APPENDIX B

Core Services Model

A Component of British Columbia's Substance Use Framework

BRITISH COLUMBIA
Ministry of Mental Health and Addictions

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Background

Objectives

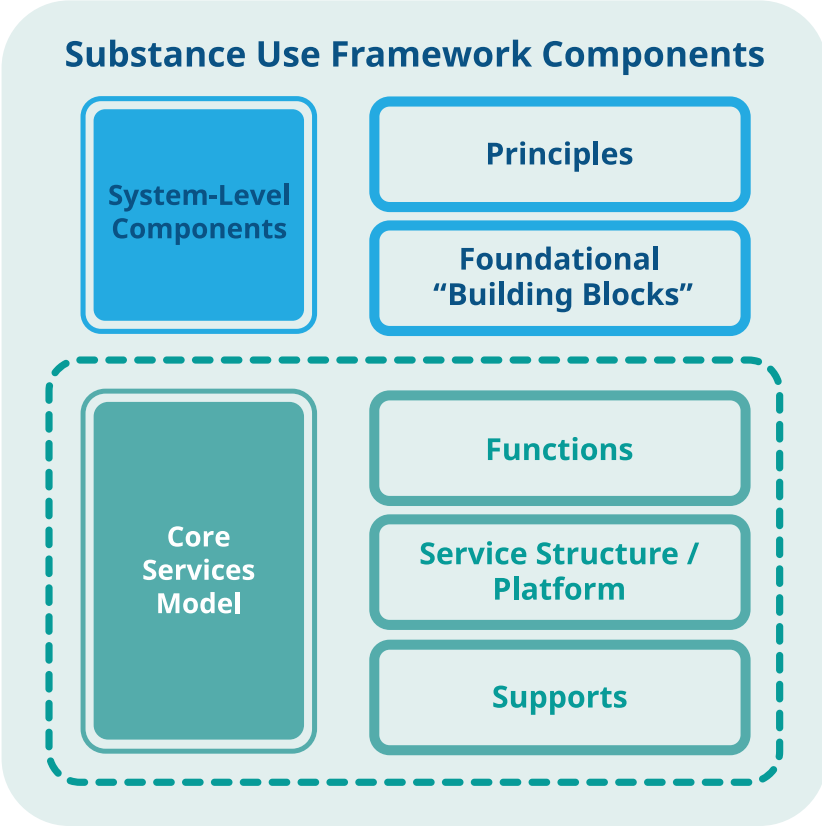
As part of a broader planning process in support of the implementation of the goals and priority actions of *"A Pathway to Hope: A Roadmap for Making Mental Health and Addictions Care Better for the People of British Columbia"*, the BC Ministry of Mental Health and Addictions is developing a framework for the substance use system of care.

A component of this work is the development of a core services model of services and supports, incorporating the input and feedback from partners and stakeholders.

This document is a working draft that includes system-level elements that are relevant for the development of the broader Substance Use Framework, as well as a specific Core Services Model.

The development of a Core Services Model for British Columbia is intended to be a tool to guide the province's thinking about system needs and gaps as it develops and invests in an adult Substance Use Framework. Within this broad objective there are many specific requirements, including:

- The need to align substance use core services between the adult and youth systems, with



particular attention to youth and young adults transitioning or entering the adult system.

- The need to articulate a full continuum of care with special emphasis on facilitating the transitions within this continuum, as well as to and from other required health and community services and supports.
- The need to acknowledge the role of a wide range of health service providers, sectors and community services that are critical to supporting people who use substances (e.g., mental health, primary care, housing) while articulating the full continuum of more specialized substance use services.

Core services models are a critical part of implementing a comprehensive provincial strategic plan, as articulated in *A Pathway to Hope*. Almost all provincial and territorial governments have developed and utilized a core services model for substance use and addiction, often in conjunction with mental health services and supports. It is intended that a BC-specific Core Services Model will contribute to the development of the Substance Use Framework and inform government's work as we continue to build a coordinated, integrated, and interdisciplinary substance use system.

Scope

In Scope

Specialized substance use services and collaborating partners: It is now widely accepted that a broad *"whole-of-government"* approach is needed in order to affect a population-level impact of public investments in substance use treatment and support systems.[1, 2] This calls for investment along a continuum of services specifically mandated to provide services and support to those who use

1 Babor, T. F., Stenius, K., & Romelsjo, A. (2008). Alcohol and drug treatment systems in public health perspective: mediators and moderators of population effects. International Journal of Methods in Psychiatric Research, 17(S1), S50-S59.

2 Rush, B. and Urbanoski, K. (2019). Seven core principles of substance use treatment system design to aid in identifying strengths, gaps, and required enhancements. J. Stud. Alcohol Drugs, Supplement 18, 9–21.

substances, including screening, assessed high-risk or diagnosable substance use disorders, and improved access and coordination to a wide range of providers of health and social services. The BC Core Services Model will pay particular attention to the former, referred to as "specialized" substance use service delivery platforms, while also recognizing the critical role for the latter, referred to as "core collaborating service providers" including mental health, housing, and primary care services. Several of these core collaborating service providers play an especially important role in the substance use system, though their scope may be much broader than just substance use. This includes primary care, corrections, and private providers which will be discussed in further detail below.

Adults and young adults: A broad systems view of substance use services includes careful consideration of developmental age when planning, delivering, and evaluating services.[2] This framework will focus on both adults and transition-age youth, aged 19-24, given the critical importance of smooth transition from youth to adult services.

Indigenous peoples: The substance use framework and core services model is inclusive of the needs of Indigenous peoples in BC. They are intended to be adapted, as needed, by communities to include Indigenous values and worldviews, and specific cultural and land-based treatment and support models.

Out of Scope

Children and youth: Children and youth are out of scope for this Framework. The ministry is also undertaking work on a children and youth-specific substance use framework.

Tobacco use and tobacco use disorders: The focus of the substance use framework is exclusive of tobacco-use disorders, while recognizing the importance of concurrent tobacco use among people experiencing harms related to alcohol and other substance use, as well as the importance of substance use services and supports having comprehensive organizational tobacco use policies and to provide linkages to smoking cessation interventions.

