REPORT:

Advancing Person-Centered Addiction Care in Canada: Diversifying Opioid Prescription Programs

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Contents

Executive Summary ... 3
Advancing Person-Centered Addiction Care in Canada: Diversifying Opioid Prescription Programs ... 4
Acknowledgements ... 5
Distribution and Disclaimer ... 5
Introduction ... 6
Methods ... 8
Themes ... 10
Core Elements of Diversified Care ... 13
Flexible Care Delivery ... 14
Responding to Clients' Needs ... 21
Supporting Social Capital ... 26
Spectrum of Medications and Formulations ... 31
Threats ... 35
Conclusion ... 43
Tools and Resources ... 44
References ... 44

Executive Summary

What is the purpose of this report?

Opioid use disorder (OUD) is a pressing public health concern that has reached crisis levels in North America as the illegal unregulated drug supply becomes increasingly potent and adulterated with toxic compounds. This report shines a light on the urgent need for diversified opioid agonist treatments (OAT), including injectable options (iOAT) and prescribed alternatives. Through showcasing the efforts of injectable and oral OAT programs across Canada towards person-centered care, we hope to generate engagement and conversation to strengthen OUD care.

Our approach

During 2023/24, our team set out to explore how treatment for OUD could be diversified to include injectable and oral OAT and other prescribed alternatives, meet clients' needs, and enhance equitable access across Canada. We travelled from coast to coast to 11 injectable and oral OAT programs, engaging in conversations with 70 key informants—clients, service providers, and experts—to capture a situational profile of current practices, opportunities, and challenges to enhance OUD care and client engagement.

Core elements of diversifying OUD care

Our fieldwork identified four core elements for diversifying OUD care:

- **FLEXIBLE CARE DELIVERY:** Adapting and increasing access to program delivery methods that align with clients' life circumstances, ensuring that treatments are as dynamic and varied as the people they aim to serve.
- **RESPONSIVENESS TO CLIENTS' DIVERSE NEEDS:** Extending beyond the medication to address the comprehensive needs of clients, including social, emotional, psychological, and medical supports.
- **SUPPORTING SOCIAL CAPITAL:** Creating opportunities for connection, employment, and capacity building to empower clients, and foster a sense of belonging and purpose.
- **OFFERING A SPECTRUM OF MEDICATIONS AND FORMULATIONS:** Providing a broad range of medications and formulations to cater to rising tolerances and consumption preferences, ensuring there are individualized options available for everyone.

Challenges to diversification

This report presents the ideas and insights we heard from clients and providers and indicates a need for treatment paradigms that bend to fit the needs of the people they intend to serve, not the other way around. The expansion and adoption of diversified care approaches to OUD cannot be achieved within a system characterized by restrictive regulatory policies, uneven funding distribution and shortages, site operational constraints, and occupational stress and burnout. These tensions become increasingly difficult to navigate within the context of rural or less-densely populated communities. Overcoming these challenges requires reshaping systems, policies, and practices to align with the needs of people with OUD and those dedicated to supporting them. The four core elements described above offer a valuable framework for policy and decision-makers to support these discussions and decisions.

Call to action

We encourage policymakers, healthcare providers, and community stakeholders to embrace flexible, inclusive, and person-centered approaches to OUD care. There is no one size fits all approach. Approaches big and small can make a difference. By providing people with OUD with care that meets their needs, is accessible, and effectively treats their disorder, we can improve quality of life, reduce economic costs, and come together as a community.

Advancing Person-Centered Addiction Care in Canada: Diversifying Opioid Prescription Programs

The present work represents a knowledge mobilization effort on pragmatic approaches that providers take to deliver injectable and oral OAT. The overarching idea of the investigators was to bring forward the aspects of care that clients, providers, and stakeholders were most proud of and to share it with the community to spark inspiration.

In a field that is unjustly politicized, the people on the ground hold the key to building a path forward. The nuances—the day-to-day ways to make it work—often do not reach decision makers and it is hard to transform this into evidence. We acknowledge that many of these approaches are no easy feat. Even when funding is available, programs face countless hoops and hurdles that stifle efforts to provide person-centered care. Using a strength-based approach, our humble work has tried to cast the net wide and illustrate some of the ways people are integrating diversified options and support continuation of care despite these challenges.

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Questions, comments or inquiries

We would love to hear from you! We welcome your comments, suggestions, and questions. Please contact us at: eugenia.joekes@ubc.ca

For more resources

https://injectable OAT-research.med.ubc.ca/

Distribution and Disclaimer

Distribution

This document is available for download at: injectable OAT-research.med.ubc.ca

We recommend sharing this link with healthcare professionals or decision-makers in your network who might be interested in using this resource to support their organisation's injectable and oral OAT program.

Disclaimer

This document does not replace policy or care guidelines. Clinical teams across the country are constantly revising processes according to changes in policy, funding, and regulations. This report is not intended as a substitute for the advice or professional judgment of a healthcare professional. It is not intended to be the only approach of clinical management. Clinical leadership is responsible for reviewing all provincial and federal practice updates to ensure that best practices are adhered to at their respective clinics. The authors of this guidance cannot respond to clients or advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a healthcare professional.

Introduction

What is the purpose of this document?

It is estimated that 16 million people worldwide grapple with the severe effects of Opioid Use Disorder (OUD).[1] Few pharmaceutical options are licensed in Canada with indication for the treatment of OUD. To date, the most effective approach is opioid agonist treatment (OAT), including injectable opioid agonist treatment (injectable OAT; iOAT). Reaching distinct populations, injectable OAT with diacetylmorphine or hydromorphone, has shown to be safe, effective, and feasible.[2–5] Yet, the availability of iOAT across Canada remains limited.

In addition to the licensed treatments, several pharmaceutical-grade opioids are prescribed off-label for OUD in Canada, despite being indicated primarily for acute or chronic pain management. These off-label prescriptions serve as alternatives to criminalized drugs, aiming to support individuals at risk of drug toxicity and death.[6–8] The practice of off-label prescribing varies significantly from place to place, both in terms of what options are available and prescribing practices. For example, in British Columbia (BC), options including slow-release oral morphine (SROM), hydromorphone (tablets), and fentanyl (tablets, patches and injectable) can be prescribed to people with OUD.[9–11] In Ontario, prescribed alternatives in the form of hydromorphone tablets, capsules, and SROM are dispensed by diverse practitioners in cities like Hamilton, Ottawa, and Toronto.[12] The evidence base for off-label prescribing varies, with some practices being more well-established than others, but it continues to grow as new approaches emerge.

Although a range of pharmaceutical agents exist to manage OUD, they are not equitably available across the country, particularly injectable OAT and prescribed alternatives. This leads to missed opportunities to reach people with OUD. Nonetheless, despite strict regulations, lack of funding, and a shortage of options, providers and clients involved in the existing programs find ways to adapt and even expand care approaches to keep clients engaged in care.

With this in mind, our aim was to investigate: **How can treatment for OUD be diversified to include iOAT and other prescribed alternatives, meet clients' needs, and ensure equitable access across Canada?** This question led us to explore the strategies currently employed by injectable and oral OAT programs across Canada to initially engage

and keep clients engaged in care. Our goal with this report is to inspire the adoption of diverse care approaches through the exchange of knowledge and experiences among injectable and oral OAT programs, showcasing their efforts towards person-centered care. We also hope for these spotlights to generate excitement and conversation to strengthen addiction care and drive meaningful change.

In the following sections we describe some of the ways that programs are engaging people in care, present four core elements of diversified care approaches, and briefly discuss the threats confronting these care paradigms, as voiced by key informants. In reading this resource, you will quickly learn that there is no one- size-fits-all approach. **This resource is not intended as a prescriptive manual, but rather as a source of insights and inspiration to diversify OUD care for different people and places.** The reality is that not all these options will be feasible or appropriate for everyone or everywhere. We acknowledge that many of the options presented are easier said than done. Nevertheless, a variety of options are available for exploration, and we encourage you to adopt and adapt them to fit your unique context. Please keep this in mind as you work your way through this resource.

Please be aware that provincial and territorial policies and regulations surrounding the delivery of injectable and oral OAT and prescribed alternatives vary significantly across Canada and are constantly evolving. The approaches discussed in this report are intended to be adapted to align with the local political and regulatory environments and specific needs of clients in your region.

Our positionality

As a team with decades of experience working in OUD treatment research, focusing on injectable OAT, our position is that every resident of BC, indeed every resident of Canada, has the right to equal access to treatment regardless of where they live. Treatment access is not the same as treatment indication. We cannot foresee if, for example, take home injectable OAT will be the right option for a person, but the possibility to access it, if indicated, is a right for any person, anywhere in Canada.

We are aware of the many difficulties surrounding person-centered addiction care, such as stigma and regulatory restrictions. The geographically dispersed nature of BC, and Canada, also presents challenges in achieving critical mass for any product or treatment beyond major urban centers. However, our position is that there is an intrinsic diversity in every site that provides OUD care; as the territory, the people, and the challenges differ, so too should the solutions they implement. It is in this dispersed diversity that we aim to envision how diversifying a panel of treatments based on clients' needs could be integrated within existing and future care systems. We believe that more options for clients in medications and approaches will translate to increased opportunities for engagement.

Finally, our position regarding injectable and oral OAT and prescribed alternatives is that the medication is a crucial part of the care a person needs. In some cases, it will be all they want to accept. However, there is a need to provide a system of support based on the diverse needs of the individuals accessing these medications.

How to read this report

In this report, several features will be integrated throughout including:

- **Vignettes:** A brief description of a real-life approach from the sites we visited to offer inspiration.
- **Tools:** Valuable resources to further knowledge of a topic or concept. This includes websites, articles, guides, videos etc.
- **Community Wisdom:** Practical tips from experts and key informants learned through experience.

Methods

To explore how injectable and oral OAT programs across Canada are initially engaging and keeping clients connected to care, we visited 11 sites across the country that offer or have offered injectable OAT or are working towards offering it in the near future. During these visits we met with key informants (23 service users and 47 service providers and administrators) to discuss their experiences with these programs, including potential ways they currently, or would like to, diversify care for people with OUD. All interviews were conducted either in-person at the program site or via Zoom to accommodate service users' and providers' schedules. The interviews were audio recorded, stored on a secure server, and transcribed verbatim by a third-party Canadian transcription service. Interviews lasted 30 – 60 minutes and both service users and providers were offered compensation of $50 per hour or fraction (although most service providers declined compensation and donated their compensation to the program site).

Prior to visiting each site, we conducted a brief situational analysis to form a general understanding of the political structures, systems, decision-making processes, and key social, public health, socioeconomic, and cultural characteristics of the community surrounding the site that may influence how it delivers injectable and oral OAT. This was done in accordance with guidance published by the World Health Organization.[13] In keeping with this WHO guidance, transcribed interviews were analyzed following a modified strengths, weaknesses, opportunities, and threats (SWOT) framework; a method to critically appraise information and provide a clear and concise summary of the current situation at each site. Since our team aimed to use a strengths-based approach, the SWOT framework was adapted to: **strengths**, **areas for development**, **exciting opportunities**, and **threats**.

