawal because we do not have 24-hour medical staff on site for this service.”

The following are some comments reflecting the second major theme of overall safety. Here we included comments related to the preferred, and presumably safer, treatment approach being Opioid Agonist Treatment.

“We have access to OAT in community, as well, withdrawal management from opioids as a stand-alone service is not evidence informed practice”.

“Safety, withdrawal without replacement is not safe,”

“Individuals at risk are automatically directed to the hospital.”

“We offer non-opioid substance withdrawal and induction for people who use opioids in our treatment centre”.

“If a client is refused admission it might be due to the expectation of a withdrawal complicated by other medical conditions and or behavior that poses a risk to themselves or others in the program (staff as well as clients)”.

“We do not admit patients for detox from opioids given risk and as per evidence/guidelines. We admit patients for stabilization on their OAT if they cannot stabilize as an outpatient due to numerous factors”.

In addition to these two major themes, two respondents noted their practice to provide flexibility.

“We try to provide the services the client is requesting. Sometimes they wish to continue use of OAT but stop using alcohol or even cannabis”.

“We seldom offer W/D from opiates due to the very high risk of OD. The only exception we make is when clients have booked treatment bed”.

A question also probed what types of provisions are made for people requesting withdrawal from opioids, if any. A variety of arrangements were noted, the most frequent (n=12) being connection to an OAT program, or strong encouragement to do so.

“Clients have been initiated on suboxone when in withdrawal management program. Clients can be on stable dose of methadone and receive withdrawal management for alcohol while here”.

“Screening before admission for willingness to start OAT; discharge from service within 2 days if client refuses to start OAT (i.e., before tolerance is lost)”.

Other commonly cited provisions included immediate connection to a physician or hospital (n=5) as well as connection to community services (e.g., housing, counselling, or psychosocial supports) (n=4).

“Send to the hospital (for medical assistance) or their family doctor for tapering. If doctor is providing tapering services, we put them on the list”.

“Primary health, mental health and addiction supports including housing and social re-integration.”

Four participants mentioned the provision of education on the risks of withdrawal, for example, loss of tolerance and overdose.

“They are educated on the risks vs benefits of OAT vs detoxing and re-entering the community with or without supports.”

“The person making the request will be met by a nurse. If the person insists on withdrawing without medication (which is very rare), they will be kept informed of the OAT treatments that are available and that they can benefit from at any time.”

Five respondents mentioned offering advice or direct support for a specific protocol for tapering.

“We do not offer inpatient withdrawal from opioids due to the increased risk of post-discharge overdose and death, as well as morbidity. Slow outpatient tapers encouraged.”

“Suboxone/Methadone treatment, if they don't want to be on long term treatment, we will taper them with Suboxone, but the taper will start at detox and finish in community.”

Two participants noted that this was addressed on a very case-by-case basis, for example:

“We have a prioritization system established according to different criteria to be able to accept someone. For example, someone who uses opiates but is significantly self-sufficient will not be given priority over someone who uses alcohol but has concurrent severe mental health issues and is considered to be at high risk. Evaluation is made.”

Finally, seven respondents noted that no special provisions were made for people requesting withdrawal from opioids.

For those respondents that reported providing WMS for persons with OUD they were then asked what criteria were in place for accepting them for opioid withdrawal. The most frequently mentioned response was the need for the person to be medically stable, often with a medical clearance and GP referral (n=25). This was followed by the person's expressed interest in OAT and often noted as being voluntary (n=11). Ten respondents noted the explicit need for a follow-up plan and small number (n=4) mentioned only that the person be from a particular geographic region. In several instances, the respondent mentioned that no specific criteria were in place other than those usually considered for WMS in general, for example, being voluntary, having an OUD and having used within a certain preceding number of days (e.g., under the influence, used in past 72 hours), being self-referred/voluntary, and signing a behavioral contract as appropriate. Notably, these various criteria were often mentioned together, and best illustrated in the following example.

“OUD dx or symptoms as indicated by physician assessment. A well-prepared follow-up plan is also necessary. Clients usually have tried and have not been successful on maintenance OAT (Suboxone and Methadone...not always Kadian). Detox from opioids is strongly discouraged, though we have found that most clients will switch to a maintenance dose during withdrawal once they are uncomfortable. We can usually get a doctor to write a maintenance script fairly quickly if needed. The argument from some physicians and nurses has been that if we had simply denied service, we may have lost them altogether. We do our best to stay connected. When someone asks for a taper, we discuss risks at intake, again during the doctor's assessment and then continue the conversation during detox. We also try to strengthen after-care supports in community or connect clients to residential treatment in a timely way.”

Other noteworthy comments related to the mix of criteria included:

“May self-refer. willingness to engage in OAT. If requesting Detox only, OAT is encouraged, and letter signed that OAT is being refused. Barrier-free admission is our goal”.

“Client must be physically and psychologically stable, able to contract for safety, able to perform activities of daily living and able to agree to program guidelines.”

“Must be referred by a physician/NP who has examined them and requested blood work for admission.”

“Client must be opioid-dependent and interested in starting OAT, and not be suitable/have not been successful in initiating OAT in the community.”

“Homeless, not on OAT or continuously relapse while on OAT, unsuccessful suboxone inductions, high risk of overdose or multiple overdoses, pregnant.”

For those participants providing WMS for opioid use disorder, Table 14 provides a summary of the means by which clients can access these services and illustrates many different routes into service including presenting directly for assistance (84.4%), various medical services (e.g., hospital-based case management team) (94.1%), the emergency department (92.4%) or medical clinic (89.7%) and community services (e.g., psychosocial treatment program) (94.1%).

Table 14. Processes for accessing WMS services.

Process for accessing	N	%¹³
By referral from a case manager team in a hospital	64	94.1
Through hospital emergency department	61	92.4
By referral from a medical clinic	61	89.7
By referral from a psychosocial treatment program	57	86.4
Patient can present directly for assistance to the withdrawal management service, phone or walk-in	59	84.4
By referral from a liaison team in a criminal justice setting	56	83.6
By referral after outpatient evaluation from a detox expert from your centre	53	82.8
Referral from a correctional facility	54	80.6

Fourteen programs also identified “other” means of access, some of which could be included in the tabled categories, for example, being referred by family and friends (n= 3) could also be taken as a direct self-presentation by phone or walk-in; and singular responses for community organization, centralized intake through a hospital (i.e. CAMH), detention centre, police referral, and referral from a psychiatry unit. Defense Canada, court order, and referral for veterans were mentioned once each.

When asked about their waiting period for WMS, 21 programs or 30% of 71 programs responding to this item reported in the affirmative. When queried on whether services were provided while on the waitlist, 14 responded yes, and then went on to describe the nature of the

¹³ Denominator for these percentages varies slightly due to non-response to some categories (i.e., missing values)

services provided. This included examples of access to support within their same organization (n=8) as well as access to support in other community organizations. (n=6). Examples included:

“Outpatient counseling & early recovery groups. Sometimes liaise with family physicians to provide treatment while waiting for appointment with our Opioid Replacement Treatment program. Wait time is less than 30 days.”

“Educational measures such as a motivational workshop are offered to clients through an organization with which we have a partnership; We also offer customers to follow community support groups like Narcotics Anonymous.”

“Not direct services, but our intake team offers ad hoc phone support and recommendations of services to access while waiting.”

“it typically takes a few days to get into Social Detox where we would initiate withdrawal protocols, but clients can access the Brief Detox as needed if they are under the influence of substances.”

“RAAM (outpatient), safe use sites, sobering centre, counselling and groups”.

Interestingly, among these few programs providing services while the client is on the waitlist, about 50% of them went on to report that less than 25% of clients accessed these services. Several survey participants (4 of the 14) were also unsure of the percentage and unable to answer.

Participants were asked the percentage of their clients with problematic opioid use who received WMS in the past 12 months (Table 15). Withdrawal from natural opioids was most frequently reported (averaging 45.3%) of clients followed by synthetic opioids (averaging 30%). Withdrawal from heroin and methadone followed (averaging 5.5% and 11.1%, respectively).

Table 15. Percentage of clients with problematic opioid use receiving WMS (past 12 months) for specific substances.

Opioid Substance	N of programs	Mean %	Median	Max	Min
Natural Opioids ¹⁴	46	45.3	40	100	0
Synthetic Opioids ¹⁵	48	30.0	15	100	0
Heroin	44	15.5	10	100	0

¹²¹² Includes naturally-derived and semi-synthetic opioids (also called opiates) such as codeine, morphine, oxycodone and hydromorphone)

¹⁵ Includes fentanyl, tramadol, and other opioids made in a laboratory

Methadone	39	11.1	5	60	0
Opium	36	4.3	0	70	0
Other	20	5.2	4.5	30	0

Participants were asked two questions about processes to formalize the commitment of clients requesting opioid withdrawal services. Firstly, when asked if these clients are required to sign a “contract” or agreement about program rules, 46 or 65.7% of participants responding to this question responded in the affirmative. When asked if clients were required to sign a statement describing the risks associated with opioid withdrawal, a much lower percentage reported “yes” (27.9%).

With respect to an agreement or contract regarding program rules, this was commonly framed as the routine package of rules for the facility/program and/or the usual consent to treatment (n=26). In some of these instances, the rules were quite specific to opioid use and the opioid service and support plan.

“Treatment agreement plan to read and sign and revised when needed, included appointment for counseling, working on personal action plan, random drug screen testing, coming to clinic appointments, agree to circle of care sharing information, explanation given regarding decrease of dose because of continued use or non-compliance, and informed that discharge from program can be explored if non-compliant and other issues.”

“Prescriptions are to be provided through the RAAM program only- an agreement to submit drug screens. - no use of illicit substances. Cannabis use is allowed when receiving OAT services, but not allowed on premises”.