Gambling, gaming and other "behavioural addictions": Compulsive gambling, formally defined diagnostically as an impulse control disorder, is not being considered within the substance use framework, while recognizing that there are people who use substances among people seeking help for their gambling related concerns. The same can be said for "addiction to gaming", which is of increasing concern among substance use, mental health, and other health care professionals. While gaming and other "behavioural addictions" such as shopping, food, sex, and love, will not be formally included in defining core services, it is acknowledged that specific supports may address these challenges within a given substance use core service or a collaborating service provider such as mental health or primary care.

Foundational Work for a BC Substance Use Framework and Core Services Model

Not all substance use is problematic; humans have used substances for various purposes, and with varying impacts, for thousands of years. Substance use occurs along a spectrum of beneficial to harmful use, which includes diagnosed substance use disorders. For most people, the use of psychoactive substances does not lead to chronic dependence, though many harms may still result from non-dependent use, such as binge drinking or driving under the influence of substances.

Given this, and with increasing rates of illicit drug toxicity events and deaths, in recent years both mental health and substance use have received considerable attention in BC, and Canada more broadly. This resulted in a wide range of reports and initiatives that provide a solid foundation for the development and implementation of a tailor-made core services model for substance use services in BC. Recognizing that there are many initiatives that point to the need for such a model, we highlight below several important pieces of work for this strong foundation, some specific to BC, and a small number that are national in focus.

Major Provincial level Initiatives

A Pathway to Hope: *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia (2019)* provides a strong rationale for strengthening BC substance use (and mental health) services, including calling specifically for the development of a Substance Use Framework to provide *"a clear roadmap for developing quality, effective, efficient, and innovative service delivery models in the years ahead"* [3].

3 *Pathway to Hope – A Roadmap for Making Mental health and Addictions Care Better for people in British Columbia, p. 25*

Provincial response to illicit drug poisoning deaths: The Overdose Emergency Response Centre (OERC) was established in December 2017 within the Ministry of Mental Health and Addictions to coordinate the province's response and to spearhead urgent action to save lives and help connect people living with substance use disorders to treatment and recovery services.

Primary care networks and specialized community services programs: Government is continuing its efforts to develop and implement community-based primary care networks and specialized community service programs to enhance access to team-based care for individuals experiencing mental health challenges and harms from substance use and is also working to implement MHSU Specialized Community Service Programs across the province.

In Plain Sight report: Government has committed to implementing the recommendations detailed by a 2020 report that reviewed anti-Indigenous racism within the health care system. As part of this response, the Ministry of Health has taken several strategic actions to support system-level transformations to improve culturally safe care for Indigenous peoples and address instances of racist care interactions, including appointing a new Associate Deputy Minister to oversee implementation of the report's recommendations and supporting the development of a tool to report unsafe and racist care experiences.

Other Foundational Initiatives External to BC

National NBP and core services/framework: An ongoing project is underway to develop, and pilot test a national NBP model for substance and mental health services and supports in Canada. This work is supported by a National Advisory Committee. A core services framework has been developed as part of this work, inclusive of substance use and mental health services.

Provincial/territorial work on core services: Nearly all Canadian provinces and territories have prioritized enhancement of substance use and mental health services and supports in recent years. Strategic plans and other reports in support of these enhancements often specify their short- and longer-term priorities in the context of a list of "core" services.

CIHI functional centres: The Canadian Institute for Health Information (CIHI) collects, synthesizes, and reports on a wide range of health data and information that are used to accelerate improvements in health care, health system performance and population health across Canada. Work is currently underway to align the CIHI functional centres with key elements of the national NBP core services framework.

Overarching Elements of the Substance Use Framework

Both the overall Substance Use Framework, and the Core Services Model (articulated in detail below), need to be guided by key principles and foundational "building block" elements that ensure the system can function effectively.

Key Principles

The Framework for a substance use system of care, and the Core Services Model, must be grounded in a set of principles. These principles serve a variety of critical functions for planning and service delivery. They describe the characteristics throughout the system that will help deliver services that meet the needs of people who use substances.

The principles articulated here are goal-oriented, can be used as guideposts to assess not only the value of the other listed model components, but also the means by which the outcomes were achieved. They provide the overarching vision for the system of care and need to be reflected and present across all components of the system.

Actively anti-racist: Working to actively eliminate systemic racism from services, policies and institutions that exist on colonial and racist foundations.

This includes anti-colonialism and anti-Indigenous-specific racism, which was found to be widespread, pervasive, and systemic in the BC healthcare[4] system, and is the ongoing race-based discrimination,

4 *Turpel-Lafond, Dr. M. E. In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care Summary Report.November 2020. https://engage.gov.B.C..ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf, pg.6*

negative stereotyping and injustice experienced by Indigenous peoples in Canada that perpetuates power imbalances, systemic discrimination, reduced access, and inequitable outcomes stemming from colonial policies and practices [5].

Adaptable: Provincial, regional, and local context will impact the specific design, implementation, and evaluation of a core service. As such a core service must be open to adaptation in delivery and open to revision based on experience, context, and evolving evidence and practice, to meet local needs.

Collaboration-based (whole-of-government/whole-of-society): Everyone and every system has a role to play in the substance use system of care, where every door is the right door. Collaboration also includes being intentional about the role of people with lived and living experience at all levels of the system, including planning, governance, and performance monitoring.

Cultural safety and humility: Ensuring that culturally safe substance use supports and services are available to everyone, particularly Indigenous peoples, and accommodate peoples' cultural contexts, values and needs.

Equity: The system, at all levels, provides an opportunity for health for all, regardless of age, gender, ethnicity, religion, sexual orientation, or socioeconomic status and includes a broad gender-based analysis approach.

Evidence-informed: The system and its services are delivered using the best available knowledge and are informed by ongoing monitoring and evaluation, including evidence that is generated from lived and living experience, stakeholder and partner expertise, conventional research processes, and traditional ways of knowing. This includes promising practices and piloting of innovations with strong evaluation and continuous improvement processes.

Person- and family-centred: The system is organized with and around the needs of people and their

5 *Turpel-Lafond, pg. 10*

families and centres the importance of autonomy and person-directed choice.