Subsequently, we expanded the SWOT framework to address our primary inquiry: How do sites initially engageclients in care and maintain that engagement? As such, within each category of the SWOT analysis, we identified recurring themes based on their frequency of discussion, alignment with the principles of person-centered care in addiction, impact on clients and providers, and feasibility and/or potential threats to implementation (see Figure 1). By employing this theoretical perspective, we were able to select themes with potential relevance for policymakers, illustrating the diverse implementation of injectable and oral OAT across Canada. We then synthesized these themes into four core elements essential for sustaining a diversified injectable and oral OAT program: flexible care delivery, responsiveness to clients' diverse needs, supporting social capital, and provision of dynamic medication and formulation options. This synthesis involved exploring the intersections of these themes and their alignment with qualitative data published on injectable OAT and person-centered care in addiction. These four core elements directly address our secondary line of inquiry: **How can injectable and oral OAT be diversified to promote equitable access to care?**

FIG 1. THEORETICAL PERSPECTIVE

- ***Frequency:*** Our analysis prioritized themes discussed more frequently, where we assumed that the more often a theme was discussed, the more salient it was.
- ***Feasibility:*** We focused on identifying approaches that could be implemented within the existing legal and regulatory context (locally and federally).
- ***Person-centeredness:*** We aimed to include approaches that respected autonomy and promoted individualized care and shared decision-making.
- ***Impactful strategies:*** Our analysis favoured pragmatic approaches that key informants indicated made a tangible difference in the day-to-day operations of the site and client care.
- ***Potential threats:*** We selected themes that highlighted areas for improvement or factors that were negatively impacting care delivery, program operation and expansion, and future expansion.

Limitations

While our recruitment approach aimed to capture a diverse range of injectable OAT sites across Canada, including those currently offering, formerly offering, or willing to offer injectable OAT, we made the decision to prioritize sites outside of Vancouver, BC. This decision was primarily driven by the extensive existing literature and research efforts available on injectable OAT in this region. Consequently, we concluded that sufficient published information, including literature, manuals and guidance, existed for this region, enabling us to prioritize our efforts towards visiting sites and conducting interviews in areas offering injectable OAT that have been less explored.

Additionally, while we intended to include sites that currently offer oral OAT but would like to offer injectable OAT (prospective sites), it takes a significant time investment to build trust to facilitate open and honest conversations with these communities. Therefore, the time constraints of this project ultimately hindered the number of prospective injectable OAT sites that we could engage in this work. Consequently, the themes discussed in this report may not fully capture the breadth of perspectives and experiences of individuals working in, accessing, or affected by injectable OAT in Canada.

Furthermore, despite our diligent recruitment efforts, our team encountered challenges connecting with injectable OAT service users at some sites, and we did not engage with former injectable OAT clients. The insights from these perspectives would be invaluable for understanding the factors influencing disengagement from care, identifying approaches that facilitate initial engagement and ongoing continuation of care, and shaping visions for improving care to better meet clients' current and future needs.

Themes

We encountered a wide range of approaches to delivering injectable and oral OAT, from integrated care sites to standalone OAT sites to community-based programs. Each site operates within a unique sociopolitical, regulatory, and geographic context that shapes the services offered and how they are delivered. Nonetheless, there were still some commonalities across sites in terms of client engagement strategies including:

SUPPORTIVE HOUSING: Given the time intensity of injectable and oral OAT, many key informants in urban and suburban regions were eager to integrate these treatments within housing. Increasingly, clients are being offered supportive housing in locations that are far away from program sites. This relocation creates challenges, as clients must now weigh the benefits of continuing with treatment against the inconvenience or inaccessibility of travel.

Treatment integration within housing has alleviated this burden by reducing or eliminating the need for frequent daily trips to the clinic, a common factor contributing to discontinuation of care. Moreover, this approach enhances the accessibility of care for individuals with disabilities or caregivers who may face significant barriers to travel. This is particularly relevant care for individuals with complex needs such as brain injuries, trauma, developmental disabilities, or psychiatric illnesses—a priority raised by key informants. While some regions have begun offering injectable and oral OAT within housing programs, bureaucratic hurdles and regulatory constraints pose significant feasibility challenges to widespread implementation.

"I wake up in the morning, I gather my phone inside my room and then it rings down at the front office. And they tell me, 'OK, you can come down and get your morning meds. Or wait 10 minutes to come down and you can get your [injectable OAT] injection at the same time.'"

–Client

"Integrated housing [with treatment], if we had a housing partner that could have a satellite site, for example. We actually have a number of people in hospital waiting for housing who are on home oxygen who are on injectable OAT, why not? It's going to be cheaper than keeping people in hospital for six months. They can't figure out the system's not designed to support that."

–Service provider

WRAPAROUND CARE AND ANCILLARY SERVICES: All the clients and providers that we spoke to stressed the importance of offering services beyond "just the medication," emphasizing that many clients have complex needs and are not adequately connected to care. Wraparound care was largely defined as offering comprehensive psychosocial care, including case management, counselling, and peer support; in some cases, it also included primary care, wound care, and on-site pharmacy services. While not everything can be offered, key informants were adamant that some form of integration and connection to ancillary supports must be available. These service

offerings are dictated by what is already near the site (i.e., existing services), and the needs of the client population. This not only streamlines care and care navigation but ensures that the site can offer clients holistic care and meet their unique needs. Key informants described the primary threat as funding and inconsistent client engagement when the site is not located near their primary residence. Additionally, there can be red tape associated with integrating primary care into service delivery.

"We were not just a medication clinic, where injectable OAT you would think is. And sure, we started out like that, but the needs are so high that it's not just 'Come in and get your dose and go.' It's expanding, and so that's why the roles have to expand. Because if we are addressing housing and food and crisis, all of these things, then it's not just a clinic for medication; there's going to be a piece with case management and needing to have the resources to be able to fulfill those requests."

–Service provider

"Like, I would probably want to see the way out, the way... but I would like to maybe have a counsellor or someone that I can talk with you know, who is going to help me to get off of it."

–Client

PHARMACY: Some sites across Canada, particularly those serving large catchment areas, such as rural or suburban communities, are seeking to expand the role and capacity of pharmacists in injectable and oral OAT program delivery. At one site, the pharmacist played a pivotal role in liaising with hospitals and community-based pharmacies to facilitate the preparation and distribution of medications for the site. They also designed workflows for their clinical team based on pharmacy regulations, clinically managed clients' care plans (including ongoing monitoring and evaluation) and medications (OUD and non-OUD) and conducted consultations to inform care plan changes. This role provided the clinic with a form of stability, as the pharmacist was employed the clinic full-time and was better equipped to communicate clinical concerns related to the medication(s) to prescribers than other site staff. Additionally, it allowed prescribers to have a more "hands-off' approach, as the pharmacist possessed advanced training for clinical work (grade II clinical pharmacist). There was also a desire to involve community-based pharmacies in dispensing and delivering injectable and oral OAT. This was seen as a viable solution for clients whose main priority is accessing the medication rather than comprehensive wraparound care. It would provide clients with greater flexibility in terms of how and where they access their medication, which would ultimately increase engagement in care.

The feasibility and limitations associated with these approaches were twofold. Firstly, in many provinces and territories, to provide OAT, pharmacists must complete training from the College of Pharmacists. However, some pharmacies avoid completing this training as a workaround to abstain from serving individuals with OUD. This, in turn, reduces the number of communities with access to injectable and oral OAT through their local pharmacy.

"I have a client right now who lives rurally and can't access an injectable and oral OAT clinic. I'd like them to be able to dose hydromorphone at a pharmacy, that would be helpful."

–Service Provider

Secondly, the costs associated with preparing the medications (e.g., sterile compounding hood, trained technician, compounding supplies) can be prohibitive for community pharmacies, and the billing for offering injectable and oral OAT services in community-based pharmacy is not sufficient nor reflects the additional clinical supports required.

"It would be nice to have a prescription so I could go to any pharmacy. If I'm traveling around, I can take my prescription in, here's my script for today... Say if I go to Prince George for a week, I can go to a pharmacy there and 'there's my prescription for a couple of days for heroin'. And you get it filled right? That would be the ultimate."

–Client

"And then alternatively in a community pharmacy-based model, I again think that their benefit would be access. You can hit more patients with that; you wouldn't necessarily maybe be able to provide the same level of comprehensive care but at least you would be getting people care [they] otherwise wouldn't."

–Service provider

STAFF: All sites emphasized the need to have staff who are non-judgemental, competent, committed, and resourceful. This manifested in various ways, such as taking the time to brush a client's hair, donating winter wear to create a cabinet for clients during the colder months, or advocating for program changes to better meet a client's goals or needs. Staff utilized the frequency of client visits to connect with them, understand their stories, learn about their struggles, and build trusting relationships. As a result of this trust, clients felt more comfortable voicing their goals or concerns, and there was a greater degree of shared decision-making or providers finding workarounds to support clients' needs and circumstances. However, because there is a shortage of prescribers and staff, alongside precarious funding structures, clinics often rely on staff passion to start and sustain their operation. This passion and dedication, while catalyzing, can also lead to significant occupational stress and burnout. Staff members report feeling unsupported by health authorities, provinces, and Health Canada as they constantly and tirelessly advocate for changes to policies, regulations, and funding to better serve their clients.

"The nurses have driven me to get my ID, to get anything I need. I can't imagine how I would get through life now without them... Yes, they help me in every way I could possibly need, anything they can do they do."

–Client

"Here we see them up to three times a day, so we see them more, so more touchpoints. And I think the relationship just builds stronger with all of those touchpoints. We know where they're living, we know they talk to us about things that are going on in their life and if they're having struggles with different things and then we can support them with those struggles as well."

–Service Provider

"I mean I've never been in where I've gotten along with everybody. There's always the one that you... or those people you [don't] jive with, but I mean everyone [the staff] here is just—nobody—they don't judge, you're not embarrassed to tell them anything. You can talk to them about anything."

–Client

OUTREACH: Most sites were eager to bolster outreach efforts to better serve clients. Outreach was frequently described as an extension of case management, wherein staff seek out clients in the community to actively engage them in care or accompany them to off-site appointments. Additionally, key informants emphasized the importance of involving people with lived and living experience (PWLLE) in outreach to engage new clients and to follow up with individuals who have been absent, are in transition (e.g. hospitalization, moving, loss of housing), or are facing other challenges that may impede their engagement in care (e.g., theft of personal possessions, loss of a loved one). As a result of outreach-based support, care navigation often sees improvement. Clients not only get connected to the appropriate services at the right time but also receive support to engage in services both on-site and off-site. Moreover, outreach services can be tailored to each individual, allowing them to adapt to clients' evolving needs. The primary challenge with outreach services lies in their resource and time intensiveness. Limited funding and staffing shortages hinders sites' ability to provide consistent and comprehensive outreach services. Outreach is also time-intensive, particularly when staff are accompanying clients to appointments, thus limiting the number of clients that can be reached.

[Referring to accompanying clients to off-site appointments]: "A huge success is when I'm able to go out with a client and—like, night and day difference of, like, finally got to the ministry, got attestation form, now they have a bank, now all these things."

–Service provider

[Discussing how they would not have known about the injectable OAT program if it weren't for the team that connected them]: "There aren't really any signs or anything telling me about it [referring to injectable OAT services], so yeah, that's about it. I mean I find that a lot of people don't know about it [injectable OAT]. I mean I told a bunch of people who were like, 'Oh, really?'."

–Client

While these themes are not all-encompassing, they offer insight into how sites currently deliver care or aspire to do so to enhance client engagement. Moreover, they serve as the foundation for a deeper examination of the core elements essential to diversifying care for OUD, as discussed in the following sections.