“Compliance with urine testing, random room searches and breathalyzers -- behavior contract if staying for residential treatment.”

In a small number of instances (n=7), the respondents mentioned the programs’ usual welcome or orientation package but as above, this may include specific information on the treatment process that lies ahead.

“People must sign our welcome guide which explains the treatments they are going to have, that if they miss 3 days of treatment their dose will be cut in half, and full of other information about the OAT program. This guide is signed by the client during a 1- hour meeting that we have with him before being admitted.”

With respect to signing a statement that describes the risks associated with opioid withdrawal, the nature of the responses sometimes overlapped with that reported above. In seven instances, this included a specific review of risks, some using a special form outlining the risks for this purpose.

“almost never support a withdrawal without replacement therapy start, on the extremely rare occasion that is supported to occur a waiver regarding the risks of decreased tolerance and potential death is signed”

“related to continuing with service and remaining in contact with our team. Also if refusing OAT and preferring detox the acknowledgment of that risk”

“review of risks of relapse and overdoses. - Naloxone training is provided by the nurse to patients as well as family and friends.”

Four respondents noted a specific waiver of responsibility if OAT was not consented and five reported using a OAT-specific consent form which may also list the risks.

“client will sign a consent to treatment/waiver as requested when an agreement is reached between the doctor and client that a taper will be provided. Risks are listed on the form and first line treatments are listed as best options.”

A survey question then probed the staffing complement and number of hours dedicated per week for the opioid WMS service. As with staffing complement and scheduling for the WMS services in general, the various arrangements were diverse and challenging to categorize. For physician availability, patterns ranged from a certain number of hours per week (e.g., 20 or more reported by 9 programs down to 1-4 hours per week, also reported by 9 programs) to being on call or generally available for consultation (also reported by nine respondents). Several (n=16) also reported a mixed pattern such as one physician for 35 hours per week and six others available part-time or that availability varied by program site. For nurse practitioners, four programs reported full-time availability and an equal number reported some part time arrangement with several more reporting quite variable arrangements. Eight programs reported not having any staffing complement of nurse practitioners. For nurses (precise level unspecified), full-time availability was more common (n=31), and another 18 programs reported some part time availability. Six programs reported not having any nursing complement among staff. A range of psychosocial professionals were also tabulated, most commonly support/WMS workers (n=12) but sometimes mentioning educators (n=5) or even smaller numbers reporting addiction counsellors, recreation therapists, or occupational therapist, pharmacist, psychologist, or simply making reference to “psychosocial professionals”. Members of this wide range of professionals were reported as working full-time in some instances, perhaps including more than one FTE and often on a part-time or variable basis.

Table 16 shows the average duration of the opioid-specific WMS services, on average 10 days, with a minimum of 6.3 and maximum of 26.1 days, the latter no doubt reflecting longer duration community WMS services.

Participants were then asked to indicate the general approach or approaches used within their withdrawal services (Table 17). The questionnaire was designed in such a way that those providing withdrawal without any medication were skipped around the remaining options, hence the significant percentage of non-responses. Due to the variable number of non-responses to each item we calculated and report the percentage of affirmative responses based on the number of respondents to that sub-items as well as the total sample of 85 participating programs. The most frequently endorsed approach to withdrawal for opioids was transition to maintenance with opioid agonists (e.g., long-term treatment) - approximately 65.8% to 86.2% depending on the choice of denominator. Since participants were able to indicate more than one approach, the results clearly indicate a wide variety of approaches are being used within the individual programs for at least some clients. Notably a significant percentage of programs offer withdrawal without any medication for at least some clients (i.e., “cold turkey”) - 41.1% to 52.8%, again depending on the choice of denominator.

Table 16. Reported duration of opioid withdrawal services

Average duration of opioid-related WMS (mean days)	Total Programs reporting N=48
Reported minimum	6.3
Reported average	10
Reported maximum	26.1

Table 17. Types of treatment provided for opioid withdrawal

Type of treatment for opioid withdrawal	Based on item respondents		Based on all respondents (n=85)
	N	%	%
Maintenance with opioid agonists (e.g., long-term treatment) (n=65) ¹⁶	56	86.2	65.8
Only management of symptoms with medication (e.g., withdrawal management medication package/kit) (n=59)	45	76.3	52.9
Taper the opioid agonist without maintenance medication (e.g.,	45	70.3	52.9

¹⁶ Indicates the number of respondents to each sub-item.

methadone, buprenorphine-naloxone) (n=64)			
Decrease of alpha2-adrenergic agonists (e.g., Clonidine) (n=62)	39	62.9	45.8
Withdrawal without any medication (i.e., “cold turkey”) (n=67)	35	52.2	41.1
Other (n=17)	2	11.8	2.3

When asked about post-detoxification follow-up services, the large majority responded that they did provide follow-up (n=58 or 85.3% of respondents to the item or 68.2% of the total sample). Table 18 shows, among those offering follow-up services these were provided most commonly by a physician and long-term maintenance treatment. A range of other types of services and supports were also endorsed.

Table 18. Types of follow-up services offered

Types of follow up	Based on item respondents		Based on all respondents (n=85)
	N	%	%
Follow up by physician (n=53)	46	86.8	54.1
Long term maintenance treatment (n=53)	42	79.2	49.4
Group therapy at your center on various topics (n=51)	33	64.7	38.8
Reinsertion (i.e., social and life skills support and training) provided <i>outside</i> your detox centre (n=50)	32	64.0	37.6
Social reintegration into an addiction housing resource (n=50)	29	58.0	34.1
Reinsertion (i.e., social and life skills support and training) provided at your detox centre (n=48)	26	54.1	30.5

Ten respondents cited other services and supports being offered, some examples perhaps fitting into the above categories. Residential substance use treatment was mentioned by two respondents and the remainder noting follow-up outpatient services and supports, which may include specific interventions such as psychoeducation and medication teaching, outreach,

“acudetox” or daytox, mindfulness, meditation, case management and/or Smart recovery/Narcotics Anonymous.

When asked to comment on the duration of each of the various categories of services and supports in Table 18, several (n=11) noted the duration of their next phase of inpatient treatment services, ranging from 21 days to 12 weeks or higher. Therapy or group counselling was mentioned to be of widely varying duration and dependent on client needs and are program specific. Follow-up by a physician or nurse practitioner was also noted (n=8) and again of varying durations. Overall follow-up services were commonly framed as tailored to the needs of the client, as reflected in the following comments.

“Depends on the service and the client. Multiple recipes for success and multiple time needs”.

“Client will see physician and support worker frequently. - For withdrawal management, follow-up with physician can happen during primary or secondary detox (1-38 days), and possibly during Daytox if attending (after- detox) as needed while still connected to our program. Daytox program (groups) is approx. 6 weeks, but we are flexible if people want to continue service for a little while longer. If longer support is needed, referrals to appropriate ongoing supports are made”.

“Duration of services is dependent on the service provided, whether medical or psychosocial supports on an outpatient basis”.

“Long term - as long as needed. Physician - connected to long term treatment Groups - 18 months physician follow up as deemed appropriate by physician. Referrals completed to short- and long-term treatment facilities”.

“Duration varies because as soon as people finish therapy, the doctor follows up until the treatment is transferred to the client's family doctor for the remainder of the follow-up”.

“Long term: depends on the client, some are maintained by our NP long term. Follow up with NP if ODT has been continued in the community. Counsellor refers to housing services and helps advocate on client's behalf. There is a weekly group offered for all current and previous detox clients....Groups are daily and are facilitated by counsellor, nurses, dietician, pastoral care and self-help.”

3.4 Involvement in Opioid Agonist Treatment

Participants were asked whether their program admits clients for withdrawal management for non-opioid substances (any other substance than opioid) who are receiving opioid agonist treatment (OAT) through another program or service. The large majority of respondents (76.5%) responded “yes, all the time” and a further 11.1%, “sometimes”. A similarly large percentage endorsed that clients are **not** asked to discontinue OAT before being initiated into their

withdrawal management service for other substances. Further, the large majority also noted that clients with problematic opioid use who are receiving OAT are **not** expected to taper their use of OAT during withdrawal from other substances through their service.

The close relationship between WMS services for opioids and initiation of OAT is shown in Table 19.

Table 19. Provision of Opioid Agonist Treatment by their own program

Initiation on OAT	N	%
Yes, program provides clients initiation on OAT	51	65.4
No, but refer clients to another program or physician within our organization that provides OAT initiation	15	19.2
No, we refer clients to another program or physician outside of our organization that provides OAT initiation	8	10.3
No, we do not facilitate OAT initiation	3	3.9

Those participants who either provide initiative onto OAT themselves or within their own organization were asked to specify the nature of that in-house program. The most common response was OAT medication management (e.g., Methadone, Suboxone, Buprenorphine-Naloxone) (n=40) followed by referral to a Rapid Access to Addiction Medicine (RAAM) clinic (n=9), no doubt for OAT initiation in most instances. A variety of other services and supports were also mentioned including education, therapy, consultation, follow-up with referrals to other providers.

This same group of programs were asked the number of clients they had initiated onto OAT in the past 12 months. Of those willing and able to provide an estimate (N=39), a total of 3885 clients were summed, with a mean and median 100 and 30 respectively, and a maximum of 1200 and a minimum of 1.

Those providing OAT within their program or another part of the organization, as well as those referring out, were asked if they had a formal or informal association with an OAT prescriber or program. The majority (66.8%) reported a formal association with an OAT service within their own program or organization and another 9.5% with an OAT service provided through outside referral.