Recovery-oriented: A recovery focus recognizes that people can and do recover; and recovery is a unique and personal process. A recovery-oriented system also includes a focus on empowerment and informed client choice in deciding their individual path. Recovery-oriented systems do not require that people set the goal to reduce or abstain from substance use, but rather that they are empowered to describe individual goals based on their holistic and individual care desires and journeys.

Reducing harms: Ensuring that inclusion of the prevention and reduction of harms associated with substance use, and overall promotion of mental wellness remains a key focus of the overall system, and the system works to meet people where they are at. Also includes responsiveness to the immediate needs of people, including life saving measures.

Stigma-free and discrimination-free: The substance use system is transparent, inclusive, and includes consideration of diverse perspectives. People can access substance use services and supports without shame, guilt, discrimination, or profiling.

Trauma-informed: A trauma-informed approach acknowledges the widespread impact of trauma; recognizes the signs and symptoms of trauma in clients, families, and staff; integrates knowledge about trauma into policies, procedures, and practices; and actively seeks to avoid re-traumatization. A comprehensive approach to trauma-informed care must be adopted at the clinical, organizational and systems levels. This also includes trauma-based and trauma-specific practice.

Foundational Building Blocks for the Substance Use System

For the substance use system to fulfill its vision of care, in addition to principles, there are key foundational system-level elements that must be in place to support a well-functioning, integrated, and principle-based system. These roots provide the building blocks for developing and maintaining the system so that clients, families, and care providers have access to the resources and information they need to be successful. Foundations for the system include practical considerations around infrastructure as well as expectations around the knowledge base and core competencies of the substance use workforce.

Evidence and knowledge translation: There is a continued commitment to research and evaluation as foundational to the system of care. As new evidence, practices, and innovation in substance use care emerges, this information is readily translated into practice system-wide to ensure that clients receive a high quality standard of care.

Accountability, evaluation, and monitoring: Regular evaluation and monitoring activities are undertaken across the system to assess the impact and effect of services, and results are used to develop and inform continued accountability structures.

Workforce development: The substance use workforce is supported by continued capacity-building and planning activities to ensure that people throughout the province have access to core services and qualified practitioners. Peer-led activities are a core component of workforce development and should inform all areas of the substance use system of care and include fair and equitable compensation that recognizes the value and importance of their contributions. Workforce development also means building community capacity to provide substance use care. Cross-sector workforce development is also undertaken to ensure collaboration and integration across systems to support people who use substances.

Workforce development is additionally enabled through training and education activities to support the continued implementation of evidence in clinical practice, including adequate education in post-secondary education, as well as ongoing training opportunities to ensure a skilled workforce. For example, training in substance use, trauma informed practice, cultural safety, and racism.

Funding: The system is adequately resourced to provide the core services and supports of the substance use system of care.

Population health promotion and planning: System planning considers population-level considerations and needs and supports community development and health promotion.

Information sharing and management: Clinical and system-level information sharing is supported across agencies and sectors to ensure knowledge mobilization and integrated service delivery.

Coordination: Cross-sector collaboration, integration, and care pathways are well-established to ensure that people are supported in accessing and moving through the system of care.

Towards a BC Core Services Model

What do we mean by a "Core" Services Model?

The term core service typically implies "universal" access within a given geographic jurisdiction, including concrete provision and accountability for ensuring that access is possible in another jurisdiction if not available geographically (e.g., given economies of scale some specialized services cannot realistically be available in all local areas). A Core Services Model articulates all the services and supports that should be widely accessible and available to people in the province.

Core services should be *accessible* to all BC residents – that is, services should generally be available in some form within the client's local health area region. If these services are provided at another location (some services are provided at a provincial level), there must be a process to ensure that individuals have access to the service (e.g., through transportation, virtual options, outreach capacity).

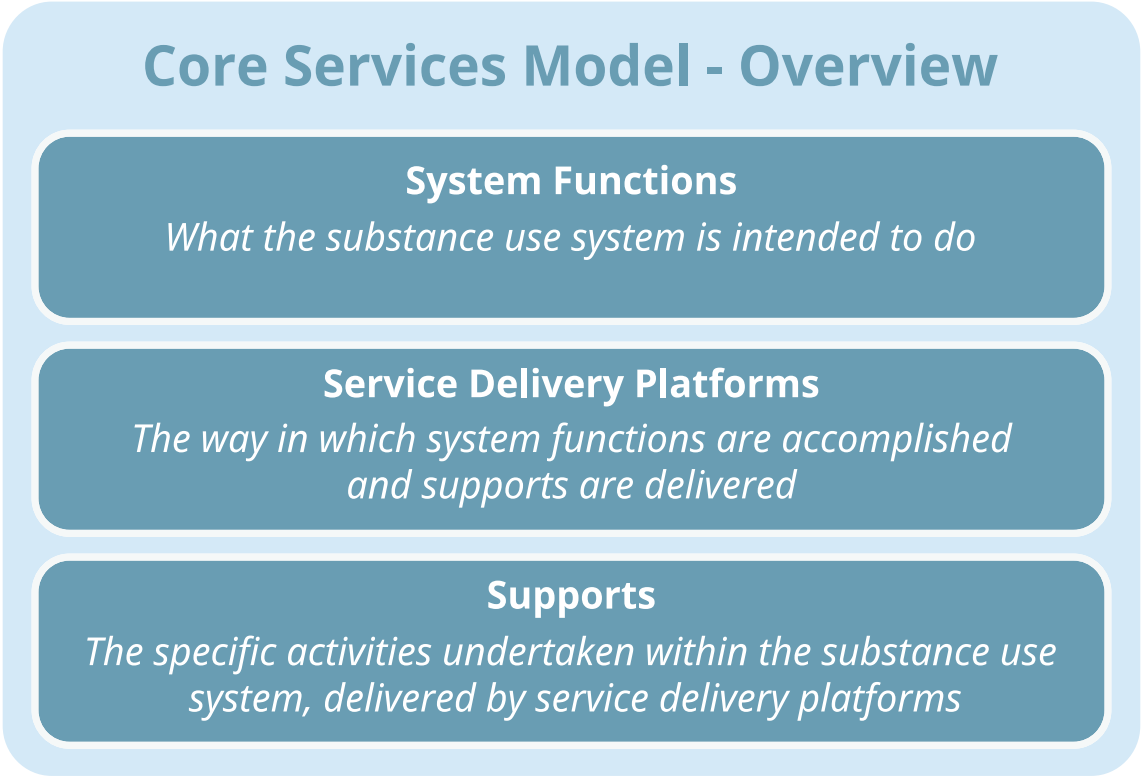
STEPS TOWARDS A BC CORE SERVICES MODEL

The steps towards developing a BC Core Services Model for substance use services and supports:

1. What is a "Core" Services Model?
2. Key definitions of the elements of the Core Services Model
   a) Functions
   b) Platforms
   c) Supports
3. Bringing Together the Conceptual Model

Core services should also be *available* to all BC residents – that is, that the funder should ensure there is adequate capacity of services for individuals who need this type and level of support, while also maintaining service quality.

Core Services Model Elements: System Functions, Service Platforms and Supports



System Functions

While health care “systems” are complex and include many inter-connected components such as governance, financing, information, and technology; the delivery of services is the critical element.

These services have basic functions that align with the needs of the population. For health care broadly speaking, this would include addressing the general health needs of people and treating them for common diseases, free or at a nominal cost in the context of the Canadian health care system.

For a system of substance use services, *system functions identify what the substance use system is intended to do*, in alignment with peoples' needs, broadly categorized as follows:

Prevention and education: aims to prevent and/or limit the onset of problematic substance use and inform the public about guidelines for the use of substances. Typically targeted at children and youth to address substance use risks early in the life course, however, prevention is also inclusive of young adults and adults. Successful prevention and education efforts need to emphasize stigma reduction and addressing harmful ideologies around substance use and people who use substances (e.g., that it is a moral failure).

Early identification and intervention: designed to screen and identify substance use behaviours that may be harmful as early as possible. Paired with evidence-informed brief interventions and harm reduction education, this can prevent the development of more serious substance use disorders or other drug-related harms.

Crisis response: ensures people do not lose their lives due to substance use, through immediate and short-term supports for people who use substances that are in medical, mental, emotional, physical and/or behavioural distress. This may include, but is not limited to, overdose prevention and intervention, emergency medical assistance, safer supply options, and stabilization, available at all times.

Harm reduction: seeks to reduce the negative consequences associated with substance use using practical, evidence-informed strategies and philosophies. It is also a movement for social justice built on a belief in, and respect for, the human rights of people who use substances. As an approach to care, harm reduction is grounded in non-judgement and preserving the dignity, autonomy, and agency of people who use substances without expecting them to change.

Screening, assessment and care planning: supports diagnoses, the development of individualized treatment and support plans, and case management with non-stigmatizing and client-centred practices. Screening and assessment of the substance use-related and broader health care needs of a person when and where they enter the substance use system and throughout their care journey.

Substance use treatment and care: helps people achieve their ongoing personal goals regarding their substance use (e.g., stop, reduce use, stabilize, separate from toxic supply, etc.), including both short-term and longer-term pharmacotherapies, other evidence-based medical or psychosocial interventions and supports and traditional healing practices.

Health promotion and ongoing recovery: supports people to improve their health and wellness, promote their own health capacity and autonomy, live self-directed lives, and strive to reach their full potential. Critically, this spans the social determinants of health by including housing (supportive or otherwise), employment and education resources, life skills training, and cultural healing practices, and includes ongoing and longer-term recovery supports, including formal continuing care supports and relapse prevention.

Service Delivery Platforms

System functions are useful for aligning the health system with people's needs and there are many ways in which these functions can be fulfilled. *Service delivery platforms are the way in which system functions are fulfilled and supports are organized and delivered in the substance use system.*

Service delivery platforms refer to the organizational entities through which supports are delivered. This distinction between a "service platform" and the supports that it will deliver is important since the core services within the model are defined at the level of service platform, not the specific supports, thereby promoting consistency among the many partners involved in its development, communication, and application.

Table 1: Substance Use Service Delivery Platforms
1. Acute intoxication service (sobering centre)
2. Supervised consumption and overdose prevention services
3. Substance use outreach teams
4. Community substance use counselling services
5. Substance use peer and family support services
6. Consultation and liaison services
7. Substance use-specific intensive case management
8. Home and mobile withdrawal management services (WMS)
9. Community bed-based WMS
10. Hospital bed-based WMS
11. Supportive housing
12. Substance use-specific day or evening treatment services
13. Addiction medicine services
14. Multi-functional substance use transition services
15. Community treatment bed-based services
16. Substance use supportive recovery services
17. Bed-based intensive (tertiary) substance use treatment
See Appendix B for detailed definition of each identified Service Delivery Platform

Collaborating Service Partners

In addition to these specialized substance use service platforms, it is important to acknowledge that people in the province who are seeking services and care may not only do so through substance use-specific service platforms. These service platforms exist across a continuum in the substance use system, from emergency and crisis response to community treatment and supports, to acute and specialized care. They also exist across a range of delivery settings, for example, with modifications in a correctional setting. Examples of these collaborating service providers, including key connections to mental health supports, are included in Table 2.

Collaborating service providers often are the entry point for people to access services related to substance use, and where they may access assessment or some treatment and harm reduction services, even if they are not substance-use specific service providers. Many of these providers are unique in several aspects and are further discussed below.

Primary care: As a core collaborating partner, primary care plays a unique and critical role in the substance use system of care. Services provided by primary care are not substance use-specific, however, this is a critical entry point for people living with, or who are at risk for, substance use harms. Primary care plays an important role in early intervention and is the appropriate place for most treatment. This often starts with screening and assessment for substance use harms and disorders and may also include medication-assisted treatment. Many people who engage in mild-to-moderate substance use may only interact with primary care providers while seeking support for their substance use. Additionally, this population is often best treated in primary care settings and may not require specialized services.