Core Elements of Diversified Care

Service providers and clients alike offered numerous examples and ideas regarding how care could be diversified to support client engagement and facilitate access to injectable and oral OAT. Through our analysis of the themes, we encountered the following common core elements that support diversification of injectable and oral OAT:

1. Flexible care delivery
2. Responsiveness to clients' diverse needs
3. Supporting social capital
4. Spectrum of pharmaceuticals and formulations

These four core elements are not exhaustive; instead, they serve as a framework to organize some of the key attributes of diversified injectable and oral OAT programs and facilitate a more structured discussion about them. The following sections will delve into each core element, using examples gathered from our conversations and site visits to illustrate them.

Flexible Care Delivery

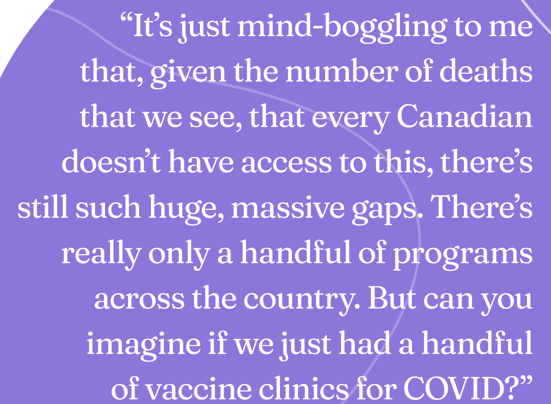
What is Flexibility?

Key informants described flexibility as the capacity of programs to adapt program delivery methods to make care more accessible and accommodate the diverse needs, preferences and circumstances of clients. Often this was done within the context of a rigid and restrictive regulatory environments. In some instances, offering flexibility involved medication deliveries or enabling non-witnessed doses, in others it involved implementing low-barrier operational and clinical processes.

Approaches to Flexibility

Key informants discussed a range of ways to offer flexible care to clients including:

MEDICATION DELIVERIES: Injectable and oral OAT programs deliver medications to clients' home/primary residence, either temporarily or as needed. Typically, deliveries are carried out by a team of two staff, which may include a nurse, pharmacist, or physician accompanied by a social worker or peer worker. At least one staff member must be licensed to handle, dispense, and witness doses (where applicable). Pharmacy outreach efforts are employed to facilitate fentanyl patch deliveries, particularly for clients residing in encampments, ensuring they do not miss their appointment to change their patches. Witnessed injectable OAT deliveries are also available to overcome ongoing and unique situations that impede clients' ability to attend the clinic. Staff deliver prefilled syringes once or twice a day to clients' homes and observe their doses. Current regulations indicate that all delivered injectable OAT doses must be witnessed, however, our field work and previous evidence indicates there is a desire among providers and clients to deliver unwitnessed daily doses where indicated.[15]



"It's just mind-boggling to me that, given the number of deaths that we see, that every Canadian doesn't have access to this, there's still such huge, massive gaps. There's really only a handful of programs across the country. But can you imagine if we just had a handful of vaccine clinics for COVID?"

–Service provider

Deliveries ensure uninterrupted care, especially during temporary or chronic physical and/or mental challenges that hinder access to the program site. This approach also addresses unreliable transportation, particularly in rural and remote areas and supporting engagement of harder to reach populations such as women and sex-workers. Lastly, home visits enable staff to check in with clients and see how they are managing.

VIGNETTE:

Braving the Storm!

Staff at one clinic are committed to ensuring clients have access to their medications, even when faced with challenges like disability or accessibility issues. Take, for instance, the story of clients in wheelchairs who found themselves unable to reach the clinic during elevator breakdowns or poor weather conditions like snowstorms. In such situations, where wheelchairs or walkers couldn't navigate through snow or where individuals using canes or crutches feared slipping, clinic staff stepped in. Whether it was two nurses, or a nurse accompanied by a social worker or peer support worker, they made sure pre-filled syringes reached those who would otherwise be stranded without access to their medication. These deliveries were not just a convenience; they were a lifeline. Many clients lived close by, making the process swift. In fact, in one case, a social worker and physician managed to complete six deliveries in under an hour! This commitment to ensuring uninterrupted care demonstrates the clinic's dedication to flexibility and meeting clients' individual needs and circumstances.

CARRIES: Carries or take-home doses of injectable and oral OAT free clients from daily or multiple daily visits to a clinic, making it possible for clients to pursue needs, priorities, and goals beyond just a few blocks surrounding the clinic or pharmacy. In the case of injectable OAT, clients in the carries program attend the site daily for their first dose (witnessed) and then can receive up to two take-home doses. While this approach is not appropriate for everyone, it is an important option along the continuum of care affording clients' greater autonomy, sense of freedom, quality of life and privacy.[14]

VIGNETTE:

Lisa's Story

Lisa has been on an injectable OAT program for over a decade, and most of her time has been stable using nothing but prescribed diacetylmorphine. She says it has given her life back. Previously consumed by the need to steal and sell stuff just to manage her addiction, Lisa lost seven years with her daughter. Thanks to the carries program, though it still takes her an hour each way to reach the clinic daily, she is home by noon, ensuring she can be there for her daughter who battles a terminal illness. Each second with her daughter is precious and the carries program has reduced Lisa's time away from her from six to three hours each day. Lisa dreams of a future where she can access a week's supply at a time, alleviating the burden of daily trips to the clinic. Recently, after snowstorm, Lisa was unable to get to the clinic and therefore had to get a prescription at a local pharmacy for methadone to try to manage. It wasn't enough. As a person who needs this medication, she continues to be frustrated by the fact that she can't just go to the pharmacy to pick it up. In that way, it still makes her feel like she's doing something she's not supposed to, even though it's her prescribed treatment.

INTEGRATING PROGRAMS WITHIN SUPPORTIVE HOUSING: An injectable and oral OAT program partners with a local supportive housing provider to offer medication and wraparound care directly on-site with nurses available to dispense and witness doses. Both clients and providers underscored the convenience of this approach, particularly for people with health limitations, accessibility needs, or other challenges that make travelling to a clinic difficult or unfeasible. Instead of navigating transportation barriers, clients can simply "pop down" for their dose, and if they are too sedated, service providers explained that it was much easier for them to come back at another time without the risk of them not returning or missing a dose entirely. This approach also facilitates regular check-ins with clients. For instance, if a client has not shown up for their morning dose, the nurse can easily check in on them or provide a gentle reminder by buzzing up to their unit.

Additionally, this approach ensures that clients remain housed, a key factor in care engagement and continuation. Integrating programs within supportive housing provides a holistic approach that addresses the intersectionality of the social determinants of health in OUD care ultimately improving continuity of care.

VIGNETTE:

Ottawa Inner City Health

The Ottawa Inner City Health's Managed Opioid Program (MOPs) is the first program to pair injectable opioid agonist treatment with assisted housing for people experiencing homelessness with severe opioid use disorder and injection drug use. The program is offered in partnership with John Howard Society and Ottawa Inner City Health staffed with RNs, RPNs, non-clinical managers and staff, and social workers. Any services they are unable to provide on-site (e.g., counselling) are referred out and coordinated for clients. Clients are also provided with several amenities (e.g., room cleaning, meals) and comprehensive wraparound care that meets their basic needs and more. Clients felt that the program was more than a place to "just get a bed" or "just get their meds," and spoke highly about having a variety of support conveniently located in one space.

"I love this place. I fucking love this place, man... we're so lucky here."

–Client

"Here's so many different reasons that I could name. It's $500 a month for a one-bedroom apartment with all brand-new appliances. Comes with a flat screen Smart TV. We have a Jacuzzi in the basement. We have one TV room over here with a 72-inch flat screen TV. We have a kitchen where breakfast is free in the morning. And an extra $100 a month gets you lunch and supper... All my medications are covered."

–Service provider

VIRTUAL CARE: Programs are leveraging virtual care technology to facilitate assessments and initiations of injectable and oral OAT in the absence of an on-site prescriber or during a time of crisis (e.g., COVID-19 pandemic). For injectable and oral OAT initiation, a nurse conducts an initial consultation with the client via video and records it, then sends the recording to a prescriber for review. The prescriber assesses the interview and determines the clients' eligibility and titration plan (if eligible). This approach is particularly beneficial in rural and remote areas where specialists or prescribers with the necessary training for injectable and oral OAT prescriptions may be scarce. Previous publications have noted that telemedicine has also been utilized to engage clients in primary care or other assessments that can be done virtually, enhancing access, convenience and reducing "no show" rates within this population.[16] Providers discussed the opportunity to expand the role of virtual care to include maintenance monitoring to offset resource constraints and support remote communities.

NURSE-PRESCRIBING: In BC, registered nurses and registered psychiatric nurses are authorized and trained to prescribe OAT (buprenorphine/naloxone, methadone, and SROM) as part of the response to the public health toxic drug crisis. This improves access and reduces wait times for OAT medications particularly in regions where Addiction Medicine Physicians are limited or non-existent.

OPERATIONAL APPROACHES: Program sites employ operational-level strategies to enhance flexibility. Some sites have extended hours of operation (e.g., weekends and 12-hour schedules) and offer walk-in appointments. This avoids clients having to keep track of the day (which many struggle with) and miss a dose as a result. In addition, this approach helps to prevent negative impacts and the increased risks associated with missing an appointment (e.g., getting sick [withdrawals], reliance on toxic drug supply, and punitive measures such as lowered doses) and facilitates continued engagement in care. Other sites have worked to reduce or eliminate waitlists for treatment initiation or service access. For example, some places offer same day starts on injectable OAT. Service providers emphasized that, for individuals who face extreme challenges getting to a clinic, waiting hours for an appointment or days to initiate treatment is not an option. Additionally, many programs aim to reduce barriers to entry by limiting eligibility criteria. For example, some sites do not require clients to try other medications before accessing their preferred injectable and oral OAT. Lastly, some programs allowed clients to self-refer or be referred by peer workers.

PRN DOSES FOR INJECTABLE OAT: Some sites have implemented PRN (pro re nata, meaning 'as needed or necessary') doses of injectable OAT for clients who are not quite ready to being an intensive treatment program but would benefit from access to a prescribed alternative to reduce reliance on the unregulated supply. Since there is no titration period or missed doses, clients receive a lower dose of injectable OAT; they can access doses up to four times a day and can miss several days without it triggering a change in dose. This allows clients to try out the medication and health services before committing to a more rigorous program.

The Impact

Key informants emphasized the pivotal role of flexibility in facilitating smoother transitions in care and engaging diverse populations with individualized needs (e.g., women and gender-diverse people, sex workers, clients with disabilities). They also acknowledged the fluctuating nature of clients' lives and circumstances, which can make presenting to program sites daily or multiple times a day to receive their medication less feasible, inaccessible or stigmatizing. They stressed that clients' needs can and will change over time for a variety of reasons, such as when they:

- Experience positive or negative changes to their physical and/or mental health
- Require hospitalization
- Secure or begin seeking employment
- Move or their living conditions change (e.g., move further away, to supportive housing, or become unhoused)
- Need or would like to travel
- Become incarcerated

Thus, offering flexibility in care allows sites to respond to and adapt to clients evolving needs. Those that have implemented flexible approaches to care emphasized its role in:

- preventing disruptions and supporting continuity in care;
- enhancing care engagement, retention, and adherence particularly in harder to reach populations;
- improving accessibility and convenience of care; and
- enabling clients to participate in a life outside of the clinic.

Visions for the Future

Key informants identified future opportunities to expand and strengthen flexible approaches to care, including:

TRANSPORTATION SUPPORT: Several sites we engaged with proposed transportation services to reduce barriers associated with clients travelling to the site daily and to improve client engagement and treatment adherence. They suggested employing or assigning staff, such as a harm reduction worker, to pick one or multiple clients up at their residence (or another predetermined pick-up location), drop them off at the program site, and drive them back home at the end of the day or on a predetermined schedule.