Table 20. Association with OAT program for provision of service

Initiation on OAT	N	%
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We have a formal association with an OAT service within our program or organization	49	66.8
We have an informal association with an OAT service	9	12.3
We have a formal association with an OAT service provided through outside referral	7	9.5
Not sure	9	12.3

Comments to explain answers confirmed a wide variety of formal arrangements with other services and supports within their own umbrella organization (n=33) (e.g., RAAM clinics, OAT program, affiliated physicians) and an almost equal number of responses reflected a formal arrangement with another organization or community partner (n=29) (e.g., Overdose Outreach Team). Several respondents note both internal and external arrangements.

For the small number of WMS services that reported not facilitating OAT initiation (Table 19), the reasons most commonly cited were that doing so was outside the scope of their organization or that they would do so if they had the means. Only one program cited lack of institutional support.

Among those respondents citing that OAT is outside their scope or that “they would if they had the means”, 13 indicated that there were specific barriers preventing their site from offering this service. For these 13 programs, the barriers are summarized in Table 21, the most common being lack of on-site physicians or nurse practitioners able to prescribe OAT (84.6%) and inability of medical staff to access support for prescribing OAT (38.5%). Smaller percentages were reported for a range of other barriers.

Table 21. Reported barriers to provision of OAT services.

OAT Barriers	N	%
Lack of on-site physicians or nurse practitioners able to prescribe OAT	11	84.6
Inability of medical staff to access support for prescribing OAT (e.g., referrals/consultations with experts)	5	38.5
Lack of safe storage capability	5	38.5
Insufficient access to medical resources (e.g., drugs, safe needles, overdose response kits)	4	30.8
Insufficient support from allied health professionals (e.g., therapists/counsellors and social workers)	3	23.1

Lack of knowledge or skills among medical staff to prescribe OAT	3	23.1
Inability of medical staff to easily access education and training opportunities	2	15.4
Lack of capacity in community for discharge	2	15.2
Client group that is unwilling or unprepared to initiate OAT	0	-
Other	2	15.2

Of the two respondents mentioning “other” reasons, one cited the lack of mandate and funding, and the other mentioned their referral processes to their harm reduction clinic.

4.0 Discussion

It is widely acknowledged that withdrawal management services (WMS) represent a critical component of the overall continuum of treatment and support for substance use disorders. Ideally, these services reflect three complementary elements: (1) safely managing any acute medical, psychological and/or behavioural complications arising from ceasing to use one or more psychoactive substances; (2) providing a period of rest and stabilization in a supportive environment; and (3) providing support in preparing for and accessing additional services as appropriate to the individual circumstance. In the case of opioid use disorder specifically, “detoxification”, may involve the gradual tapering of the substance in a safe and effective manner or substituting it with a cross-tolerant pharmacological agent, and then gradually tapering that agent.

While the research literature has much to offer on various models of WMS, including the importance of follow-up treatment and support as well as matching criteria for residential and non-residential options, there is limited information about the full nature and scope of WMS in the Canadian context. This gap became particularly salient as the opioid overdose crisis accelerated and questions arose about the scope of opioid-related practice in pan-Canadian WMS services, especially with respect to published guidelines to maximize safety. These guidelines, from CRISM (2018), recommend that “*offering withdrawal management alone (i.e., detoxification without immediate transition to long-term substance use/addiction treatment) should be avoided, since this approach has been associated with increased rates of relapse, morbidity, and mortality.*” (p. 21) Similarly, these guidelines state that “*withdrawal management alone is not an effective nor safe treatment for OUD and offering this as a standalone option to patients is neither sufficient nor appropriate.*”

Individual client, service provider and community context and infrastructure may challenge adherence to this guideline in all circumstances. Although WMS for opioid use disorders was included in the CRISM guidelines, a need was identified for a deeper assessment of evidence-based guidance and support for opioid withdrawal management approaches, and potential facilitators and barriers to implementation in the Canadian context. As a first step in improving evidence-based guidance on approaches for WMS for opioid use disorder, the present environmental scan was undertaken to provide more information on current practices across Canada. Importantly, the national scan and the summary of results herein was inclusive of programs that do offer WMS to people with opioid use disorders as well as a small minority which reported not providing these services for a variety of reasons, and which we explored. This national picture will be incorporated into a second phase of the work which will develop more detailed guidance for opioid withdrawal management services in Canadian substance use services, and related knowledge exchange activities.

Our national scan was successful in engaging key stakeholders across the country who plan and provide policy advice to provincial and territorial governments for substance use services. With their support, a national inventory of substance use services was compiled¹⁷; the inventory included organizations that either focused exclusively on WMS or which included WMS as a core service component. This in and of itself represents a significant achievement, as such a comprehensive pan-Canadian inventory had not been previously undertaken. It also presented some challenges for survey purposes. For example, identifying and managing often complex arrangements for satellite locations or multiple services within the same organization such as those provided to men versus women or adults versus youth. Identifying and securing participation of private treatment providers (profit and non-profit) was also a challenge and much more successful in Quebec than elsewhere. Upon sorting through these nuances with regional/provincial/territorial representatives, and in some cases in discussion with representatives of the organizations themselves, a total inventory of 147 WMS services was identified in Canada, of which 85 participated in the survey, about 60%. While other potential survey limitations are noted in a subsequent section below, it is important to reiterate this participation rate in order to emphasize that the results do not necessarily paint a full picture of WMS in Canada, and the nature and scope of practice specific to opioid use disorder, particularly from the private sector outside of Quebec. The results are, however, drawn from a significant percentage of the existing programs as well as a wide variety residential and non-residential programs from across the country.

WMS are a critical component of the Canadian Substance Use Treatment System

¹⁷ The inventory also served as the initial sampling frame for another national CRISM survey aimed at the broader range of psychosocial substance use treatment and support services.

At the time this national scan was initiated, every province and territory, with the exceptions of Nunavut and the NWT, had a specialized WMS available to a wide range of clientele and, in many instances, offering gender-specific and age-specific options. Challenges with respect to the return rate aside, the difference in accessibility for youth compared to adults is striking (54.2% compared to 96.1%, respectively). Similarly, while a precise ratio of services focused on men versus women cannot be determined, we note many programs offer WMS to both these genders, including both residential and non-residential services, while others offer male- or female-only beds in the same or separate facility. That being said, we would encourage a more detailed national assessment of accessibility of WMS services from a gendered lens including people identifying as transgendered or non-binary.

The total number of annual admissions accepted into the participating WMS programs (n=52860) is clearly significant, although reflecting this number as a percentage of the broader substance use treatment caseload was beyond the scope of the present project. Estimates of the percentage of these clients receiving WMS services for specific substances highlight the important role for opioids (e.g., heroin, codeine, morphine, fentanyl, opium) while also speaking to the frequent presentation of multiple-substance use. Aside from opioids, reported at 30.4% of caseload, stimulants figured prominently (e.g., cocaine, crack, methamphetamine - 32.7) and with alcohol clearly topping the list at 62.2%. Interestingly, the average percentage reported for cannabis is significant (21.3%), which probably speaks to this substance being one of several substances significantly involved with clients at the point of service initiation. This warrants further investigation given recent legalization of recreational cannabis use and limited information at present on its impact on seeking and receiving substance use treatment and support services. In addition, we point out that the percentages reported here are not necessarily reflective of the substance use profile of those clients presenting with opioids as the primary substance of concern for WMS. This was not queried specifically in the present study but will be important for future work given the increased risk of overdose/complications due to unacknowledged risk and concomitant use of alcohol, benzodiazepine and/or stimulants.

Our scan of relevant literature on WMS summarized at the outset of this report spoke to two important aspects to the evidence base for WMS, the first being strong evidence for both non-residential and residential models and the second being the critical need for linkage to subsequent treatment services so as to support longer-term recovery.

On the first point, we identified an important mix of both non-residential and residential models, often provided through the same organization and no doubt to maximise options and facilitate a stepped care approach when needed. Important factors such as population size and rurality probably affect the relative mix of these options within a given region. While our sample size precluded an assessment of regional differences, we would encourage system planners to fully explore the value of non-residential services given existing matching criteria and the evidence-base in terms of their extended reach and higher cost-effectiveness for appropriately matched

clients. Importantly, and as noted in the earlier review of the literature, flexibility is required in applying existing matching criteria and with a strong focus on individualized, client-centred decision-making, including a role for well-informed client choice. Importantly, the literature is rather sparse with respect to considerations for many minority and marginalized groups, or those with special needs, and for which a patient-centered, age- and sex/gender-appropriate, and culturally sensitive approach will be needed in utilizing residential or non-residential WMS options.

Further, with respect to models of WMS, it is important to note that Canada's residential and non-residential options are administered through both hospitals and community-based service providers. This, however, does not translate into a simple dichotomy of "medical" versus "non-medical" WMS, given the reported staffing complements among residential and non-residential options, often delivered through the same organization. Further, there is good evidence that strong collaboration between hospital and community-based services can contribute to positive client and system level outcomes, such as reduced ED visits (Quelch et al. (2018). Clearly, a range of community and hospital-based WMS options are required and supported by research, and this should be noted as a strength of the Canadian WMS services. In many respects, the key question for planners and policy makers is not whether to support certain evidence-based options over others, but rather to emphasize the appropriate **combination** of these options within a continuum of services and tailored to the specific communities they serve.

On the second point, we found close integration of a large percentage of the participating WMS services with other treatment providers, sometimes within the same organization and at other times through relationships with other service providers in the community. For example, many residential WMS services were reported as offering, what is essentially, a first phase of extended, in-house treatment and services. Others reported close connection with RAAM clinics and inpatient hospital beds. Options were also mentioned for accessing treatment beds in the community, including beds available in community residential treatment services or multi-functional beds in low barrier community settings. While laudable, this does not mean that connectivity to continuing treatment and support is in place for **all** WMS programs nor for **all** WMS clients. Rather, in the pan-Canadian context, there are clearly good examples of continuing treatment and support arrangements.