As the province continues the implementation of Primary Care Networks (PCNs), Urgent Primary Care Centres, and team-based care, this will continue to influence access to team-based care for individuals who use substances. PCNs are an integrated system consisting of clinical models that are networked

with each other and with primary care services designed to provide universal, comprehensive primary care services that are holistic, person-centred, culturally safe, and responsive to the individual needs of a geographical community population. PCNs have established, clear mechanisms and referral pathways for providers to contribute to their patients' care planning, including referrals to substance use services. These pathways are critical to access appropriate substance use services, including harm reduction services.

In addition to PCNs and traditional primary care structures, many First Nations are implementing culturally specific primary care services to better serve their communities. The First Nations-led Primary Health Care Initiative aims to both increase access to primary care for Indigenous peoples by addressing the disparities and barriers to health that disproportionately impact Indigenous peoples and incorporating traditional wellness practices into their care models. These approaches to care are critical to providing culturally safe and appropriate primary care and include a range of pathways into care.

Corrections: As with primary care, a broad range of services, including substance use specific services (e.g., psychoeducational programs, addictions counselling) are provided to individuals who are currently incarcerated in provincial correctional centres. Within that broad scope, critical substance use services such as OAT are delivered and facilitated by Correctional Health Services (CHS) and BC Corrections.

People who are incarcerated are more likely to have experienced substance use related harms than the general population. Additionally, those with a history of incarceration are four times more likely to experience a toxic drug death, particularly when transitioning into or out of correctional facilities. This highlights the critical importance of delivering substance use services in correctional centres.

Private providers: The core services in this model are intended to be publicly funded so that they are available to everyone who needs them. Currently, substance use services in BC are provided by a combination of public and private providers, including for-profit and non-profit organizations. Private

providers play an important role in the substance use system of care and are likely to do so for the foreseeable future. They secure funding from diverse funding sources, including some government grants.

The Ministry aims to ensure that private providers maintain a high standard of care using evidence-based practices. In developing the BC Substance Use Framework, we intend to strengthen our commitment to ensuring quality, evidence-informed care in both the public and private sectors.

Table 2: Core Collaborating Service Providers

Health Services	Primary care
	Emergency departments
	Hospital bed-based acute and tertiary care
	Disorder-specific/complex tertiary care
	Other specialist services
	Forensic inpatient care
	Pharmacies
	PHSA Corrections Health Services
	Private healthcare providers
Social Sector Services	Housing providers
	BC Corrections
	Legal advocacy services
	Education-based services (including post-secondary)
	Private social sector providers

Table 2: Core Collaborating Service Providers	
Crisis response services	Crisis response teams
	First responders (fire department, EMS, etc.)
	Police
Mental Health Services	Community mental health teams
	Intensive case management
	Intensive day/evening services
	MH-focused peer and family supports
	MH-supported housing (e.g., housing first)
	e-MH digital services and supports
	Private mental healthcare providers

Concurrent Disorders (CD)

The inclusion of many specific types of mental health services in the BC Core Services Model reflects the close relationship between mental health and substance use challenges and the need for **all** substance use and mental health services to develop a level of capability for identifying, treating, and otherwise supporting people with concurrent disorders. This service-level capability falls into three broad categories – CD-Informed, CD-Capable and CD-Enhanced (see below for definitions) which can be measured for purposes of program development and evaluation.

The key system design feature reflected here is that of "graduated integration", where the more severe and complex the profile of needs among the client, the more prepared the service must be for developing and implementing integrated substance use and mental health treatment and support plans. For mild to moderate cases, this preparedness may be achieved through strong collaborative relationships across different substance use and mental health service providers. Then, as the

severity and complexity of concurrent disorders increases, so does the need for highly integrated, multi-disciplinary teams within the same service delivery setting.

Three levels of concurrent disorder capability can be defined for the specialized substance use core services[6]. In Appendix B1, a list of definitions for the service delivery platform also includes a reference to the expected level of concurrent disorder capacity, while anticipating some variation across community contexts and populations being served.

Table 4: Concurrent Disorders Capability

CD-Informed	Majority of staff are aware of the importance of concurrent disorders and when to seek guidance. However, the primary focus of the service is substance use and addiction - concurrent disorders are not treated.
	May admit people with mental health challenges of low acuity but typically directs people with mental disorders or symptoms to other services in the community.
	Pre-intake screening for mental health based on self-report and clinical judgement.
	No capacity to monitor, guide or prescribe medication for mental health challenges.
	No staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.

6 *This service-level rating of concurrent disorder capacity is adapted from the original work of McGovern and colleagues (2007; assessing the dual diagnosis capability of addiction treatment services: The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. Journal of Dual Diagnosis, 3(2), 111-123) and the DDCAT Toolkit which is now widely used for purposes of program development and evaluation at the organizational level (Substance Abuse and Mental Health Services Administration, Dual Diagnosis Capability in Addiction Treatment Toolkit Version 4.0. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011). A complementary approach is to assess the level of concurrent disorder competency at the level of individual staff members (see, for example, Mumford, S. (2019). Enhancing Capacity for Concurrent Disorders Education and Training. Report for the B.C. Mental Health and Substance Use Services, Provincial Health Services Authority).*

Table 4: Concurrent Disorders Capability	
CD-Capable	Primary focus of the service is on substance use and addiction, but accepts people with mental health challenges of mild to moderate severity if relatively stable.
	Has no barrier to providing mental health treatment or treating co-occurring disorders within the context of addiction treatment.
	Formalized and documented coordination or collaboration with a community mental health agency.
	Routine set of standard interview questions for mental health using a generic framework (e.g., ASAM). May use some standardized screening tools.
	The program has a mechanism for providing diagnostic services in a timely manner.
	Present, coordinated medication policies. Some access to prescriber for psychotropic medications and policies to guide prescribing are provided. Monitoring of the medication is largely provided by the prescriber.
	Some staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.
CD-Enhanced	Primary focus of the service is on persons with concurrent disorders; admits persons with moderate to high acuity, including those unstable in their mental health disorder.
	Most mental health services are integrated within the service and/or through case management staff to address mental health challenges.
	Screen using standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
	Assessment for mental disorders is formal, standardized, and integrated with assessment for substance use symptoms.
	Clear standards and routine for medication prescriber who is also a staff member. Full access to prescriber and guidelines for prescribing in place. The prescriber is on the treatment team and the entire team can assist with monitoring.
	At least half the clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.