"We're going to do a temporary hire for three months and possibly have someone with a van go to some of the shelters and pick up three or four people who are going to come in to get on the program. Get them on it and then drive—well, you drop them off, go to another—bring them back, pick these ones up, deliver them home... we got four ideal clinics that we could do and if we can get people onboard for that, with the free transportation, it might be a win-win."

–Stakeholder

VIGNETTE:

Wheels of Hope

Transportation programs to help clients get to appointments exist in many other areas of healthcare, including cancer care. The Canadian Cancer Society's Wheels of Hope Transportation Program provides people living with cancer rides to and from their cancer-specific medical appointments or supportive care services in Alberta, Ontario, Saskatchewan, and Manitoba.[17] The program has volunteer drivers that will use their own vehicles, or vehicles owned by the Society, to help bring patients without access to transportation to and from their appointments.[18] The service helps alleviate additional stress for people already coping with a cancer diagnosis and provides opportunities for patients to socialize with volunteers.[19] Patients are referred to the program by their healthcare provider based on financial, physical. or emotional need for the service.[17,20] This program is an excellent example of a service model that could be adapted for injectable and oral OAT where volunteers or support staff provide scheduled, 1-on-1 transportation support to clients who face challenges with accessing program sites and attending appointments.

FLEXIBLE PICK-UP LOCATIONS: Service providers also delved into the idea of integrating injectable and oral OAT programs into pharmacies or other satellite sites. While there was a lack of consensus around how this could be rolled out, the desire to offer flexible pick-up locations, so that clients are not tied to one site, was clear. Both clients and providers were eager to involve pharmacies or satellite sites so that clients could travel or pick up their medication(s) from different places. This may involve integrating small-scale injectable OAT services within community health clinics to serve as satellite sites or allowing clients to pick up their doses from a local pharmacy rather than the clinic. Notably, this approach would have implications for the cost of production and shipping of medications and may also require a shift in how they are prescribed and prepared. Additionally, it would also necessitate greater electronic medical record integration.

"Every little mom-and-pop, community health clinic in every small town should have a little injectable OAT integrated in it."

–Service provider

"I would actually love to see more injectable OAT clinics in different parts of our health authority. I think they could set up smaller scale clinics in communities like Vernon, Penticton, and then of course Kamloops being another large site, there's just no access."

–Service provider

VIGNETTE:

A Pharmacy-Based Delivery

Following several previous unsuccessful attempts with oral pharmacotherapy and high overdose risk, a 48-year-old man was initiated on injectable hydromorphone by his primary care physician (who had experience in addiction medicine). The client completed induction at the primary care clinic under nurse supervision and was subsequently transitioned to a community pharmacy for ongoing witnessed administration of injectable OAT. At the community pharmacy, a pharmacist completed the pre-and post-dose assessments, and witnessed administration.[21] This case report illustrates that embedding injectable OAT within primary care clinics and designated pharmacies is a feasible and cost-effective approach to support expansion of this treatment option. It eliminates the need for specialized injectable OAT clinics and can be implemented at a relatively low cost by relying on existing infrastructure and processes. While not all primary care clinics and pharmacies are well-positioned to offer injectable OAT, increasing the number community clinics and pharmacies with this capacity would allow for expansion of these programs, particularly in rural settings or geographically dispersed communities.

DEDICATED PROGRAMS FOR WOMEN AND GENDER-DIVERSE PEOPLE THROUGH SUPPORTIVE HOUSING: Integrating injectable and oral OAT programs within supportive housing programs designed for women (cis and trans) was proposed as a potential strategy to better engage women, gender-diverse people, and sex workers. One provider expressed the need to create safer spaces for women to access care. Currently, most of the clinics are occupied primarily by older men and are in neighbourhoods where many women do not feel safe, particularly at night or in the winter months when it gets dark by late afternoon. Community-based women's housing organizations have demonstrated interest in partnering with injectable and oral OAT programs to make care more accessible.

Community Wisdom

Providers, experts, and clients offered advice based on their experience on flexible care. Here is what they had to say:

- Develop partnerships with organizations that can support the delivery of flexible care approaches. For example, partnering with housing non-profits for supportive housing, harm reduction or outreach organizations for transportation support, or pharmacies for client medication pick-ups and deliveries.
- Drop-in is essential and should be prioritized where possible. Scheduled appointments are often a barrier.
- Leverage down time at program sites to complete medication deliveries and/or transportation services. For example, if a site is slow every day at 10am after clients come in for their morning dose, schedule staff to make deliveries or pick clients up at this time.
- Partner with agencies that have peer support workers or outreach workers who regularly engage with the community. They are key to bridging people into the healthcare system that many do not trust. Peer support workers and outreach workers can help facilitate conversations between prospective clients and providers, in-person or virtually, and can facilitate an initial virtual assessment.
- Consider piloting new approaches to flexible care delivery, such as carries, medication deliveries, and transportation services prior to fully implementing. This allows programs to assess the feasibility and resources needed before committing to offering the service at a larger scale. For example, medication deliveries can be initially trialed for extenuating circumstances like bad weather or accessibility needs.

- Providers can initiate conversations about carries with clients rather than waiting for clients to bring up transitioning to take-home doses. Clients may be reluctant to ask for this option due to fear of rejection; this requires a good understanding of clients' self-defined goals and needs and the intersections as they relate to age, gender, race, and geography.
- Ensure drivers involved in transportation programs for clients receive appropriate training, are familiar with the client's needs (e.g., accessibility), and are accompanied by an additional support person. Rules and expectations around where clients can be picked up and dropped off need to be well-established and upheld. Be mindful of interpersonal relationships that could put drivers or clients at risk and schedule accordingly.

Responding to Clients' Needs

Defining Diverse Needs

Providing diversified care involves recognizing and tending to the diverse needs of clients. Needs were conceptualized holistically, encompassing mental, physical, social, and cultural aspects. Sites recognized that an individual's background, history, beliefs, and goals will also influence their needs. Emphasizing the multi-faceted nature of the populations they serve; sites highlighted the importance of offering holistic services along the continuum of care. Some clients require assistance with basic needs like food and shelter, while others need psychosocial supports, primary care, or help with employment. Thus, sites have expanded their services beyond medication-assisted treatment, tailoring them to their population's needs within funding and regulatory constraints. For instance, one site offers community meals, while another prioritized providing primary care and on-site pharmacy services. Despite service variations, all aim to respond to clients' underlying needs, understanding that holistic care is fundamental for maintaining client engagement.

Approaches for Meeting Diverse Needs

Program sites provided a range of services to meet clients' diverse needs, including:

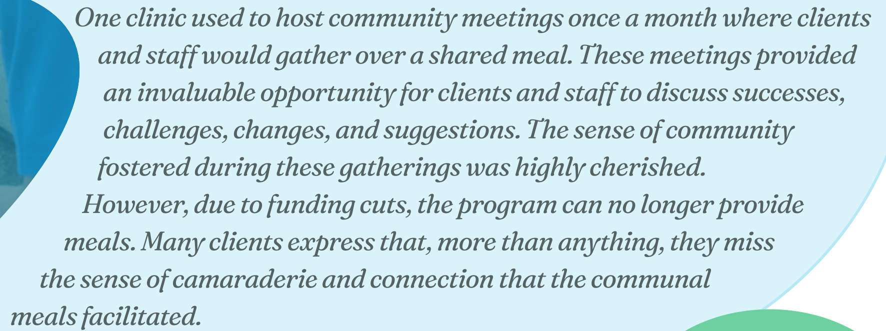
FOOD PROGRAMS: Food support varies across sites, ranging from snacks and juice boxes in drop-in rooms to community gatherings with hot meals. While some sites use existing funds for food provisions, others rely on food bank donations or staff contributions due to funding constraints. Food was described as a vital resource for clients' overall health and well-being, as staff elucidated the challenges clients often encountered in obtaining sufficient nutrition.

"Calories are an issue. Whether it's from the Food Bank or from our budget or... People joke about [food] but it's necessary. The level of chaos in peoples' lives and disorganization from a myriad of issues means that knowing how to safely obtain, store, prepare, and eat food is not possible."

–Client

"We just hand out bucket loads of coffee a day. [laughs] Some just come just for the coffee, it's a thing, coffee and now they ask for a bubble [pipe] and then they might get brave enough eventually after they come here for a while to use a booth [this clinic has an OPS attached to it]."

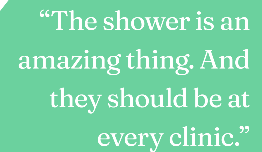
–Service provider



VIGNETTE:

Community Meals

One clinic used to host community meetings once a month where clients and staff would gather over a shared meal. These meetings provided an invaluable opportunity for clients and staff to discuss successes, challenges, changes, and suggestions. The sense of community fostered during these gatherings was highly cherished. However, due to funding cuts, the program can no longer provide meals. Many clients express that, more than anything, they miss the sense of camaraderie and connection that the communal meals facilitated.



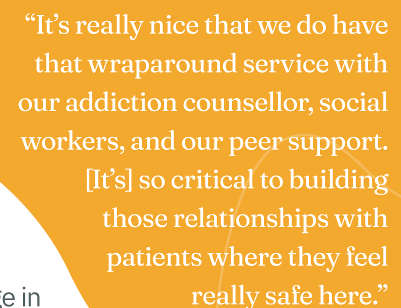
"The shower is an amazing thing. And they should be at every clinic."

–Client

HYGIENE SUPPORT: In some places, hygiene resources, such as accessible showers, a foot soak, and clothing donations are available on-site for clients. Service providers explained that hygiene support was easily overlooked but emphasized that it is essential for clients, particularly those that are unhoused, who may not otherwise have a way to bathe.

WRAPAROUND CARE: This encompasses various forms of support that extend beyond addiction medicine including psychosocial care, case management, counselling, peer support, and in some cases, primary care and wound care. Service providers noted that these supports can create a feeling of safety for clients and can help keep them engaged and retained in care despite destabilizing life events.

ONE-STOP SHOP: As the name implies, this approach can offer clients a range of services in one convenient location. For some sites, this entails integrating primary care and pharmacy on-site; for others, injectable and oral OAT and wraparound care services are integrated within supportive housing. Having all of clients' medication, psychosocial, and primary health needs in one place makes accessing services and facilitating connections to care easier and more convenient for both clients and service providers. Size and time are key factors that can restrict this model. Nonetheless, there are creative ways to facilitate service integration such as having injectable and OAT programs located adjacent to a primary care clinic or pharmacy or offering mobile services.



"It's really nice that we do have that wraparound service with our addiction counsellor, social workers, and our peer support. [It's] so critical to building those relationships with patients where they feel really safe here."

–Service Provider

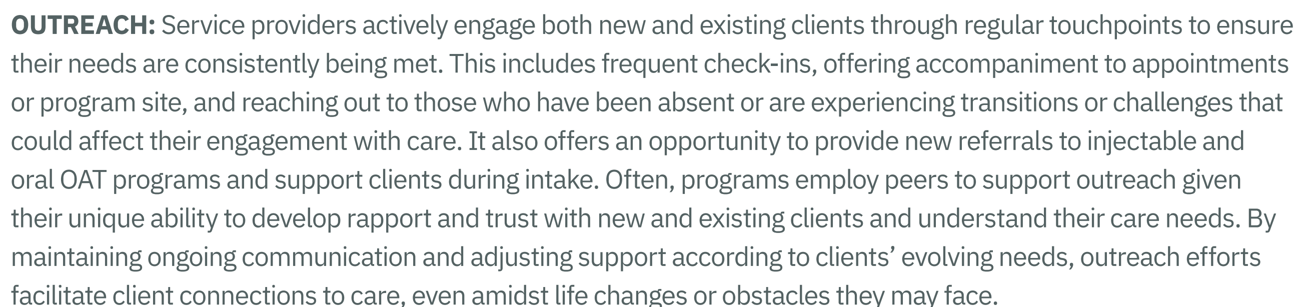
BUS AND LEISURE ACCESS PASSES: At some sites, clients are offered activity and transportation vouchers or passes at no charge to enable access to facilities such as recreation centers, gyms, pools, and zoos. The ability to engage in these activities offers positive outlets for leisure time, enhances social interactions and quality of life.