As reflected in the research literature, the effectiveness of any WMS will be influenced by the relative emphasis on pharmacological strategies (using medications to help manage withdrawal), psychosocial strategies (using cognitive, counselling and/or psychosocial supports), or a combination of pharmacological and psychosocial strategies. The fact that such a multi-modal approach should be tailored to the individual circumstances, including the substance(s) involved, speaks to the need for a multi-disciplinary team approach. A diverse staff mix will also be helpful in assessing the individual's match to alternative models of WMS in a stepped care

approach. Medical supports are critical to this process and a wide range of medical supports were reported within the participating WMS services. These medical supports were most frequently on site (60%) or offered through various formal arrangements within other parts of a larger organization (e.g., an affiliated emergency department), or through an arrangement with one or more external partners. A diverse range of professional resources were identified, the most frequently being physicians (78.6% of respondents) and a range of nursing professionals and wide variety of other health care workers (e.g., counsellors, social workers, pharmacist, case managers). Hours of operation and availability of staff of various training varied significantly. Similarly, a wide range of clinical and psychosocial interventions were reported as being offered including information about services available, medication management, a range of harm reduction services and resources, support for basic needs and counselling. While results were too varied to identify a “common staffing profile” or “a core service mix” for Canada’s WMS services, suffice it to say that medical supports are very common (but not universal) and often intermixed with many other types of professionals in order to deliver a range of services beyond immediate substance use detoxication and stabilization.

WMS services are significantly involved in delivering opioid-related services

Clearly the involvement of the WMS services with clients with opioid use disorders is significant, both in terms of individual caseloads (averaging about 30% of clients) and the estimated national caseload of 19,785 admissions. Keeping in mind the survey participation rate, it is still reasonable to conclude that this sector of the national substance use treatment continuum is a significant stakeholder in the current response to the national rise in opioid use and opioid-related overdoses. Tragically, respondents reported significant direct involvement in opioid overdoses among their clients, often on-site or *en route* to their program, or while participating in affiliated community support services. The nature and extent of their participation in the local community response to the opioid crisis also signals that WMS services are significantly engaged as important local and regional stakeholders, including support for prevention and harm reduction initiatives. That being said, the results of this national scan highlight the need for WMS programs to formulate clear overdose prevention protocols including provision of individual naloxone kits and encouraging safe disclosure of plans for on-site use, as well as ensuring adherence to an overall organizational harm reduction philosophy. The scope of involvement of fatal and non-fatal overdoses also speaks to the need for inclusion of WMS-based overdose incidents in provincial/territorial and national opioid surveillance systems.

When those programs reporting an impact of the opioid crisis on their work were probed on their use of clinical guidelines, most participants acknowledged the use of some guidelines but with considerable variability in the specific ones utilized (e.g., CRISM, BCCSU). This presents an opportunity to bring more consistency across WMS providers to this important aspect of their

work. Also, as the current project enters Phase 2 to expand upon the current CRISM guidelines for opioid WMS, a systematic approach to their implementation will be important in order to maximize reach and adherence among the workforce of WMS services across the country.

Going further to explore participants' direct involvement in provision of withdrawal management to people with opioid use disorder, it was noted that only about 15% of programs indicated that such prospective clients would NOT be admitted for WMS. The large majority indicated that they do offer WMS for such prospective clients when opioid use disorder is the *primary* presenting problem (about 55%) or as a *secondary* problem (about another third). Similarly, a large majority of participants reported accepting clients for withdrawal management for non-opioid substances but who may be receiving OAT through another program or service. A large majority also indicated that clients with problematic opioid use who are receiving OAT were not asked to taper their use of opioids during withdrawal from other substances. Further, a large majority also indicated that clients currently on OAT would not be asked to discontinue that treatment before being initiated into their withdrawal management service for other substances. Contrary to current guidelines, however, this still leaves an unacceptable minority declining access to services for individuals on OAT.

Together these results indicate that, with notable exceptions in this national sample of programs, there is a broad acceptance of clients with opioid use disorders into WMS services, and under many individual circumstances. This then begs the question as to what services are provided in these settings that are specific to opioid use disorder and what supports may be needed in that role.

Importantly, of the relatively few participants that indicated that people with opioid use disorder were not admitted for WMS, the reasons offered tended to fall into the two inter-connected themes of "insufficient capability" and "safety concerns". Both factors present opportunities for building capacity, including additional and sufficiently trained medical supports. Some of these participants also noted the accessibility of OAT in the community and hence their reluctance, consistent with best practice, to offer WMS as a stand-alone service. This relationship between WMS for opioid use disorder and OAT was a recurrent theme in several other aspects of the data as well (see below). In general, the data reflect an acceptance among many participants that WMS for opioid use as a stand-alone intervention is not consistent with best practice and therefore to be avoided, especially when their own resources were considered insufficient for appropriate medical supports and subsequent induction into OAT.

With respect to accessing WMS services for opioid dependence, results highlighted the many avenues into service, citing referral from either hospital-based or community programs, in addition to self-referral. Only about one-third of respondents reported a waiting period, and of those, most reported making available some services or supports while waiting. The most

frequently cited criteria for accepting someone into service for withdrawal from opioids was a medical clearance from a physician and expressed and voluntary interest on the part of the prospective client. A variety of risk mitigation strategies were also cited including education of the client regarding risks associated with tapering, especially if there was no follow up plan for induction to OAT. Clearly, client choice plays a role in these decisions and, while we can conclude that the majority of the participating WMS programs are following recommended practices to maximize client safety, there remains considerable variability in how this is managed. For example, while about two-thirds of participants required the individual to sign a contract/agreement about program rules, considerably fewer (less than one-third) required clients to sign a statement describing the risks associated with opioid withdrawal.

Overall, the data reflect considerable variability in approaches to WMS for opioid dependence. The most common substances reportedly involved in the provision of WMS were naturally derived or semi-synthetic opioids (e.g., morphine, oxycodone, hydromorphone) followed by synthetic opioids including fentanyl), although we note challenges often reported by physicians and other key stakeholders, as well as people who use drugs, in distinguishing natural from synthetic substances. Withdrawal from heroin and methadone were less commonly cited but still reported in the 10-15% range of clients in the service. The duration of the withdrawal management varied considerably, averaging 10 days, but with a reported minimum of about 6 days and up to 26 days. To a large extent, the staffing complement mirrored that of the WMS services broadly, and with highly variable availability and scheduling of physicians and nurses, including nurse practitioners. In a smaller number of instances, various psychosocial supports were also cited, and again with varying availability and scheduling. A variety of specific approaches were also reported, the most common being maintenance with opioid agonists (i.e., longer term treatment) but also other approaches such as tapering without maintenance medication, and use of medication to manage symptoms. Just over half of participants reported implementing withdrawal without any medication (i.e., “cold turkey”). While the data do not reflect how frequently each of these various approaches were utilized, it is clear that for at least some proportion of clients, each of these approaches were utilized by the participating programs. Follow-up services were reported by the majority of participants, again showing the close engagement with physicians and/or long-term maintenance treatment as well psychosocial supports.

As noted elsewhere, the data also reflect the close relationship between WMS and subsequent initiation into OAT, either through formal or informal arrangements within the same program or another part of the same organization, or an external referral for this purpose. Among those reporting the provision of OAT as being outside the scope of their program or organization, the most common barrier was a lack of on-site physicians or nurse practitioners for prescribing purposes. Other reported barriers included limited access to external support for prescribing, safe storage capacity, access to medical and/or psychosocial resources, or training. This speaks to the need for relevant authorities in all provinces and territories to carefully examine barriers to

accessing OAT and plan and implement strategies for addressing these barriers, including training needs. In addition, it is important to reiterate the under-representation of private versus public programs among our survey respondents and that these results may not be representative of the needs for training and other capacity development with respect to opioid WMS and treatment guidelines.

5.0 Summary and Implications

In large part, this environmental scan was stimulated by an interest in a more in depth exploration of the need and national context for more detailed guidelines for WMS services for people experiencing opioid dependence. In brief, the current national guidelines from CRISM (2018) recommend that:

“offering withdrawal management alone (i.e., detoxification without immediate transition to long-term substance use/addiction treatment) should be avoided, since this approach has been associated with increased rates of relapse, morbidity, and mortality”; and further that

“withdrawal management alone is not an effective nor safe treatment for opioid use disorder and offering this as a standalone option to patients is neither sufficient nor appropriate”.

By way of summary, it is helpful to identify key findings that may facilitate or challenge adherence to these guidelines.

Facilitating factors:

Overall, the data suggest a strong national capacity for WMS services in general, including a publicly-funded mix of residential and non-residential WMS options, and available matching criteria from the research literature so as to support client placement in a stepped care approach. These services exist in all provinces and territories, with the exception of NWT and Nunavut. Private facilities also offer WMS services as a part of their treatment program, although they are not well-represented in the survey results outside of Quebec. While the results do not allow for an accurate assessment of provincial/territorial capacity in relation to population size and level of need or important factors such as availability by sex/gender or other important factors related to service accessibility, there is clearly a strong foundation within which to strengthen evidence-based capacity for safe withdrawal from opioids. An important part of this existing foundation is the apparent multi-disciplinary staffing model, including in-house available medical supports. These services also represent a significant part of the regional/local treatment continuum with strong relations to other service providers, or other parts of the same organization, to facilitate client transitions after the withdrawal phase. They are also significantly involved currently with clients using opioids, and not infrequently have been touched directly by the tragedy of one or

more drug overdoses among the people they serve, the latter calling for vigilance and clear policies with respect to safety protocols and harm reduction. These and other factors have prompted significant engagement in community prevention and harm reduction initiatives as well as the community response to the overdose crisis.