Supports for People That Use Substances (Supports)

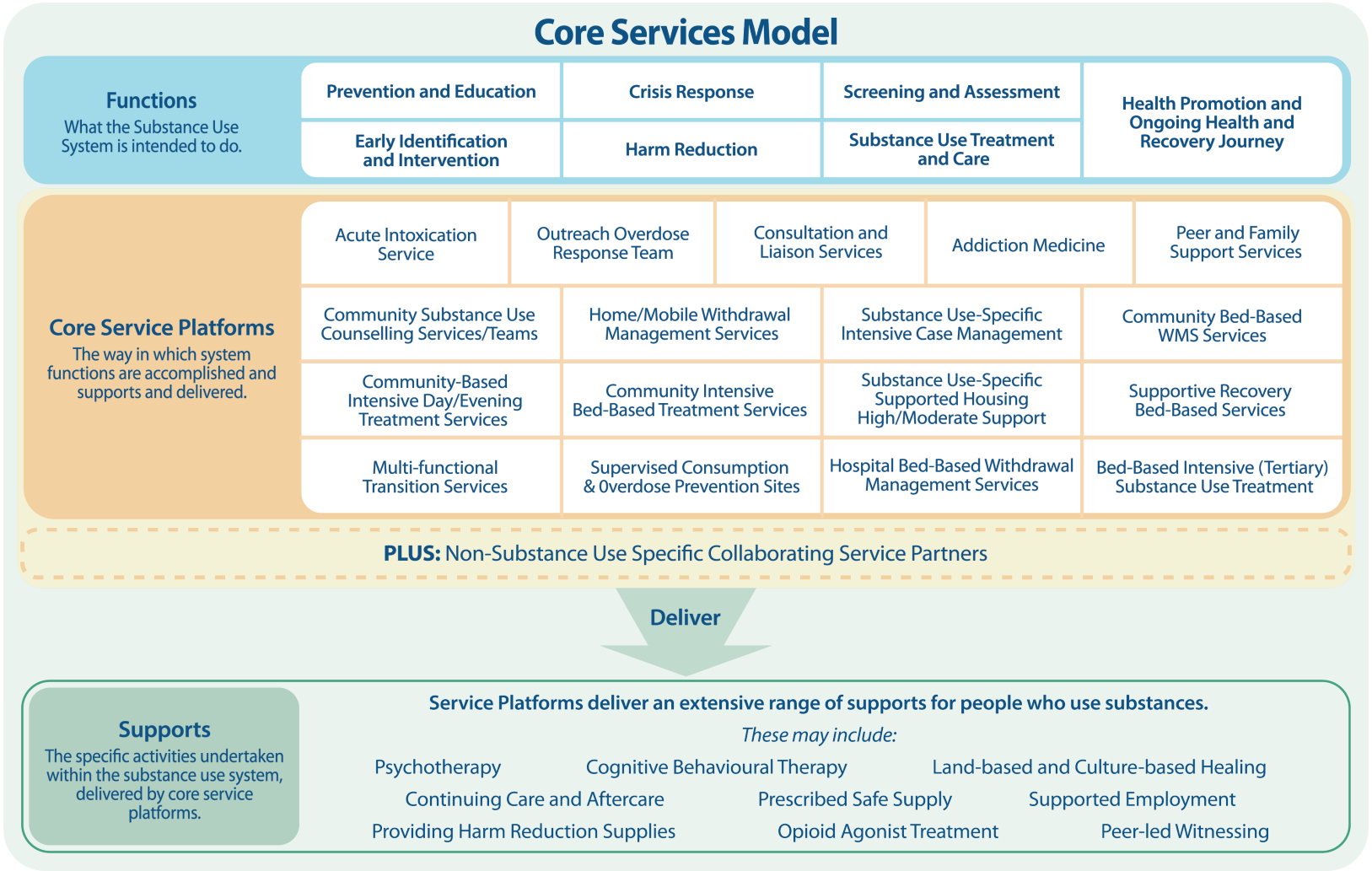
Each service platform provides a number of varied supports. *Supports are the specific activities or interventions undertaken within the substance use system, delivered by service platforms.* For example, an intensive case management team might provide psychosocial assessment and referral, but also support in navigating and accessing these services, case coordination, home visiting, ongoing monitoring and perhaps counselling and medication management. Withdrawal management services might provide rest and stabilization of symptoms, medical monitoring, medication management, screening and psychosocial assessment and transition planning.

Table 3: Examples of Specialized Substance Use Supports
Screening, assessment, and service and support planning
Motivational interviewing
Individual and group counseling (e.g., trauma-based)
Psychotherapy
Psychosocial treatment interventions (e.g., Cognitive Behavioural Therapy (CBT), Mindfulness Cognitive Behavioural Therapy (MCBT), Dialectical Behavioural Therapy (DBT), Social Network Therapy, etc.)
Contingency management therapy
Land-based and culture-based healing supports
Continuing care/aftercare
Physical and psychiatric assessment

Table 3: Examples of Specialized Substance Use Supports
Pharmacotherapies (e.g., Acamprosate, OAT, iOAT, etc.)
Prescribed safe supply
Managed alcohol
Acupuncture
Harm reduction supplies
Peer-led witnessing
Overdose prevention and intervention
Supported employment
Supported education
Life skills training
Peer and family support
Self-help recovery support (e.g., 12-Step (AA, NA), SMART Recovery; Secular Organizations for Sobriety (SOS)
Transition support (including from corrections or bed-based services)
Note: This is not intended to be an exhaustive list of supports

Bringing the Model Together

When bringing together the model and considering how it can aid in considering the gaps in current services and supports in the province, it is important to make the distinction between service platforms and the supports they deliver. Additionally, it is important to consider how all the elements of the system are integrated and coordinated, to work together as a system.



Discussion and Conclusion

The Core Services Model articulates the key elements of an integrated and comprehensive substance use system. As we look to build a Framework to guide the development of a new substance use system of care, this model will provide a foundational component in articulating what the core services are and how they can be organized. However, this model has been designed for a moment in time and will need to be adapted to suit unique service delivery conditions throughout the province (e.g., rural or urban communities, First Nations communities or urban Indigenous populations, etc.) and to reflect the continually evolving evidence and promising practice knowledge in the substance use field.