WELCOMING ATMOSPHERES: Some program sites are 'non-medicalized' and homey. Sites have achieved this by incorporating artwork (including pieces clients created), comfortable chairs, couches and pillows, and post-dose hangout areas. Creating a welcoming and comfortable environment encourages clients to take their time and "hangout" before or after their dose, allowing them the chance to connect with staff and discuss their needs, and for staff to support care navigation and referrals.

VIGNETTE:

Stay a While

Nestled at the end of a residential street, an injectable OAT clinic offers a warm and cozy space for clients. Its cozy facade, resembling a quaint home, conceals the vital services it provides. Conveniently located within walking distance from downtown, the clinic is close to other essential services for clients such as the shelter and overdose prevention site. Inside, clients are greeted by a homey atmosphere, with a spacious living room with couches and chairs, an accessible shower, vegetable garden, smoking shed, and snacks. Privacy is paramount, with privacy hedges on either side of the property and trellis planters to obscure the view of people smoking from passersby. Beyond the physical comforts, the clinic's ethos of taking care of others permeates staff-client interactions. From brushing their hair to encouraging clients to take their time and "stay a while" after their doses, staff work to understand and tend to clients' needs in a supportive, low-threshold environment.



OUTREACH: Service providers actively engage both new and existing clients through regular touchpoints to ensure their needs are consistently being met. This includes frequent check-ins, offering accompaniment to appointments or program site, and reaching out to those who have been absent or are experiencing transitions or challenges that could affect their engagement with care. It also offers an opportunity to provide new referrals to injectable and oral OAT programs and support clients during intake. Often, programs employ peers to support outreach given their unique ability to develop rapport and trust with new and existing clients and understand their care needs. By maintaining ongoing communication and adjusting support according to clients' evolving needs, outreach efforts facilitate client connections to care, even amidst life changes or obstacles they may face.

The Impact

Sites that have implemented strategies to respond to clients' varied needs have emphasized their effectiveness in improving engagement, care navigation and coordination, and building connections with clients.

Reducing Trade-offs

Clients often find themselves grappling with the challenge of balancing their medication schedules with other important activities or needs, which can lead to difficulties in managing time and accessing services.

This often leaves clients feeling torn between attending the program multiple times a day and participating in other essential activities or off-site services necessary for their health and well-being. By addressing clients' fundamental and diverse needs, programs can help alleviate the need for clients to choose between adhering to their medication-assisted treatment and prioritizing other aspects of their lives. This enables clients to continue engaging in care while working towards their self-defined goals.

“So, many of our clients who go to injectable OAT, will be accessing, or not accessing, primary care somewhere else, nursing care somewhere else, counselling somewhere else... food services somewhere else, they’ll be doing laundry somewhere else. And so, all these pieces and different touch points means that an individual’s ability to fully engage in their medication management is restricted.”

–Service provider

Streamlined Care Coordination

Additionally, catering to clients’ needs within one or fewer sites eases care coordination for staff. Managing care within a single site, rather than across multiple settings, streamlines the tracking of clients’ access to services, ensuring their needs are effectively addressed. Furthermore, offering services on-site increases the likelihood of client engagement, as it facilitates warm hand-offs, promoting smooth transitions between services within the clinic rather than redirecting clients elsewhere.

Increased Touchpoints

Lastly, meeting a range of client needs through multiple service offerings meant that staff had more touchpoints with clients overall. The frequent check-ins and communications with clients enable staff to build and maintain relationships with clients, positively impacting clients’ engagement in care.

“You lose people in the ten-minute walk. So, this way, it’s like, ‘Do you want to see the addiction counsellor? Sure, let’s introduce you right now.’ There’s nothing like that warm hand-off, right? Like, it’s huge. And, if it’s someone they trust introducing them to someone else, they’re more likely to take that on.”

–Service provider

Community Wisdom

Providers, experts, and clients offered advice based on their experience of responding to clients’ diverse needs. Here is what they had to say:

- Create opportunities to bring clients together to gather input and feedback (e.g., client advisory boards) to inform how to best tailor services to clients’ needs.
- Build partnerships with other agencies that can bridge service gaps (e.g., housing, food security, employment, primary care etc.) and ensure there are coordinated processes for referrals and care connections. This will make care navigation easier for both clients and staff and prevent duplicating services.

- Organize for staff to tour partnering programs and vice versa so that they have a firm understanding of the service offerings and can better help clients find the right fit for them.
- Where possible, prioritize warm hand-offs (i.e., accompanying a client to new service providers) over superficial referrals, such as handing them a card with a date and time circled on it. Warm hand-offs are more effective, as it helps clients build trust with the new team.
- Incorporate processes for continuous evaluation and revision of service delivery (e.g., weekly staff meetings focused on quality improvement).
- Develop roadmaps and survival guides to highlight key services within your local community and assist client care navigation. Regularly update the guide to ensure it remains current.
- Assess and revise policies to support staff with lived/living experience on an ongoing basis. Programs are responsible for creating accessible workplaces that are responsive to peer support workers' evolving needs.
- Start small. While addressing all clients' needs simultaneously may not be feasible, implementing small-scale initiatives or thoughtful accommodations can still meaningfully impact care outcomes.

Visions for the Future

Many sites envisioned being able to address most or all of their clients' needs under one roof to streamline access. Much of this mirrored the approaches described above including on-site pharmacy, primary care, psychosocial supports, outreach and case management, and recreational programming. They also desired more space to accommodate a post-dose hangout area and storage cubbies. These were particularly important for clients who are unhoused and for those who are concerned about leaving their belongings unattended, which in turn may deter them from attending the site.

"Having all those additional resources because there are so many outreach teams and so many organizations, non-profits, and health authorities that are doing so many different things that are overlapping. If you can start creating things that are one-stop-shop, then it's like a food fair in a mall... If you can come there with your buddies or whoever you're hanging with and, OK, I've got an appointment. OK, well, I'm going to stop in and see if I can do this. You can manage all your issues under one roof."

–Service provider

"Our clients' belongings are super important to them, and if they have a cart [to carry belongings], like, we can't allow carts in here because it's a fire hazard. So, they're not going to leave their carts at the shelter and come over here. So, even a barrier as small as to not want[ing] to abandon their stuff because they know it's going to be stolen."

–Service provider

"Well, more exam rooms, you could have nurses doing wound care, sometimes they don't have enough space to do that. Meeting rooms actually. A lunch room, we don't have [one] in the clinic space. Even a point of care ultrasound, like an area where you could actually put a machine you know? We should be evolving a little bit more."

–Service provider

Supporting Social Capital

Deconstructing Social Capital

Central to diversifying care was the need to create opportunities for clients to actively engage and participate in social life. The sites we visited defined social capital in terms of skills and connections that enable (or disable) an individual from participating in their community in a meaningful way. Sites sought to support clients' social capital by providing avenues for clients to:

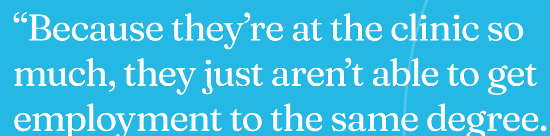
- cultivate sense of purpose
- develop a range of essential life skills
- forge meaningful relationships
- feel part of a community

Social capital initiatives aimed to offer clients diverse ways to spend their time, ranging from vocational training and daily recreational programming to self-organized activities and community meals. These initiatives largely operated under the assumption that fostering positive social capital not only enhances engagement in care but also leads to positive treatment outcomes.

Approaches to Support Social Capital

Programs sites have adopted several approaches to support positive social capital, including:

ECONOMIC ENGAGEMENT OPPORTUNITIES: Paid work opportunities for clients range from piecework to formal part or full-time employment, which can involve tasks within the program site or with external organizations. Examples include on-site roles such as peer support workers or cleaners, off-site community work, or positions with local organizations like Block Leaders or providing upkeep services to the local library or businesses. By incorporating economic engagement opportunities at or near program sites, clients develop valuable employment skills and have access to income generation opportunities despite demanding medication schedules.



–Service provider

"Maybe even like a centre where you just went and you start by getting your drugs every day and doing classes and, you know, slowly getting yourself out of it."

–Client

VIGNETTE:

Piece Work

A clinic introduced a tiered employment model, offering clients a gradual pathway into job opportunities. At the program's outset, entry-level positions require minimal commitment, involve no formal application process, and allow clients to choose their own hours. These accessible roles encompass odd jobs such as cleaning and sweeping the clinic, with daily postings available at the front desk.

As clients progress through the tiers, they encounter increasing levels of commitment and formality, accompanied by a rise in job complexity. For instance, those in higher tiers commit to set weekly work hours and may tackle more skilled tasks such as clinic maintenance. Moreover, individuals with scheduled shifts must notify a program supervisor if they cannot attend.

The highest tiers of the employment model require clients to submit a resume and supervise others' piecework. While most job opportunities are currently available on-site and leverage the program's existing cleaning budget to compensate clients, promising partnerships with local organizations are expanding horizons. These collaborations offer additional piecework opportunities such as cleaning bookshelves at the public library, broadening employment avenues, and supporting community integration.

VIGNETTE:

Peer-Led Recruitment and Education

Clients who have achieved stability with their medications can be employed as peer support workers. These clients play a vital role in the program, actively engaging with the community to raise awareness about the program, facilitating client referrals, and providing mentorship to newcomers. Outreach efforts extend to frequented areas like the overdose prevention site, where they offer information and support to potential new clients.

Beyond their outreach efforts, peer support workers also serve as invaluable sources of feedback and ideas to enhance program effectiveness. Service providers noted the transformative impact of employing clients in this way. Not only has it helped foster trust among clients, but it has also significantly improved client retention rates and dispelled misinformation about the program. For instance, one notable challenge addressed by peer support workers is the tendency for some clients to prematurely disengage from the program due to initial discomfort with medication side effects, such as pins and needles sensations. Peer mentorship provides crucial support during these critical moments, encouraging clients to persevere and continue with the program until they reach their therapeutic dose. Moreover, hiring clients as peer support workers has proved instrumental in addressing staffing shortages within the clinic. By expanding their workforce through client employment, the clinic has successfully eliminated their waitlist and expanded their capacity to accept more clients.

RECREATIONAL AND CULTURAL PROGRAMMING: Some sites offer a variety of group recreational and cultural programming, both on- and off-site. This includes cooking, gardening, drumming and smudging groups, as well as group or individual outings with peer support workers to parks or community spaces. By offering scheduled and drop-in programming, clients are afforded positive avenues for leisure time and opportunities to build a sense of community and connection with others. For example, one site has a dedicated "group room" where clients can engage in activities like colouring and board games. These services and activities provide clients with a safe space to connect with staff and other clients, enhancing the building of meaningful relationships.