With respect to their current involvement with WMS for opioid dependence specifically, the apparent client-centred approach is noteworthy, respecting client choice but also generally focused on safety and risk management protocols. There is also a basic familiarity with opioid-related treatment guidelines as well as a general openness to clients seeking help with other substances while remaining on OAT. They are also generally open to supporting clients to withdraw from opioids when longer-term treatment resources are in place and/or other medical and follow-up services are needed. The staffing complement of medical and psychosocial professionals supports this level of service delivery. Their apparent close relationship to the provision of longer-term opioid agonist treatment and other medical supports is particularly noteworthy as is their close relationship with other community partners for other medical and psychosocial needs, including a next stage of focused substance use treatment.

Challenges and opportunities for capacity building:

These many strengths in the national WMS system notwithstanding, it is important to note that while these strengths reflect general patterns observed in the study, they should be taken to obscure the considerable variability that is also evident in many features of the national system. Keep in mind too that we report on only about 60% of the WMS program nationally, although we have no reason to believe our sample is biased in any specific direction with the exception perhaps of the under-representation of private for-profit organizations outside of Quebec and who may be more open to practices that are not normative in the publicly funded system. Particularly noteworthy is the variability across the national WMS system on key features of high relevance to adherence to the current opioid treatment guidelines including:

- a significant minority of programs not accepting clients maintained on OAT but who are seeking WMS services for other substances;
- variability in familiarity and adherence to guidelines, including policies related to client education on risks of tapering without transition to OAT and/or a concrete follow up plan;
- variability in availability of medical supports (in some cases a clearly identified gap) and other reported barriers to transitioning clients from WMS to longer-term treatment;
- variability in client education about the risks of opioid withdrawal;
- variability in specific procedures for WMS for opioid dependence, including withdrawal without supporting medication, and corresponding need for more specific guidelines;
- variability in follow-up supports; and.

- variability in organization-level harm-reduction based protocols for prevention of overdose and inclusion of overdose-related quality indicators in system level surveillance processes.

In citing these summary points of strengths and opportunities for capacity development, it is important to also note that there are no doubt considerable provincial/territorial variations beyond the scope of this report to pursue, as well as significant variation within and across local health planning areas. We therefore encourage health system planning authorities to use the present report and key items from our national survey questionnaire to explore the strengths and challenges in their jurisdiction through more focused needs assessment. More focused regional or community-level needs assessment must also take into account the impact of the COVID-19 pandemic on the nature and extent of substance use in the population, including the apparent increase in opioid use and overdose (Canadian Institute for Health Information, 2021) and the required health system response through more telemedicine and other virtual care options. In many respects, the key question for planners and policy makers is how to embrace an appropriate **combination** of WMS options within a broader continuum of services and supports and tailored to the specific communities they serve.

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7.0 Appendices

Appendix A. Provincial - Territorial Addiction Policy Leads

No	Province/Territory	Contact/ Position	Contact Detail
1	Manitoba sent	Sean Leggett Addictions Policy and Support Branch Manitoba Health, Seniors and Active Living	4th Flr-300 Carlton St Winnipeg MB R3B 3M9 P: 204-784-3914 Email: Sean.Leggett@gov.mb.ca
2	Quebec (tentative)	Jean Marc Menard Directeur clinique RISQ / Recherche et intervention sur les substances psychoactives	731 rue Ste-Julie, bureau E3-304 Trois-Rivières QC G9A 1Y1 Tel: (819) 374-4744 ex 57115 Email: jean-marc_menard@ssss.gouv.qc.ca
3	Quebec (tentative)	Joël Tremblay Professeur agrégé, Département de psychoéducation Université du Québec à Trois- Rivières Directeur scientifique, RISQ (Recherche et intervention sur les substances psychoactives) Chercheur CRDM/IU, CICC, RQSHA Professeur associé École de psychologie/École de service social, U. Laval UQTR/Centre universitaire de Québec	850, avenue de Vimy, C.P. 32 Porte 8, bureau 5, Québec, QC, G1S 0B7 Tél. : (418) 659-2170 poste 2820 Télé : (418) 659-6674 Email: Joel.Tremblay@uqtr.ca
4	Nunavut sent	Opal McInnis Community Mental Health Specialist Mental Health and Addictions Department of Health Government of Nunavut	Tel: (867)975-5928 Email: OMcinnis@GOV.NU.CA
5	Alberta sent	Jesse Jahrig Senior Program Consultant Alberta Health Services Provincial Addiction & Mental Health	#212, 10909 Jasper Avenue Edmonton, Alberta T5J 3M9 P 780.415.0898 F 780.422.5237 Email: Jesse.Jahrig@ahs.ca
6	Prince Edward Island	Shauna Reddin (follow up- Amanda Hudson) Addictions Programming Manager Health PEI	PO Box 2000 Charlottetown, PE C1A 7N8 Tel: (902) 620-3550 Email: smreddin@gov.pe.ca
7	Yukon sent	Dallas Smith Project Manager, Mental Wellness Health System Improvement & Integration	Yukon Government Health & Social Services Tel: 867-667-8205 Dallas.Smith@gov.yk.ca
8	New Brunswick sent	Anne Pellerin Health Consultant	Office: 506-292-8581 Fax : 506-453-8711

		Addiction & Mental Health Health Services Department of Health	Email: Annie.Pellerin@gnb.ca
9	Newfoundland/Labrador sent	Monica Bull (follow up- Debbie Curtis) Mental Health and Addictions Consultant, Department of Health and Community Services, Government of Newfoundland and Labrador	My Office: 1-709-677-2797 Email : MonicaBull@gov.nl.ca
9	Nova Scotia sent	Lynn MacNeil Consultant Mental Health & Addictions Nova Scotia Health Authority NSH Site/Purdy Building, Rm 278	300 Pleasant Street, Dartmouth, NS B2Y 3Z9 Office: 908-424-3784 Personal: 902-233-3870 Email: CherylLynn.MacNeil@nshealth.ca
10	Saskatchewan	Kathy Willerth Director of Mental Health and Addictions Ministry of Health Community Care Branch	3475 Albert Street Regina, Canada S4S 6X6 p 306 787 5020 f 306 787 7095 Email: Kathy.Willerth@health.gov.sk.ca
11	Ontario sent	Andrea Demers Ontario Ministry of Health and Long-Term Care	Email: Andrea.Demers@ontario.ca
12	British Columbia sent	Sherry Mumford, PhD Systems and Projects Consultant 45282 South Sumas Road Chilliwack, BC V2R 1R7	Cell: 604 819 0966 Email: shermumford@shaw.ca
13	British Columbia sent	Keva Glynn (follow up- Carolyn Davis) A/Executive Director Mental Health & Substance Use BC Ministry of Health	1515 Blanshard St. Victoria BC V8W 3C8 Office: (250) 952-1003 Cell: (250) 812-7324 Email: Keva.Glynn@gov.bc.ca
14	Northwest Territories sent	Dr. Jennifer Harris, MD CCFP FCFP General Practitioner/ Associate Territorial Clinical Lead for Addictions Sara Chorostkowski Manger Mental health and Addictions	Yellowknife Primary Care Clinic Northwest Territories Health and Social Service Authority Government of the Northwest Territories P.O. Box 1320, X1A 2L9 Phone: 867 920-7777 Fax: 867 920-7711 Email: Jennifer_Harris@gov.nt.ca Government of Northwest Territories Email: sara_chorostkowski@gov.nt.ca

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Appendix B. Brief Project Description sent to Provincial and Territorial Representatives

CRISM Projects Requiring National Surveys/Interviews of Substance Use Treatment Providers

Background:

CIHR, through its Canadian Research Initiative in Substance Misuse (CRISM) program, has launched a coordinated Emerging Health Threat Implementation Science research program to promote the scale-up and uptake of evidence-based, secondary prevention and treatment approaches that reach the breadth and diversity of populations affected by opioid use disorder. Two of the CRISM projects falling under this umbrella involve:

- the collection of survey and/or interview based information from current providers of substance use treatment in Canada;
- synthesis of the resulting information to identify current practices and model programs with respect to treatment and support for people with opioid use disorder; and
- a knowledge translation (KT) process to improve current practice across the country in a manner consistent with research evidence.

Leaders of these two projects, briefly summarized below, have agreed to coordinate their efforts with respect to the national survey component and perhaps other aspects of the work. There is high value in proceeding with this coordinated approach in order to best liaise with provincial and territorial stakeholders, achieve some efficiencies in the data collection, and optimize the impact of subsequent KT processes.

Project 1. Treatment of Opioids in Psychosocial Programs (TOPP)

Background: This project addresses the issue that there are “two worlds” of treatment services for opioid use disorder: specialized addiction treatment and recovery services that provide a variety of psychosocial interventions across a range of settings (outpatient, day programs, residential programs) and opioid antagonist treatments (OAT) that provide methadone and/or buprenorphine in medical services. Individuals in some communities can access either or both of these options, whereas many other communities have limited access to OAT. Until recently, these two worlds operated largely independently, but the opioid crisis has both increased recognition of the gap between these models and facilitated a shift toward integration in some areas of the country. However, at present we do not have a fulsome, comprehensive understanding of the current status of the treatment of opioid use disorder within the “mainstream” psychosocial treatment system. This is one key objective of the TOPPS project; the other objectives being focused on identification of model programs, development of KT materials and an implementation plan for program and system improvement.

Workplan/Activities: The data collection phase of this project aims to: “*survey the range of current approaches to the treatment of individuals with opioid use disorder within psychosocial addiction treatment programs across Canada*”. Briefly, the approach outlined in the current project workplan is to:

- Conduct an online, national survey of programs to assess current treatment and support practices for patients with opioid use disorder, admission policies, attitudes, philosophical beliefs about treatment goals and the role of recovery, barriers, perceived program needs, and types of outcomes collected (if any). This would include psychosocial and recovery services offered to people with opioid use disorder as well as the delivery of, or collaborative arrangements for, OAT. Withdrawal management programs will be excluded.