Appendix B1: Definitions and Examples of BC Substance Use Service Delivery Platforms

1. ACUTE INTOXICATION SERVICES

Definition:

This service, sometimes referred to as "sobering centre", provides shelter and safety as well as short-term monitoring and management of symptoms of an episode of heavy alcohol and/or other drug use that can not be managed at home. The service is accessed through police, emergency response services, hospital referrals or by client walk-in.

Most sobering centres focus exclusively on individuals that do not have an apparent medical or psychiatric condition necessitating emergency interventions. Length of stay can be relatively brief, typically less than 24 hours depending on individual circumstances. Typically, services in this category are provided in a community (i.e., non-hospital setting) but with arrangement for quick transfer to the hospital ED if needed. The focus is on low barrier access, individual safety, and harm reduction. Staffing includes nurses at varying levels of training and certification and perhaps other regulated and/or non-regulated health professionals.

Concurrent disorders

CD-Capable

Examples:

- BC sobering centre examples, e.g., Quibble Creek Sobering and Assessment Centre (Surrey), Sobering and Assessment Centre (Victoria, Duncan, Campbell River)

2. SUPERVISED CONSUMPTION AND OVERDOSE PREVENTION SERVICES

Definition:

Supervised consumption and overdose prevention services provide a safe, clean space for people to bring their own drugs to use, in the presence of trained staff. Staff in these services are able to respond to drug toxicity poisonings and help to reduce the spread of infectious diseases, such as HIV and Hepatitis C. The sites also provide access to important health and social services, including substance use treatment for those who are ready or interested. Sites can be set up in areas where there are high rates of public drug use to provide important health, social and treatment services, such as access to safer substance use supplies and a place to safely dispose of items such as needles, as well as drug checking services to detect if drugs contain other more harmful substances. They can also provide emergency medical care in case of drug poisoning, cardiac arrest, or allergic reaction. Additionally, some services can also provide basic health services, such as wound care testing for infectious diseases like HIV, hepatitis C and sexually transmitted infections (STIs). Access is provided to health care providers and various other support services which may include education on the harms of drug use, safer consumption practices and safer sex as well as access to prescribed safer supply and medications to treat opioid use disorder under the oversight of a healthcare provider. Referrals may be made to withdrawal management and substance use treatment as well as social services such as housing or employment supports.

Staffing usually consists of nurses [RNs, RPNs], peer support workers, health care workers, social workers, access to a physician or Nurse Practitioner.

Concurrent disorders

CD-Capable

Examples:

- Most BC Health Authorities have safe consumption sites, the majority of which include overdose prevention services.

3. SUBSTANCE USE OUTREACH TEAMS

Definition:

These multidisciplinary teams provide support services to individuals and their families with accessing substance use treatment (e.g., OAT, medications for AUD), related psychosocial treatment interventions and supports and harm reduction services. Some teams may administer medication to clients under the direction of nursing staff. These teams may also monitor clients by methods such as observing client's health condition and environment and play a significant role in creating linkages to other community resources and programs. Prevention, harm reduction, assessment, and health promotion are included in provision of services. The target population are generally those who are at a high risk of experiencing drug related harms

Staffing could include a variety of professional and non-professional teams such as outreach workers, nurses, social workers, and peer support specialists. The province is currently working to expand nurse (Registered Nurse and Registered Psychiatric Nurse) prescribing of medications for the treatment of opioid-related harms.

Concurrent disorders

CD-Capable

Examples:

- Vancouver Coastal Health Overdose Outreach Teams operating out of 8 different VCH communities
- Substance Use Integrated Teams (SUITS)

4. COMMUNITY SUBSTANCE USE COUNSELLING SERVICES

Definition:

These services, which vary in intensity, offer structured efforts to provide screening, assessment and implementation of individualized treatment and support plans to people who use substances which may or may not include concurrent disorders. This typically involves a scheduled course of counselling sessions for substance use and related problems, including group or individual formats. Provision of case management also falls into this category (It is important to note that Substance Use Intensive Case Management Teams (ICMT) are identified as a separate core service). Specialized outpatient forensic teams provide assessment, treatment, and case management services.

There are many variations within this core services category. Supports may include either short-term or extended counselling, psychotherapy, or other evidence-based psychosocial treatment interventions (e.g., DBT, CBT, etc.) as well as outreach, medical consultation, psychiatric consultation, assessment, referral, education sessions, and prevention and health promotion. Such services may be provided in the home, office-based or in community or virtually, either through referral or walk-in access. Outreach may include services designed to contact, engage, and link adults who are at risk of developing, or are known to have substance use problems, to treatment and support systems. Dedicated homeless supports may also be provided.

Services may be provided directly by Health Authorities or community-based organizations or may be hospital-based outpatient services. The distinguishing feature, however, is that there is no live-in component, although arrangements may be made with other services for accommodation while the person participates in treatment and support services.

Staffing can vary but generally includes individuals with post-secondary education in clinical counselling/therapy at a Masters' degree level, along with addictions counsellors – generally at a

Bachelors' level in a relevant discipline, and outreach workers with varying education related to the health care/substance use/mental health fields. If the service includes prevention and health promotion, then individuals will have non-specific training in this area including a focus on harm reduction and public health.

This platform can also be also be team based, and may feature a diversity of team members, credentials, and expertise to meet local and client needs.

Concurrent disorders

CD-Capable

Examples:

- All BC Health Authorities have direct services and/or contracted community based [outpatient] substance use or combined mental health/substance use counselling services. For example, Umbrella Society and SOLID in Victoria.

5. SUBSTANCE USE PEER AND FAMILY SUPPORT SERVICES

Definition:

Peer and family support is a healing relationship between people who have a lived or living experience in common. In the case of substance use specifically, this refers to the experience that individuals or groups have in common with respect to substance use, including a substance use disorder and/or a concurrent disorder that impacts substance use. Many individuals providing peer support services are also involved in advocacy work. There are also peer and family support services for people with lived and living experiences with mental health challenges, including mental illness.