SKILL BUILDING AND LEARNING OPPORTUNITIES: Program sites offer opportunities for clients to acquire new skills and knowledge. Some of these opportunities are directly linked to available employment opportunities, providing clients with job-specific training such as WHMIS (workplace hazardous materials information system) or peer support worker training. Additionally, sites aim to offer a variety of practical and vocational skills, including budgeting education workshops, life skills training, and resume building workshops.

"I have found this population harder to engage in groups than any other population with addictions. We have tried, I can't tell you, countless groups. And I think, very often, people feel like, 'The medication is what I need.' Which makes sense, right? [They] feel better, right? But we also know there's probably a lot of other things going on. So, we try to do things that are like, you come and do a craft type thing, right? Come and build dreamcatchers, anything to build relationships and community. We know that if you are lessening your illicit use, you have more time on your hands, so how do you fill that time? [Peers] take them to sweats, they take them medicine-picking, you know, just take them on various outings and through a park or something."

–Service provider

VIGNETTE:

Block Leaders

An inner-city clinic has introduced trainings and paid opportunities for clients to become "Block Leaders." This initiative, co-developed with peers, aims to address growing concerns regarding community safety and social disorder. Block Leaders work in pairs for two-hour shifts, serving as ambassadors to demonstrate and encourage positive social behaviors in their community. These behaviours include picking up discarded needles and garbage, engaging with neighbours and passersby, and alerting people using substances if kids are nearby ("Kids Up"). Training for Block Leaders is held every two weeks, and all Leaders undergo debrief sessions with a supervisor following their shift.

The Impact

Sites highlighted that supporting clients' social capital helps them to develop a stronger sense of purpose and improves their ability to engage in their communities in ways that are meaningful to them. Group activities offer a more accessible alternative to traditional therapy or counselling, providing a safe and low threshold space to build trust, connection, and relationships. This not only benefits clients personally but also contributes to community cohesion through volunteer and employment opportunities. On-site work opportunities further instilled a sense of pride by allowing clients to gain the essential hard and soft skills needed to work with others and support clients transitions into more formal employment.

"I think the things like the drumming group out in the park and the kitchen group that we're doing, just things where it's like this doesn't feel like therapy, but it is therapy, and that stuff is just the coolest stuff to me... It's really cool to [hear] people who... never want to engage in therapy' be like, 'They actually all want to engage in therapy, they just need it done in a way that fits for them,' right? Like, basic things, just creating purpose and helping them feel safe."

–Service provider

"There's a lot of clients who were not ready to engage in traditional therapy or counselling, [and] would be safer in a group setting. It's just a little less intimidating and they'll be like 'I'll go hang out in a group, I'll make muffins, I'll draw, I'll colour, but I'm not going to talk to a therapist'... We have a really full calendar of gardening group and pancake breakfast and going to the park. So, we try to give purpose in other ways because we all need purpose."

–Client

Community Wisdom

Providers, experts and clients offered advice based on their experience of implementing opportunities that support social capital. Here is what they had to say:

- Use tiered or stepped care approaches for income generation opportunities (i.e., providing options for clients that may desire commitment and responsibility as their situations and needs evolve).
- Ensure flexible scheduling and payment options for income generation opportunities (e.g., clients do not need a bank account and work can be picked up on a day-to-day basis).
- Incorporate staff oversight and supports in all employment, volunteer, and group activities for clients (e.g., supervisors review work to ensure completion of tasks and facilitate post-shift or activity debriefs and gather feedback).
- Where needed, work with staff with lived/living experience to develop individualized workplans that support their health and wellness (e.g., spaces to decompress, scheduled debriefing, outdoor walks).
- Create leadership opportunities for staff with lived/living experience.
- Food is a major draw and helps to facilitate connection and bring people together. Host community meals and/or offer snacks and beverages in group rooms or during programming to help engage clients and create community.

"It's a way of getting people employed as pieceworkers, so they get paid in cash, right after the job is finished, or they can then move up where they could get paid weekly or biweekly. But at first, they don't even need a bank account."

–Service provider

- Implement specific training sessions and capacity building opportunities for clients that cater to their interests and needs (i.e., that are job-specific or build essential skills).
- Partner with local businesses to provide piecework or volunteer opportunities for clients (i.e., regularly scheduled or one-off opportunities).

"I think there's obviously a lot of room that we can improve. But, you know, we have a pet therapy dog that comes in, and people just love that, right? We have fish tanks in some of the offices. But, ideally, what we want is peers to work on stuff like, what do people in the clinic want? What do they want to see? What would make them more comfortable?"

–Service provider

"So a local employer can say, oh maybe I need people regularly for something. Like the public library already hires two of our people for deep cleaning that [their] regular cleaners don't want to do when it involves taking every book off the shelf, dusting and cleaning the shelf. So, they [clients] do that."

–Service provider

Visions for the Future

Key informants offered a wealth of ideas to expand and strengthen social capital approaches in OUD care, including:

VOLUNTEERING AND COMMUNITY ENGAGEMENT

Sites discussed the desire to get clients involved in volunteer opportunities such as walking rescue dogs from the local shelter.

PEER SUPPORT PIECE WORK

Building on the cleaning program, a site proposed using the same piecework approach for peer support work opportunities. The tiered approached would allow clients to build their skills in peer support work in a way that is flexible and low barrier, providing opportunities for increased responsibility and commitment over time. For example, this may involve assisting with putting together safer injection kits at the first level and accompanying a client to a scheduled appointment at one of the higher levels.

SKILLS SHARING

Offering opportunities for clients to showcase and share their skills with others by running a workshop such teaching other clients how to make beaded earrings.

Spectrum of Medications and Formulations

Defining a Spectrum of Medications and Formulations

Sites unanimously agreed that offering a range owf medication and formulation options is essential for engaging and retaining clients in care. However, there was also consensus that the current system is overly complicated and prohibitive, making it challenging to be dynamic and responsive to the increasingly potent and evolving illegal drug supply. Although our work did not delve into specific regulatory barriers, we heard evidence that sites lack access to diacetylmorphine and other medications and formulations, placing significant stress on care providers. Sites expressed a desire for access to medications and formulations that:

- Match the potency of drugs available in the illegal market.
- Are available in a range of formulations that aligns with clients' preferred method of administrative (e.g., powdered, inhalable, injectable, intranasal, transdermal, and oral) and/or can be reconstituted by the client.
- Are available in doses that match clients' tolerance needs or can be provided in combination with other agents based on the client's needs.
- Allow the provider to discuss options with clients and offer person-centered care.
- Offer flexible monitoring such as longer prescriptions or carries for clients who have stabilized.
- Are available in acute care settings, long-term care, and correctional facilities to support treatment continuation of care during transitions.

> [Describing the impact of offering clients medication/formulation options]: "From an OAT clinic perspective, you had few things that you could offer and it didn't fit for them so it's always nice to be like, 'You would be a good candidate for this' and... 'You might be a good fit for that.' So just having that option was always nice rather than to say, 'Well, I don't have anything for you, sorry.'"
>
> **–Service provider**

Despite funding and regulatory constraints, each site offered as many options as possible. Some sites offered injectable hydromorphone and diacetylmorphine, fentanyl patches, and oral alternatives, others offered only injectable and oral hydromorphone. This capacity to provide clients with options allowed sites to offer clients more autonomy, enabling them to better individualize care to clients' unique needs—both key principles of providing client-centered addiction care.

The Impact

Offering a diversity of medication and formulation options has profound positive implications on client care outcomes. Individualized treatment options and shared decision-making, around both medication and dose, have shown to increase treatment satisfaction and improve quality of life scoring.[22,23] This is true for both oral and injectable OAT [24–27], whereby clients who like the medication they are receiving are more likely to feel satisfied with their dose. Simply having a few pharmaceutical options for clients to choose from is very empowering for them and their care. Moreover, allowing clients to trial different prescribed alternatives until an effective treatment is developed facilitates smooth transitions from one medication to another. Lastly, co-prescribing of medications to optimize client stability has also been beneficial in retaining people in care. Thus, offering clients choice to find and access a medication that best fits their needs not only contributes to care engagement, but is also necessary to facilitate shared decision-making and promote client autonomy.

"But yeah, our numbers, we didn't have very good engagement prior because people didn't… really like the hydromorphone, right? But now we're busy, busy, busy. So, we've got all 30, 35 on injectables, they're coming mostly three times a day."

–Service provider

"This works. It really is the thing that's keeping me from, you know, going crazy, to tell you the truth… I don't know how. It helps with the sickness for sure. It gives you that kind of a blanket so that you don't have to go… look for drugs you know?… I mean it's not enough but it's enough, you know what I mean?"

–Client

Visions for the Future

WIDE RANGE OF MEDICATION OPTIONS

All sites were eager to diversify injectable and oral OAT to include medications that better respond to clients' increasing tolerances. Specifically, most sites desired access to fentanyl and diacetylmorphine in a range of formulations. Moreover, key informants emphasized the need to build out a non-opioid depressant program due to the increasing prevalence of non-opioid depressants such as benzodiazepines and xylazine in the illegal supply, leading to unintentional dependence. Providers also desired medications to be manufactured in higher potencies given clients' rising tolerance. Lastly, in acknowledgement that many clients are polysubstance users, sites stressed the need to expand stimulant replacement treatments.

"If you had diabetes we wouldn't be like, oh, it's not covered. Instead of giving you the insulin that you need we're going to give you something else."

–Service provider

"They should offer a better benzo program. That's what I think, personally. And that's what's mostly in fentanyl now is benzos. That's what people are paying for."

–Client

"But the real elephant in the room is fentanyl, right? It's very hard for diacetylmorphine to compete with fentanyl because most people don't want diacetylmorphine, sadly."

–Service provider

"I'd like to see more medications added. I don't think hydromorphone, given the current tolerance that we see for people even at very high doses, it's not meeting the needs of everybody. So, we are having people who don't stay in the program, or who really want to stop using fentanyl or carfentanil, but hydromorphone at the doses we're using are not sufficient for that. I'd like to try diacetylmorphine if we had access to it here, or something else, because I don't think we're meeting the needs."

–Service provider

INHALABLE AND OTHER FORMULATION OPTIONS

Clients and providers stressed that the current injectable and oral OAT programs do not effectively reach individuals who smoke substances. Hydromorphone, diacetylmorphine, and fentanyl are not currently available in inhalable formulations. As a result, this treatment is not an option for the growing number of people who inhale rather than inject. Moreover, maintaining a consistent method of administration, such as inhalation, is essential to clients to remain engaged in care. Sites envisioned a future where they could readily offer intranasal prescriptions or powdered formulations that could be reconstituted for inhalation (e.g., powdered diacetylmorphine or fentanyl). This would require funding and operational support to retrofit clinics to meet the air exchange requirements for medications to be inhaled onsite, meet work safe regulatory requirements to ensure staff safety, and facilitate filter collection and disposal.

"If we could have this type of package for smokers ... If we could prescribe substances that they inhale in the clinic to capture people that need this model... that don't inject and, therefore, don't qualify. It's just such a beneficial model for many people that are quite low functioning."

–Service provider

"The other thing is, we're still not able to fully engage people who are smoking large amounts of fentanyl or carfentanil. We obviously don't want them to start injecting. We don't have another option. If our oral agents don't work, we're really limited."

–Service provider

COST-EFFECTIVE FORMULATIONS

Providers were eager to offer formulations that would reduce the resource intensity involved in preparing and dispensing injectable and oral OAT medications, particularly in the context of injectable OAT. Providers desired formulations that could be readily prepared in advance (pre-filled with appropriate dosed syringes), with a longer shelf-life, or that clients could reconstitute themselves into their desired formulation (e.g., a powder version that could be smoked, snorted, or diluted for inhalation).