A subsequent phase of the TOPPS project aims to identify, through the survey and from stakeholder input, examples of model programs with safe and effective psychosocial approaches and supports for the treatment of opioid use disorder and the development of “good practice” descriptions through key informant interviews and in-depth case study. These models will include OAT integrated, collaborative, and supportive programs as well as programs providing only psychosocial treatment.

Together the survey results and model programs are to provide the basis for developing an intervention plan for improving the treatment of individuals with dependence, based upon services gaps, attitudes, barriers, and the perceived needs of programs. The implementation of this plan is being conceptualized with an implementation science framework.

Within TOPP there is an associated CRISM sub-project that also involves a national survey of substance use treatment providers. The focus is on knowledge/attitudes/utilization of contingency management-based interventions for substance use services, which is a well-established evidence-based practice but significantly under-utilized in the Canadian context. Embedded in this sub-project is a proposed Master’s Thesis project focused more generally on knowledge, attitudes, and behaviours with respect to evidence-based practices in the substance use treatment field. The target population for this third CRISM project is at the clinician-level; that is, sampling *within* organizations. The focus of the broader TOPPS project is at the organization-level only, which is an important difference. There are some time constraints for the completion of the Master’s thesis project – to be 100% completed and defended by end of August 2019. An approach has been agreed upon such that the student thesis work will be undertaken in the three Prairie provinces (Manitoba, Saskatchewan, Alberta) and thereby implemented more rapidly and in the time frame for completion of the Master’s Thesis. Field work would begin in February-March of 2019 whereas the overall national survey would be implemented closer to April-May, also 2019.

Project 2: Opioid Withdrawal Management (WMS/Detox)

Background: Treatment interventions for opioid use disorder consist mainly of long-term (e.g., opioid pharmacotherapy/ treatment) as ‘first-line response’ options. There are, however, other therapeutic interventions which, for various reasons (e.g., limited OAT infrastructure, resources or expertise), are offered or practiced in Canada, including what are often referred to as ‘detoxification/withdrawal management’ approaches. Some of these, as currently practiced, rest on a limited evidence-basis and include considerable risk for harms to the patient (e.g., overdose due to lowered tolerance). For other practices, such as opioid tapering or provision of naltrexone, evidence is only slowly emerging. Overall, evidence-based guidance on these approaches is currently limited, which this project aims to address and improve.

Workplan/Activities: The data collection phase of this project has been framed as a: “comprehensive environmental scan of current institutional practices and information/evidence-needs related to detoxification and withdrawal management services for opioid use disorders across Canada”. Briefly, the planned approach is to:

- develop a full list of institutions/facilities involved in the practice/delivery of opioid and other detoxification/withdrawal management.
- Based on an on-line survey and, potentially, as amml number of follow-up semi-structured interviews, information will be gathered on current detoxification/withdrawal management practices with respect to opioid dependence, and related evidence/information and resource needs.

The main deliverable of this phase of the project is an ‘environmental scan’ report, summarizing current practices and information/evidence needs for opioid disorder-related detoxification and withdrawal management in substance use services across Canada.

The second component of the WMS/Detox project is the “*Development of Opioid Detoxification/Withdrawal Management review and ‘Best Practice’ document*”. This second component aims to develop a scoping/narrative review of the current evidence on opioid disorder-related detoxification and withdrawal management (including opioid tapering, naltrexone provision) practices, safety issues, and outcomes. The review includes therapeutic approaches to opioid use disorders that, either by patient and or system/environmental circumstance, are not geared towards long-term opioid pharmacotherapy treatment. This will involve:

- a review of available scientific literature/evidence;
- assembly of a core group of expert stakeholders, (e.g. 8-10 addiction service providers/clinicians in the subject area);
- development of a condensed evidence-based summary of ‘best practice’ recommendations formulated by the Leadership Group and reviewed, revised and finalized with input from the expert stakeholder group (including expert meeting with pre-meeting review work); and
- production of a final, evidence-based best practice document on opioid disorder-related detoxification and withdrawal management for subsequent dissemination through different KT strategies.

Deliverables of this second project component will include: 1) scientific review of opioid disorder-related detoxification and withdrawal management approaches; 2) a ‘best practice’ summary and recommendations - development and product document (as described); and 3) comprehensive pan-Canadian KT and distribution efforts for deliverable #2.

Convergences/divergences of the two projects:

Sampling: Both projects require the identification and full enumeration of existing substance use treatment programs across Canada; essentially the sampling frame. For TOPPS the sampling frame is broader than for the WMS/Detox project although the process of identification will be the same, relying heavily on available data, such as through the CCSA treatment Indicators database, as well as provincial/territorial key informants (e.g., Ministerial program/policy leads).

Both projects aim to include both private and public providers and both will require guidelines for exclusion of what are essentially outpatient models of service delivery on a fee-for-service basis (e.g., services offered by psychologists, physicians/psychiatrists, psychotherapists).

Neither project will include specialized outpatient addiction medicine programs providing OAT. Further, neither project will include designated FN/Indigenous programs, as this is the focus of other planned work by CRISM. That being said, Indigenous clients may be served by the participating programs. Both projects also aim to exclude collaborative care models whereby a substance use specialist is co-located in a primary health care service, mental health program, school, or correctional service, for example.

Data collection: Both projects will include an on-line survey component, available in both official languages.

Appendix C. First Survey Communications



Initial invitation

Subject: Invitation to Participate in CRISM Survey of Opioid and Other Withdrawal Management Services in Canada

Date:

Dear [*Manager first name*] [*Manager last name*],

Thank you for expressing your interest in participating in the Survey of Withdrawal Management Services in Canada being implemented by the Canadian Research Initiative in Substance Misuse (CRISM) through the Centre for Addiction and Mental Health (CAMH), in Toronto, Ontario.

Your input will be very helpful in understanding withdrawal management services for substance use and addiction, including opioid use disorder, and the development of better service guidelines.

As discussed previously with you or a Senior Manager, we anticipate this survey will represent value added to the [*name of province/territory*], although we acknowledge that some details may overlap with surveys you may have recently completed.

Prior to completing the questionnaire through the link below please read, sign and return the attached consent form to me at phebe_zaytoun@camh.ca

To then complete the survey, please click on the link below. The length of time for completion will depend on the scope of withdrawal management services you provide, and may take between 15-30 minutes.

We would appreciate your survey completed by two weeks from the above date. You may stop and return to the survey questionnaire at any time, since your results are saved as you go forward.

Please note that your input will be treated as confidential and no qualitative or quantitative information in our reports will be attributed to you personally.

If you have any questions, or if you experience any technical difficulties, please contact phebe.zaytoun@camh.ca or brian.rush@camh.ca

You can withdraw your participation and request that any or all data collected on your behalf be removed from the study at any time prior to August 15, 2019.

Thank you very much for your support for this important work.

[Survey link](#)

We thank you for your consideration.



First reminder

Subject: Reminder: Invitation to Participate in CRISM Survey of Opioid and Other Withdrawal Management Services in Canada

Date:

Dear [*Manager first name*] [*Manager last name*],

Thank you for expressing your interest in participating in the Survey of Withdrawal Management Services in Canada being implemented by the Canadian Research Initiative in Substance Misuse (CRISM) through the Centre for Addiction and Mental Health (CAMH), in Toronto, Ontario. We are sending this as a gentle reminder as we have not yet received your questionnaire.

Your input will be very helpful in understanding withdrawal management services for substance use and addiction, including opioid use disorder, and the development of better service guidelines.

As discussed previously with you or a Senior Manager, we anticipate this survey will represent value added to the [*name of province/territory*], although we acknowledge that some details may overlap with surveys you may have recently completed.

To complete the survey, please click on the link below. The length of time for completion will depend on the scope of withdrawal management services you provide, and may take between 15-30 minutes.

We would appreciate your survey completed by two weeks from the above date. You may stop and return to the survey questionnaire at any time, since your results are saved as you go forward.

Please note that your input will be treated as confidential and no qualitative or quantitative information in our reports will be attributed to you personally.

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You can withdraw your participation and request that any or all data collected on your behalf be removed from the study at any time prior to August 15, 2019.

Thank you very much for your support for this important work.

[Survey link](#)

1. If you are using a shared computer, **ensure that all cookies have been deleted before starting**. A guide can be found [here](#).

We thank you for your consideration.

The Centre for Addiction and Mental Health/University of Toronto Research Ethics Board has approved this research study. To view a copy of the informed consent form, please [click here](#).



Second reminder

Subject: Reminder: Invitation to Participate in CRISM Survey of Opioid and Other Withdrawal Management Services in Canada

Date:

Dear [Manager first name] [Manager last name],

Thank you for expressing your interest in participating in the Survey of Withdrawal Management Services in Canada being implemented by the Canadian Research Initiative in Substance Misuse

(CRISM) through the Centre for Addiction and Mental Health (CAMH), in Toronto, Ontario. We are sending this as another gentle reminder as we have not yet received your questionnaire.

Your input will be very helpful in understanding withdrawal management services for substance use and addiction, including opioid use disorder, and the development of better service guidelines.

As discussed previously with you or a Senior Manager, we anticipate this survey will represent value added to the [*name of province/territory*], although we acknowledge that some details may overlap with surveys you may have recently completed.

To complete the survey, please click on the link below. The length of time for completion will depend on the scope of withdrawal management services you provide, and may take between 15-30 minutes.

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If you have any questions, or if you experience any technical difficulties, please contact phebe.zaytoun@camh.ca or brian.rush@camh.ca

You can withdraw your participation and request that any or all data collected on your behalf be removed from the study at any time prior to August 15, 2019.