INNOVATE CLINICAL PRACTICE AND GUIDANCE

Providers desired clinical guidance to accompany powdered formulations as well as guidance on how to manipulate pharmaceutical products to meet clients' needs. Where this is not possible or non-existent, they desired mechanisms that would allow clinics to pilot strategies outside the product monograph or clinical guidelines (e.g., opening vials and weighing medications intro sachets or gelatin capsules) and protect them from reprisal or reprimands from regulatory bodies such as colleges or partnered agencies. This would encourage agile and creative approaches to treatment, enabling providers to tailor emerging approaches to the unique needs of their clients without the fear of punitive actions.

VIGNETTE:

Intranasal Heroin-Assisted Treatment Safety and Feasibility Study

In a recent study, researchers examined the safety and feasibility of intranasal heroin-assisted treatment (HAT) over a four-week period.[28] This multicenter observational study, conducted in Switzerland, aimed to assess the viability of administering heroin nasally as an alternative delivery method within a supervised treatment context. The study employed a supervised administration model, where participants received intranasal heroin doses under the direct supervision of healthcare professionals. The administration process involved the preparation of a liquid heroin solution, which was then atomized into a fine mist using a specialized nasal delivery device. Participants self-administered the intranasal heroin doses through each nostril, ensuring consistent and controlled delivery of the medication.

Preliminary findings from the study indicate promising results regarding safety, feasibility, treatment adherence, and patient satisfaction. Participants demonstrated high levels of adherence to the intranasal HAT regimen, with the majority successfully completing their scheduled doses throughout the four-week observation period. Additionally, patient satisfaction with the intranasal delivery method was notably high, with participants reporting favorable experiences and expressing a preference for this approach compared to traditional injection methods. This study highlights the potential of intranasal HAT to enhance treatment adherence and patient satisfaction, offering valuable insights that could inform the development and implementation of future opioid-assisted treatment programs.

VIGNETTE:

Evidence for Inhalable Heroin Treatment

Offering a range of formulations for diacetylmorphine is not new. For over two decades, inhalable diacetylmorphine has been approved in the Netherlands as a treatment option for individuals who have not responded to conventional OAT. Beginning in 1998, a multicentre study investigated co-prescription of diacetylmorphine and oral methadone maintenance (MMT) in the Netherlands. The study consisted of two randomized controlled trials: one comparing injectable diacetylmorphine + MMT to MMT alone, the other comparing inhalable diacetylmorphine + MMT to MMT alone. The findings showed that 12 months of methadone plus diacetylmorphine was significantly more effective than 12 months of methadone alone. This was true for both injectable and inhalable diacetylmorphine.[29] Another trial conducted between 2011 and 2013 in Belgium found similar results, including a significant reduction in illegal heroin use and a significant decline in self-reported benzodiazepine use among both groups receiving either injectable or inhalable diacetylmorphine relative to those in the MMT group.[30]

Several pharmaceutical diacetylmorphine products are commercially available in Europe and the UK including injectable, immediate release tablets, slow-release tablets, and a powder base for inhalation.[31] This demonstrates that there is not only an evidence base for inhalable diacetylmorphine, but also the infrastructure to procure it in a range of formulations that meet clients' needs.

Threats

In our conversations with key informants, several threats to diversifying injectable and oral OAT emerged. Threats were characterized as factors that constrained programs' abilities to meet the four core elements of diversified care: flexibility, responding to clients' diverse needs, supporting social capital, and providing a spectrum of medications and formulations. The degree of constraint varied by site, especially between provinces and territories with different regulatory and funding landscapes.

Occupational Stress and Burnout

Many injectable and oral OAT programs rely heavily on the unwavering dedication and perseverance of their staff to serve clients to the best of their ability within the context in which they work. However, occupational stress and staff turnover are prevalent. Service providers often grapple with navigating restrictive regulatory environments that conflict with the provision of evidence-based and person-centered care. Tensions arise when providers cannot find flexibility within or outside the healthcare systems to improve client engagement, which in turn can strain therapeutic relationships.[32] Additionally, burnout is a significant concern, often compounded by the high demands placed on healthcare providers. Many are so committed to delivering exceptional care that they find themselves overworked, especially in the face of understaffing, which increases the risk of burnout.

> “They [regulators and administrators] grab you and you’re like, ‘Urgh you can’t do that. God, I can’t do that. I can’t do that… [referencing approaches to diversify care].’ That’s really hard when you’re used to just doing what needs to be done for the patients. But we’re working with that. We’re working within that. But we push boundaries… because the health authority doesn’t really understand what’s going on, so you just have to push. So, it can get tiring for people who work in this kind of field, butting heads all the time.”
>
> **–Service provider**

For instance, a client receiving outreach injectable OAT care during the COVID-19 pandemic expressed it was unnecessary for his care team to come so many times per day (i.e., once would have been enough). Despite a shared desire to dispense take-home doses, this was not possible due to restrictive regulatory structures beyond the control of both the provider and client.[15] This situation highlighted an opportunity to reallocate resources (i.e., staff) to other clients who might need more personalized care and to offer more flexibility to both client and staff based on individual assessment.

> “We joke in meetings about, ‘Okay, whose stress leave is next? Can we just sequentially do it, because if we were all off that would be bad.’ Which is sick. So sick. It’s really disturbing.”
>
> **–Service provider**

Moreover, frontline care providers uniquely shoulder the responsibility of developing close connections with clients while frequently performing emergency medical procedures on them. Another significant contributor to stress is witnessing the structural violence inflicted on clients, which is largely beyond the providers’ control to prevent or appropriately respond to. The helplessness one experiences when realizing clients may not return to the clinic because they died overnight or were evicted or arrested weighs heavily on staff. Moral distress and subsequent moral injury are compounded by vicarious trauma.

The current healthcare staffing crisis further intensifies these challenges. Many new healthcare workers are coming straight from school and have not received adequate training or mentorship, which leads to a stressful work environment. Precarious funding models exacerbate this issue. These models often provide only the bare minimum resources necessary to sustain important work, leading staff to show up early, bring food from home, or buy supplies out of their own pockets. Such funding constraints, coupled with the restrictive nature of being beholden to a health authority, limit a program’s ability to act nimbly and adapt to changing participant needs and emerging trends.

> “I’m being told I have to be compliant, however my clinical opinion is that this [regulation] is not evidence-based, this is harmful… We’d like to keep working but we’re seeing patients fall apart left, right, and centre.”
>
> **–Service provider**

Provincial/Territorial Drug Formularies

All sites expressed frustration regarding the limited access and choice in injectable and oral OAT medications and formulations through their respective provincial or territorial drug formularies. In certain regions, specific medications, such as diacetylmorphine, were entirely absent from the formulary for substance use, while in others, medications such as fentanyl were only covered for indications of pain management. In some cases, medications that were on the formulary were only covered in doses that do not align with the tolerance needs of clients. Moreover, many of the commercially available products are manufactured to treat pain and therefore are often insufficient for clients with OUD.

Providers also stressed that the current medications and formulations don't lend themselves to flexible delivery methods (e.g., frequent clinic visits 3–5 days) nor are they feasible for rural, remote or other sparsely populated communities. This creates inequities in access to the medication. Thus, medications need to be available in more stable forms such as powdered formulations that can be reconstituted a variety of ways at point of care or by the client themselves.

> [Discussion about mismatch between doses on the formulary and clients' tolerances]: "But I think the issue with that is the only thing that's covered is like the 50 microgram patches. So, you know, again if… a substance user has a high tolerance using fentanyl… we're going to just slap quite a few 50 milligram patches on them."
>
> **–Service provider**

VIGNETTE:

Limited Potency of Available Manufactured Products

In the current landscape of injectable and oral OAT medications and formulations and prescribed alternatives, healthcare providers and clients face significant challenges due to the limited potency of available manufactured products. These limitations not only affect the ease of administration but also impact client compliance and comfort. For example:

DIACETYLMORPHINE ADMINISTRATION:

- **Product Available:** Diacetylmorphine comes in 200mg vials, with a concentration of 100mg/mL.
- **Typical Dose Requirement:** A standard 400mg dose requires administration of 4mL.
- **Resulting Issue:** Clients are required to inject large volumes.

FENTANYL TRANSDERMAL PATCHES:

- **Product Available:** Each patch releases fentanyl at 100 micrograms per hour.
- **Typical Dose Requirement:** For a dose of 1000 micrograms per hour, a client needs to use 10 patches simultaneously.
- **Resulting Issue:** Wearing multiple patches is impractical and often clients run out of surface area for the patches.

FENTANYL INJECTION:

- **Product Available:** Fentanyl is supplied in a concentration of 50 micrograms per mL.
- **Typical Dose Requirement:** To achieve a minimum dose of 100 micrograms, a client must inject at least 2mL.
- **Resulting Issue:** The necessity to inject a higher volume can contribute to injection-related complications.

Red Tape to Access Medications

In a similar vein, sites highlighted the administrative red tape associated with accessing medications that are listed on their provincial/territorial drug formulary (e.g., one-to-one prescribing, funding from health authority) as well as the difficulties obtaining new formulations like powdered diacetylmorphine which have not been added to the drug formulary. For example, a stipulation of the provision of diacetylmorphine by the manufacturer restricts access to health authority overseen pharmacies, most of which are licensed as hospital pharmacies. This in turn creates significant administrative barriers and limits flexible delivery models such as in community pharmacies. The current inability to access diverse medications and formulations hinder the ability to meet clients' tolerance needs and preferred method of administration, ultimately negatively impacting their engagement in care.

"I hope, given that it's in the legislation, I hope that in the future we do have the autonomy to prescribe one of those three that's written within the legislation: hydromorphone, fentanyl, or diacetylmorphine, based on the clinical presentation and what we think is probably most effective."

–Service provider

"I think there needs to be a little bit more flexibility around where doses are witnessed. Currently under [provincial legislation] anyone involved in [injectable OAT program] those doses have to be at the clinic. And with only [several] in the province, people are—it's not that easy for everybody who might benefit, to get to one of those places multiple times per day. And we do have precedent for delivering high-intensity care and service and chemotherapy and dialysis, many other things that people need to have regularly. We have been able to figure out how to do that safely in a more distributed model, to provide greater access. So, I think that would be another thing to consider is whether, could we, once all the kinks are worked out, find a way to increase access to that program, but still maintain safety for patients and the general public?"

–Service provider

Regulatory Constraints

Related to the challenges with accessing diverse medications and formulations, various aspects of pharmacy and prescriber regulations were discussed, highlighting their impact on the delivery of injectable and oral OAT. This encompassed restrictive policies related to dispensing, compounding, drug stability, and witness dosing, as well as challenges with documentation and record-keeping systems (e.g., PharmaNet, auditing by the Ministry of Health (or similar)). While our work did not delve into the root cause or factors influencing these constraints, it was evident that system-level regulations create a trickle-down effect on how care is provided on the ground including prescriber and pharmacist comfort and causing hesitancies.

For example, the current system leaves pharmacists vulnerable to being audited by the Ministry of Health (or comparable authority), particularly if a client misses a dose or if the prescription dates do not match the quantity specified (a common error or miscalculation by busy prescribers). This in turn, restricts pharmacists' ability to be agile to clients' needs and can create tensions between pharmacists and prescribers due to the necessity of more frequent faxing of clinics and physicians. As a result, there are calls to provide community pharmacists with the means to officially "adapt," "amend," or "revise" OAT prescriptions to ensure they can provide person-centered care without fear of financial recourse.

Additionally, fear of reprisal by the Colleges was also a major concern for both prescribers and pharmacists. It is important to note that while the Colleges do not create clinical guidelines, they do use them to inform regulating practices. However, the current OUD guidelines have been criticized as being too conservative, leading to similarly conservative regulations. This creates a dichotomy: providers are encouraged to use their clinical discretion and treat clinical guidelines as a "guide," yet the rules and regulations they are bound by do not allow significant deviation from these guidelines. The key issue is not changing the guidelines themselves, but re-examining the types of tools and evidence, including clinical guidelines, that should inform practice regulations. This re-examination is crucial for fostering practice change.

Reduced Funding for Ancillary Programs

As previously discussed, the success of injectable and oral OAT is not only about the medication, but also on ancillary services such as food, hygiene, psychosocial support, self-management programs, support groups, education, and recreation. However, many programs have faced funding cuts, leading to various repercussions including staffing reductions and reduced food service offerings. In response, some sites have attempted to bridge these gaps by bringing in their own supplies, such as oatmeal and granola bars, or by offering clothing donations. Nonetheless, this ad hoc response is not sustainable. Food programming and other ancillary services must be recognized as integral components of injectable and oral OAT programs and as equal in importance as the medication itself. Additionally, it is important to note that in BC (and other provinces), pharmacists are not funded for anything other than dispensing and witnessing methadone (witnessing of other medications is not funded). Client support, assessment, deliveries, and other services are not funded, necessitating a significant shift in the funding model for expanded care.

"That's why we bring in stuff. I'll stash some oatmeal in here for the people that I know, or hot soups, we'll bring in our own. It's hard for us to stand here at the door and just tell somebody, 'Sorry, all I have is coffee, you have to starve today.' It's terrible."

–Service provider

"They need to expand these programs, not cut them and whittle them back. Like I said, just a little bit of things like cutting oatmeal, you can't tell me that's a big expense."

–Client

Prescriber Autonomy

Currently, injectable and oral OAT programs are predominantly physician led. While some provinces permit nurse practitioners, registered nurses, and registered psychiatric nurses to prescribe, others restrict prescribing privileges solely to specialized physicians (i.e., Addiction Medicine). Key informants emphasized the implications of this arrangement, particularly regarding the challenge of expanding these programs to rural and remote areas where physicians are scarce, let alone specialists. Nurses certified to prescribe OAT in BC also face challenges. Currently, their scope is too limited to practice autonomously (e.g., they cannot prescribe dual OAT even though this is common for most clients).

Additionally, in Alberta, short-acting opioid for the indication of OUD cannot be prescribed outside of the Narcotic Transition Services clinics. This significantly restricts the number of prescribers that can offer this treatment option. Moreover, prescribers must get approval from the Provincial Medical Director to prescribe certain short-acting opioids within these settings. Consequently, many providers are only granted approval to prescribe hydromorphone, despite legislation allowing the prescription of diacetylmorphine and fentanyl. These additional criteria, along with bureaucratic hurdles, significantly hinder the potential reach of injectable and oral OAT and impede equitable access.

"I don't believe that is the case in the rural centres. I think that the nurse practitioners have been kind of delegated to providing primary care instead of treating opioid use disorder. And because they're not addiction medicine certified the regulation also specifies that they cannot do certain things. And so, that's taken away some of the things that they could do in the urban centres, also prevented some of that care that they could provide in the rural settings."

–Service provider

[Discussing limitations of policy and regulations for prescribing injectable OAT]: "How do we support people's competency and interests and either build the skill [prescribing and administering injectable OAT] if they're missing it or absolve them of the need to be involved and have the people that want to be involved, involved at that level... I don't work in oncology, I know nothing about chemo, so I don't work there. I do know about this [injectable OAT prescription and administration]. That's why I work here. But they've taken people who are not skilled or competent in prescribing a certain treatment strategy in charge of deciding how other people should provide this certain treatment strategy. It's eroded relations across addiction medicine and between physicians and nurse practitioners who can't get those credentials but who've worked a lot in the field."

–Service provider

Managing the Fear of Diversion

Key informants outlined the challenges stemming from concerns about medication diversion and its impact on the administration and delivery of injectable and oral OAT. Medication diversion causes stress for providers and the community. However, diversified opioid prescriptions can support clients and providers by allowing them to choose the medication that match the clients' needs, lessening the risk of disposal. Additionally, a system of support can understand the situations clients may experience that prompt them to share their medications. This is very important, as fear of diversion often serves as a rationale for imposing

restrictions on aspects of care such as take-home doses, which can limit the flexibility and accessibility of injectable and oral OAT. Providers and clients expressed that, there is little to no rigorous evidence suggesting that diverted OAT medications are used by individuals other than regular users of criminalized opioids, or for purposes unrelated to managing their own OUD in the absence of care that meets their needs. While they are not suitable for everyone, key informants stressed that take-home doses are an important and necessary option along the continuum of care. Providing take-home doses allows for tailored care to meet clients' needs, such as facilitating employment, accommodating caregiving responsibilities, or granting more freedom from the program site. These measures foster stability in both their health and personal life hence reduce the likelihood of diversion. Providers advocated for the inclusion of injectable and oral OAT carries in routine conversations with clients.

VIGNETTE:

Unpacking Diversion

In the complex landscape of OUD treatment, the practice of take-home doses has spurred extensive debate, particularly concerning the risks and benefits associated with medication diversion. Diversion—defined as the selling, trading, sharing, or giving away of prescription medications [33] is often viewed with suspicion and considered a risk to be managed. However, a growing body of evidence challenges these traditional fears, suggesting that the narrative may not be so straightforward.

Systematic reviews have revealed insufficient evidence to suggest that arbitrary restriction on take-home doses effectively reduces diversion.[34,35] Providers who implemented flexible take-home policies observed minimal or no increase in diversion, overdose, or adverse events. Initially cautious, these providers were reassured when anticipated negative consequences did not materialize, leading them to support increased flexibility and take-home doses.

Studies have shown that diversion often stems from unmet treatment needs rather than nefarious intentions.[35–40] For instance, people might share medications out of compassion for others in pain or withdrawal, due to survival or financial necessity, or in response to threats of violence, theft, or conflict.[39,41] This highlights a complex socio-economic dimension requiring careful consideration and understanding. Keeping clients and their loved ones safe necessitates a person-centered approach that considers these intersectional aspects of people's lives. Educating clients on the risks of sharing medications, such as increased withdrawal or adverse reactions, and collaborating with outreach teams to support clients outside clinical settings are some of the non-punitive measures that can help prevent diversion.

Clients provide valuable insights into diversion, influenced by their experiences with punitive addiction care policies. In a study on take-home doses of injectable OAT, clients showed no intention to divert their medication, emphasizing their need for it: "And I ain't going to share my dose because I need it. And mostly everybody in their needs it. They can't go and sell their dose because you ain't going to get it." – Reese.[14]

However, they feared that others diverting their medication could jeopardize everyone's access to take-home doses: "There's always a fear that somebody will wreck it for the rest of us by trying to sell their dose." – Jude.[14]

While risks associated with diversion exist, addressing them by treating clients like criminals is not the solution. Just as it would be unreasonable to remove someone's EpiPen prescription for sharing it, a more compassionate and understanding approach is needed: "I think you just have to give people the benefit of the doubt until they make a mistake, and then you have to figure out a way to make it work for that person. Because not everybody's—we don't all have the same life."[14]

These perspectives highlight the importance of addressing diversion situations on an individual basis, rather than imposing blanket restrictive and punitive measures that remove crucial care options from all clients. A more balanced, person-centered approach would consider individual client circumstances, aiming to address root causes of diversion such as economic hardship or lack of access to appropriate medications. "We gradually worked out who needed let's say closer supervision for their own safety, right?"[38]

The discourse on diversion needs to shift from one of control and restriction to one that is individualized to each client and their context. By focusing on empowering clients and addressing their broader needs, we can foster a system of care that reduces the need for diversion while enhancing the efficacy of OUD treatment.

Tensions Between Evidence Standards and Practice Innovation

As previously discussed, both prescribers and pharmacists are weighed down by a fear of getting in trouble with the college, creating a culture of stagnation. Providers are reluctant to try new approaches including prescribing off-label unless they are supported by robust evidence and receive written protection from the college. Key informants emphasized the need to shift how we approach evidence generation, advocating for avenues that encourage providers to use innovative methodologies and bring forward practice-based evidence to establish indications for the treatment and care of OUD. Current approaches to evidence generation are overly restrictive, failing to reflect the intricacies of real-world addiction medicine and take too long to implement, which is particularly problematic during a crisis when rapid solutions are needed. We do not need to sacrifice rigour for innovation instead, we need strategies to support practice change and reduce prescriber and pharmacist fear. This might include creating agreements between the colleges and certain prescribers or pharmacists to pilot new approaches, receive an exception, or other forms of support, all formalized in writing. Additionally, it is crucial to support providers in accessing the global evidence base to inform their clinical decision-making and create an environment that encourages providers to share their clinical protocols. Currently, the fear of deviating from the clinical guidelines and regulations discourages this knowledge sharing, leading providers to keep their proof of concepts within their inner circles.

Conclusion

Our fieldwork underscores the critical role of diversified OUD care in supporting person-centered care in addiction. It identifies smart practices such as flexible delivery options, responsiveness to clients' diverse needs, support for their social capital, and offering a range of medications and formulations. These elements provide a framework for policy and decision-making, encouraging us to embrace being dynamic and creative in our approaches to OUD care.

It is important to re-iterate that there is no one-size-fits-all approach to OUD care. All of these options need to be viewed on the same playing field and normalized, regardless of where they fall along the continuum of care. Although not all the options presented will be feasible or appropriate for every situation, it is worth discussing the possibilities to pave a way forward. This report is meant to serve as inspiration and offer ideas to diversify OUD care for different people and places. We encourage you to use it as a resource to facilitate discussions within your own organization and settings.

When people with OUD are provided with care that meets their needs, is accessible, and can effectively treat their disorder, remission becomes possible, their quality of life can improve, and engagement in risky or illegal behaviours can be reduced. Diversified approaches to OUD are a long-term solution that benefit clients, providers, and the greater community. As such, policies and practices must be shaped to not only promote but facilitate this framework, aligning with the needs of people with OUD and those dedicated to supporting them. In doing so, we can reduce reliance on the toxic unregulated drug supply and promote the well-being of individuals, families, and communities impacted by this crisis.

Tools and Resources

- **Carries Real Stories:** https://med-fom-ioat.sites.olt.ubc.ca/files/2023/08/iOAT-booklet-web.pdf
- **Carries Clinical Guidance:** https://med-fom-ioat.sites.olt.ubc.ca/files/2023/06/IOAT_Clinical_Guidance_document_21JUN2023.pdf
- **Carries Client Education Brochure:** https://med-fom-ioat.sites.olt.ubc.ca/files/2023/10/Client-Education-Brochure.pdf
- What's included in my prescription client brochure: https://med-fom-ioat.sites.olt.ubc.ca/files/2023/07/Take-Home-Client-Information-Guide_21JUL2023.pdf
- **Clients' experiences on North America's first take-home injectable opioid agonist treatment (injectable OAT) program: a qualitative study:** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10215060/
- BCCSU ECHO
- Creating forms or groups chats with other colleagues working in the field (e.g., fellow community practitioners, hospital-based colleagues, rural connections etc.). This allows you to share your questions openly.

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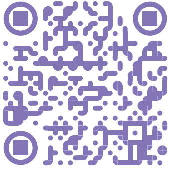

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