Thank you very much for your support for this important work.

[Survey link](#)

2. If you are using a shared computer, **ensure that all cookies have been deleted before starting**. A guide can be found [here](#).

We thank you for your consideration.

Brian Rush, Project Director
Phebe Zaytoun, Research Staff
Fariyah Ali, Node Manager, Ontario CRISM Node Team, Canadian Research Initiative in Substance Misuse
Centre for Addiction and Mental Health

The Centre for Addiction and Mental Health/University of Toronto Research Ethics Board has approved this research study. To view a copy of the informed consent form, please [click here](#).

Appendix D. Survey Questionnaire (English Version)

Program & respondent information

1. What is the name(s) of the program you are responding on behalf of?

Click or tap here to enter text.

2. What is your position or role within the program you are responding on behalf of?

Click or tap here to enter text.

3. Which catchment area(s) does your program serve? (Catchment area refers to the city/county/region you draw your clients from and are legally responsible to service. If this does not apply to your program, e.g. your clients are typically referred from a national registry, please indicate the geographic area you serve.)

The focus of this survey is on withdrawal management services (WMS) in Canada. If your program does not provide WMS the next question will help you exit the survey.

4. Does your program provide withdrawal management (“withdrawal management (WM)” refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence (WHO, 2009)) services to clients with problematic substance use? “Problematic use” is broadly defined as use of a psychoactive substance that interferes with an individual’s psychosocial wellbeing or health. For this survey, withdrawal management can be for any psychoactive substances for which this service may be needed.

R1. On a residential basis only (**Skip to Q6**)

R2. On a non-residential basis (e.g., home or mobile team)

R3. Both residential and non-residential

R4. No, we do not provide withdrawal management services (**Exit to thank you page**)

5. Please describe the nature of your non-residential withdrawal management services? (check all that apply)

- R1. Daytox- (clients come for a significant part of the day and return home)
- R2. Mobile team (to client's home or other location)
- R3. Internet-based support (to client's home or other location)
- R4. Other [Click or tap here to enter text.](#)

6. Please indicate the number of beds designated for withdrawal management.

- R1. Beds exclusively for males _____
- R2. Beds exclusively for females _____
- R3. Beds not designated by gender _____
- R4. Not sure

7. Are these beds officially designated as hospital beds?

- R1. Yes, all of them
- R2. Yes, some of them (please explain)
- R3. No, none are hospital beds
- R4. Not sure

8. In addition to these designated withdrawal management beds, are other beds available on an as-needed basis?

- R1. Yes (Please comment on how many and the nature of the arrangement)
- R2. No, other beds are not available

9. Please estimate the average number of the designated withdrawal management beds in use by clients at any given time (i.e., average occupancy rate)?

[Click or tap here to enter text.](#)

- R1. Not sure

10. What was the average length of stay (in days) for your withdrawal management service in the last 12 months?

Click or tap here to enter text.

R1. Not sure

11. Is your withdrawal management program affiliated with a residential addiction treatment program?

R1. Yes (Please comment on the nature of the affiliation)

R2. No, we are independent of any such residential program

12. Which of the following best describes your capacity to provide medical supports to a person admitted to your withdrawal management services? (check one only)

R1. Medical supports are provided on-site (or in the team if home, mobile or Internet-based)

R2. Provision is made for medical supports through formal arrangement with another part of your organization

R3. Provision is made for medical support through a formal arrangement with a hospital emergency department

R4. Provision is made for medical supports through formal arrangement with another organization or health care provider]

R5. Provision is made for medical supports through informal arrangement with another organization or health care provider

R6. No provision is made for medical support (**Skip to Q15**)

R7. Not sure (**Skip to Q15**)

13. Please indicate the nature of the medical supports available to clients in the withdrawal management service (check all that apply)

R1. Physician (please note speciality)

R2. Nurse practitioner

R3. Other nursing professional

R4. Other health care professional (specify)_____

R5. Not sure

14. Please describe the availability of these medical supports for clients through your withdrawal management service (e.g. 24/7, daily but not evenings, Mon-Friday only)

Click or tap here to enter text.

15. Please indicate which of the following forms of additional treatment or other support are offered to clients through your withdrawal management service. (Check all that apply.)

- R1. Information about treatment or services available for mental health issues
- R2. Information about treatment or services available for addictions
- R3. Medication to help with mental health issues
- R4. Medication to help with addictions
- R5. Hospitalization overnight or longer
- R6. Residential (non-medical) treatment overnight or longer
- R7. Counselling or support on a non-residential basis, including any kind of help to talk through problems
- R8. Responding to basic needs such as housing, finances, or food security
- R9. Help to improve clients' ability to work
- R10. Education supports (e.g., to undertake self-care, to use their time, or to meet people)
- R11. Help to reduce the risk of harm related to using drugs, such as needle exchanges, testing for diseases that can be passed on through drug use, etc.
- R12. Other (please describe)

Service Utilization

(Note: For the following question:

“Admissions” refer to admissions to the withdrawal management service with an associated discharge event or case closure in the past 12 months. Total admissions may count the same person more than once in the reporting period.

16. In the past 12 months, how many admissions were accepted into your withdrawal management service? (i.e., possibly counting the same individual more than once)

Click or tap here to enter text.

R1. This is an exact number

R2. This is an estimate

R3. Not sure

17. In the past 12 months, approximately what percentage of admissions to your program were provided withdrawal management services for the following substances? Note that these percentages are not required to sum to 100%)

Alcohol _____ %

Inhalants (e.g., glue, solvents) _____ %

Non-alcoholic depressants (e.g., barbiturates, benzodiazepines) _____ %

Opioids (e.g., heroin, codeine, morphine, fentanyl, opium) _____ %

Hallucinogens (e.g, LSD) _____ %

Cannabis(e.g., marijuana, hash) _____ %

Stimulants (e.g., cocaine, crack, methamphetamine, ecstasy) _____ %

Tobacco/nicotine _____ %

Other (please specify): Click or tap here to enter text. _____ %

R1. These are exact percentages

R2. These are estimates

R3. Not sure

The next few questions explore your involvement with clients with challenges related to problematic opioid use

There has been a dramatic increase in opioid–related overdoses in many part of Canada in recent years.

18. Has this “opioid crisis” impacted your program’s involvement in prevention or treatment-related work with opioids. (check all that apply)

R1. Yes, within our broader community (please specify)

R2. Yes, within our program

R3. No

R4. Not sure

If yes above, to within your own program (R2) (check all that apply)

R5. All staff have read the [CRISM National Guideline for the Clinical Management of Opioid Use Disorder](#)

R6. We follow the CRISM guidelines

R7. We follow other guidelines (please specify)

R8. We have developed our own guidelines (please specify)

R9. Other (please specify)

19. Have any drug overdoses occurred on-site or among your caseload in the past 12 months?

R1. Yes *(please specify the number of drug overdoses that have occurred and any other details to help explain your answer, e.g., if this happened through an outpatient or residential service):* Click or tap here to enter text.

R2. No

R3. Not sure

20. Does your program provide withdrawal management services to clients with problematic opioid use as either a primary presenting problem or a secondary/co-occurring problem?

(For the purposes of this questionnaire, opioids include the illicit drugs heroin and fentanyl, as well as prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, street methadone, street buprenorphine/naloxone as well as prescribed methadone and buprenorphine/naloxone and any synthetic derivatives thereof. “Problematic opioid use” is broadly defined as use of opioids that interferes with an individual’s psychosocial wellbeing or health.)

R1. As a primary presenting problem

R2. As a secondary or co-occurring problem only (i.e., not as a primary presenting problem)

R3. Neither (not admitted to this program for withdrawal management) (Skip to Q34)

21. What are the admission criteria for accepting clients for opioid withdrawal?

Click or tap here to enter text.

**22. How are clients able to access your opioid withdrawal management services?
(check all that apply).**

	Yes	No
Patient can present directly for assistance to the withdrawal management service, phone or walk-in	☐	☐
By referral from a psychosocial treatment program	☐	☐
By referral from a case manager team in a hospital	☐	☐
By referral from a liaison team in a criminal justice setting	☐	☐
By referral after outpatient evaluation from a detox expert from your center	☐	☐
By referral from a medical clinic	☐	☐
Through hospital emergency department	☐	☐
Referral from a correctional facility	☐	☐
Other (please specify)	☐	☐

23. Do you currently have a waiting list for accessing your opioid withdrawal management services?

R1. Yes

R2. No (**If No, skip to Q26**)

24. Do you offer other services during the waiting time?

R1. Yes (Please describe) Click or tap here to enter text.

R2. No

R3. Not sure

25. What proportion of these clients would you estimate access these services while waiting for your opioid withdrawal service?

R1. Less than 10%

- R2. 10-25%
- R3. 26-50%
- R4. 51-75%
- R5. 76-99%
- R6. 100%
- R7. Unsure

26. Please indicate the percentage of your clients with problematic opioid use who received withdrawal management services for the following opioids in the past 12 month. (Note that these percentages are not required to sum to 100%)

Natural opioids (Includes naturally-derived and semi-synthetic opioids (also called opiates) such as codeine, morphine, oxycodone and hydromorphone)	_____ %
Synthetic opioids (Includes fentanyl, tramadol, and other opioids made in a laboratory)	_____ %
Heroin	_____ %
Methadone	_____ %
Opium	_____ %
Other and unspecified opioids	_____ %

- R1. These are exact percentages
- R2. These are estimates
- R3. Not sure

27. Are the clients requesting your opioid withdrawal service required to:

(a) Sign a « contract » or agreement about program rules?

- R1 Yes (please specify)
- R2. No

(b) Sign a statement that describes the risks associated with opioid withdrawal?

- R1. Yes (please specify)
- R2. No

28. (a) What is the number of professionals and the number of hours dedicated each week for the withdrawal management service?

	Physician	Nurse	Nurse Practitioner	Psychosocial professional	Other
Number of professionals					
Number of hours per week					

(b) What is the minimum, average and maximum duration for your opioid withdrawal management service?

Minimum duration (days): [Click here to enter text](#)

Average duration (days): [Click here to enter text](#)[Click here to enter text](#)

Maximum duration (days): [Click here to enter text](#)[Click here to enter text](#)

(c) How many clients in total, expressed in number of beds, are you able to accept at one time for the opioid withdrawal service? [Click here to enter text](#)[Click here to enter text](#)

(d) Which type of treatment is available for opioid withdrawal?

Type of treatment	yes	No
Withdrawal without any medication (i.e., « cold turkey ») (If yes to this option, skip to Q29)	☐	☐
Only management of symptoms with medication (e.g., withdrawal management medication package/kit)	☐	☐
Taper the opioid agonist without maintenance medication (e.g., methadone, buprenorphine-naloxone)	☐	☐
Decrease of alpha2-adrenergic agonists (e.g., Clonidine)	☐	☐
Maintenance with opioid agonists (e.g., long-term treatment)	☐	☐
Other: (specify) : Click here to enter text Click here to enter text	☐	☐

(e) What are the medications used for opioid withdrawal? Check all that apply?

Type de Medication	Yes	No
Burpenorphine//Naloxone	☐	☐
Methadone	☐	☐
Other opioid agonists(specify)	☐	☐
Dicyclomine (e.g., Bentylol)	☐	☐

Benzodiazepines (e.g., Valium, Ativan, etc.)	☐	☐
Loperamide (e.g., Immodium)	☐	☐
Anti-inflammatory (ex. : Ibuprofene, Naproxen, etc.)	☐	☐
Acetaminophen	☐	☐
Dimenhydrinate (e.g., Gravol, etc.)	☐	☐
Proton Pump Inhibitors and others (e.g., Dexilant, Zantac, etc.)	☐	☐
Muscle relaxants (e.g., Antiphlogestine, etc.)	☐	☐
Cyclobenzaprine (e.g., Flexiril, etc.)	☐	☐
Prebagaline (e.g., Lyrica, etc.)	☐	☐
Other medications : Click here to enter text	☐	☐

29. After the period of detoxification, is a follow-up service offered?

R1. Yes

R2. No (If No, skip to Q31)

30. What types of services are offered?

Type de Service	Yes	Duration	No
Long term maintenance treatment	☐		☐
Follow-up with physician	☐		☐
Reinsertion (i.e., social and life skills support and training) provided <i>outside</i> your detox center	☐		☐
Reinsertion (i.e., social and life skills support and training) provided at your detox center	☐		☐
Social reintegration into an addiction housing resource	☐		☐
Post-detoxication group	☐		☐
Group therapy at your center on various topics	☐		☐
Other (specify): Click to enter textClick to enter text	☐		☐

31. Does your program admit clients for withdrawal management for non-opioid substances (any other substance than opioid) who are receiving opioid agonist treatment (OAT) through another program or service?

R1. Yes.

R2. Sometimes

R3. No (If “No” or “Not sure”, skip to 34)

R4. Not sure (If “No” or “Not sure”, skip to 34)

32. Are clients asked to discontinue OAT before being initiated into your withdrawal management service for other substances?

R1. Yes (if so, please specify the reasons for this): Click or tap here to enter text.

R2. No

R3. Not sure

33. Do you expect clients with problematic opioid use who are receiving OAT to taper their use of OAT during withdrawal from other substances through your service?

R1. Yes, this is expected

R2. This is encouraged, but not expected

R3. No, this is not expected

34. (a) (If Q20 = R3) If withdrawal services are not offered please comment on individual or structural factors, behind this decision,

Click or tap here to enter text.

(b) What types of provisions are made for people requesting withdrawal from opioids, if any?

Click or tap here to enter text.

The next few questions ask about other opioid-related services you may offer.

35. Does your program provide clients initiation on Opioid Replacement Therapy (OAT)?

R1. Yes, our program provides clients initiation on OAT (If R1 or R2, continue to Q36)

R2. No, but we refer clients to another program or physician within our organization that provides OAT initiation (If R1 or R2, continue to Q36)

R3. No, we refer clients to another program or physician outside of our organization that provides OAT initiation (If R3, skip to Q38)

R4. No, we do not facilitate OAT initiation (If R4 or R5, skip to Q40)

R5. Not sure (If R4 or R5, skip to Q40)

36. What is the nature of the Opioid Replacement Therapy (OAT) your service or your organization provides?

Click or tap here to enter text.

37. How many of your clients in the past 12 months were initiated on OAT through your program and/or through linkage to another program in the same organization?

Click or tap here to enter text.

R1. This is an exact number

R2. This is an estimate

38. How many of your clients in the past 12 months has your program referred to other sites for OAT initiation? Click or tap here to enter text.

R1. This is an exact number

R2. This is an estimate

39. Does your program have a formal or informal association with an OAT prescriber or program? (After the response to this question skip from here to Q43).

R1. We have a formal association with an OAT service within our program or organization (please provide details to help explain your answer): Click or tap here to enter text.

R2. We have a formal association with an OAT service provided through outside referral (please provide details to help explain your answer): Click or tap here to enter text.

R3. We have an informal association with an OAT service (please provide details to help explain your answer): Click or tap here to enter text.

R4. Not sure

40. What is your organization's policy on providing OAT to clients at your site?
(Check all that apply.)

R1. We do not provide OAT because we do not believe it is an effective method of treating addiction

R2. We do not provide OAT because we have concerns about its long-term safety, adverse effects, or the risks it poses to clients

R3. We do not provide OAT due to lack of institutional support

R4. Providing OAT to clients is outside the scope of our program/service's treatment goals

R5. We do not provide OAT but would do so if we had the means to

R6. Other (please specify): Click or tap here to enter text.

R7. Not sure

41. (If Q40=R4 or R5) Are there specific barriers preventing your site from offering this service?

R1. Yes

R2. No (If "no" or "not sure" skip to Q43)

R3. Not sure (If "no" or "not sure" skip to Q43)

42. Which of the following barriers apply to your site? (Check all that apply.)

R1. Lack of on-site physicians or nurse practitioners able to prescribe OAT

R2. Inability of medical staff to access support for prescribing OAT (e.g. referrals/consultations with experts)

R3. Insufficient support from allied health professionals (e.g. therapists/counsellors and social workers)

R4. Lack of knowledge or skills among medical staff to prescribe OAT

R5. Inability of medical staff to easily access education and training opportunities

R6. Client group that is unwilling or unprepared to initiate OAT

R7. Lack of safe storage capability

- R8. Insufficient access to medical resources (e.g. drugs, safe needles, overdose response kits)
- R9. Lack of capacity in community for discharge
- R10. Other (*please specify*): Click or tap here to enter text.
- R11. Not sure

Take-home naloxone and harm reduction services

43. Are overdose response kits available to clients on- site? (*Note that overdose response kits can also be referred to as take-home naloxone kits.*) just one and one for if provision is made

R1. Yes (*please provide details to help explain your answer*): Click or tap here to enter text.

R2. No (If “no” or “not sure”, skip to Q46) (*please provide details to help explain your answer*): Click or tap here to enter text.

R3. Not sure (**If “no” or “not sure”, skip to Q46**)

44. Are overdose response kits made available to your clients using opioids?

R1. Yes, to all clients reporting use of opioids

R2. Yes, to the majority of clients using opioids

R3. Yes, to some clients using opioids

R4. No, we don’t make these kits available to clients using opioids

R5. Not sure

R6. Not applicable (e.g., no clients using opioids)

45. If a client has been tapered off opioids through your service, are provisions made for an over-dose kit for the client?

R1. Yes (*please provide details to help explain your answer*): Click or tap here to enter text.

R2. No

R3. Not sure

R4. Not applicable, we do not provide tapering off opioids

46. Is information provided to clients regarding availability and access to harm reduction services (e.g., needle exchange, overdose prevention site)

R1. Yes, routinely

R2. Yes, when it seems to be indicated

R3. Yes, when the client requests this information

R4. No

R5. Not sure

R6. Not applicable, these services are not available in the community

The next few questions ask for some general information about your program. The results help us organize the other survey responses.

47. How is your withdrawal management service funded and operated?

R1. The program receives its funding primarily from a provincial or territorial health authority or government department and is operated by that same authority or department.

R2. The program receives all or the majority of its funding from a provincial or territorial health authority or government department but operates independently

R3. The program receives only partial funding from a provincial or territorial health authority or government department, but operates independently

R4. The program receives all funding from sources other than a provincial or territorial health authority or government department (please specify)

48. Over the last 12 months, please indicate whether your program explicitly accepts or exclude certain client groups:

Client group	Accepts	Excludes
Males	☐	☐
Females	☐	☐
Youth: age range ____ to ____	☐	☐
Adults: age range ____ to ____	☐	☐
People mandated to treatment by justice system	☐	☐

People with concurrent mental health challenges	☐	☐
Incarcerated offenders	☐	☐
First Nations, Metis, or Inuit peoples	☐	☐
LGBTQ clients	☐	☐
Other cultural groups (e.g., newcomers)	☐	☐
People with developmental disabilities	☐	☐
People with physical disabilities	☐	☐
Pregnant or post-partum women	☐	☐
Seniors or older adults	☐	☐
Other (please specify): Click or tap here to enter text.	☐	☐

Optional comments & feedback

49. Do you have any suggestions, questions or comments about the provision of services and supports to individuals with problematic opioid use in withdrawal management programs that you would like to share?

Click or tap here to enter text.