Peer and family support is characterized by a set of values and processes of peer support—among them, recovery, empowerment, and hope. The most common form of peer and family support is community support groups where peers or family meet regularly to provide mutual support, without the involvement of professionals, and one-to-one peer and family support such as co-counseling, mentoring, or befriending. With increasing levels of recognition and government investment, there are also many types of peer and family support services that are more specialized, many of which are delivered through, or in collaboration with, mainstream providers. Examples include support in overdose prevention and harm reduction services; support with housing, education, and employment; support in crisis (e.g., emergency department, and crisis services); traditional healing, especially with Indigenous peoples; system navigation (e.g., case management); and material support (e.g., food, clothing, storage, internet, transportation).

There are varying levels of training and certification for peer and family support workers, training that needs to be tailored to the different roles in peer support initiatives.

Concurrent disorders

CD-Informed

Examples:

- Peer Navigator Program (CMHA) in Vancouver
- Peer support and peer coaching in ICMTs
- Mutual Support Groups (e.g., Alcoholics Anonymous)

6. CONSULTATION AND LIAISON (EMERGENCY DEPARTMENT, HOSPITAL, LONG-TERM CARE, HOME CARE, SCHOOLS, POLICE-BASED)

Definition:

Consultation and liaison services are professionals designated specifically to work as a liaison between a specialized substance use or concurrent disorder service and a community or hospital service which is frequently accessed by people who use substances, including concurrent disorders. This may include consultation to one or more hospital departments, including but not limited to the ED, long term care homes, mental health services, housing services and even secondary and post-secondary educational institutions. The role is partly service provision (e.g., supporting discharge planning) and partly capacity building (e.g., screening and brief interventions when appropriate to the needs of the individual). Ongoing case management is not part of this role. Services such as Addictions Medicine Consult Teams (ACMTs) provide access to addiction medicine expertise 24 hours a day/7 days a week to any hospital-based patients.

Aboriginal Mental Health and Substance Use (MHSU) Liaison services support linkage between acute care hospitals, community mental health and substance use services, Aboriginal community agencies and organizations on and off reserve, primary care services providers and other community services. These services work closely with service providers, clients and/or their families to ensure that they are supported in a culturally sensitive manner. These services also include consultation and education to clients, families, service providers and community agencies by developing and delivering training sessions, collaborating with members of the interdisciplinary team.

This may be done by physicians, nurses, or social workers.

Concurrent disorders

CD-Capable

Examples:

- ACMTs
    - Burnaby General Hospital
    - Surrey Memorial Hospital
    - St. Paul's Hospital
    - Royal Columbian Hospital
- Fraser Health Virtual Health Addictions Clinic
- Fraser Health Aboriginal mental health liaisons
- Older Adult Transition Liaisons, Substance Use-Specific Supports

7. SUBSTANCE USE-SPECIFIC INTENSIVE CASE MANAGEMENT

Definition:

This is a formalized case management/outreach service delivery model for either urban or rural practice, that provides comprehensive services to individuals with severe substance use disorder, with or without mental illness, concurrent disorders or coexisting functional impairment. While this case management model is similar to the ACT, case management model clinicians have larger case loads (1 to 20 staff client ratio) and the range of services are more frequently provided through a collaborative approach with other community providers rather than through an internal team.

According to the BC Standards and Guidelines for ICMT, an integrated case management approach is used with a goal of improving health, social functioning, and access to care; services are wrap-around in nature; clients are engaged via multi-disciplinary teams who provide direct services and navigation to other services and systems within the community the individual is geographically located.

They may be a health authority direct services team or community-based organization team or a combination of both and, therefore, offer varying levels of, or access to, medical supports. The distinguishing feature, however, is that there is no live-in component, although arrangements may be made with other services for accommodation while the person participates in the intensive case management services and support.

Staffing generally includes case managers, peer support works, nurses, social workers, an addiction specialist or nurse practitioner, housing specialist and access to a psychiatrist as needed with a team size of 8-10 members.

Concurrent disorders

CD-Enhanced

Examples:

All BC Health Authorities have examples throughout their geographical landscape.

8. HOME AND MOBILE WITHDRAWAL MANAGEMENT SERVICES

Definition:

This involves withdrawal management with support provided in a client's home or other safe accommodation such as multi-functional substance use transitional beds with service delivery via on-site visits or remote support. It may also involve visits to a central location (e.g., community non-bed-based addictions program such as "daytox") while returning home at night or to a safe location. This service involves a medical assessment by a physician or nurse practitioner, and regular monitoring by a physician, nursing and/or other health care worker during the withdrawal process to provide medical management and support. Supports may also be provided by a variety of in-home services that could include outreach substance use counsellors and nurses.

"Daytox" refers to a medically monitored group-based day program offering withdrawal management for individuals in early recovery, or whose substance related challenges do not require intensive community or hospital-based withdrawal management services. Programs offer daily psychoeducational groups and complementary therapies.

Before the client is "discharged", case workers work collaboratively to support the client, and/or those supporting the client, to connect to post-withdrawal management services (e.g., treatment, housing, other supports). However, not all clients will require WMS prior to seeking treatment and may engage with detox services at any point along their recovery journey.

Staffing includes nurses at varying levels of training and certification (RN or RPN) and other regulated and/or non-regulated health professionals. Access to a physician is required.

Concurrent disorders

CD-Capable

Examples:

- Vancouver Coastal Health Substance Use Treatment and Response Team (START)
- Vancouver Coastal Health Daytox program

9. COMMUNITY BED-BASED WITHDRAWAL MANAGEMENT SERVICES

Definition:

This involves withdrawal management from alcohol and/or other drugs in a non-hospital, bed-based setting. Although "community-based", these services may have a relationship with or be otherwise administratively linked to a hospital for quick access during medical emergencies. In-house medical management and supports are provided and involve a medical assessment and regular supports during the withdrawal process by a physician, nurse practitioner, other nursing and/or other health care worker. The intensity of the medical management and monitoring may vary by setting and, depending on the situation, withdrawal may be supported with or without medication management, depending on client needs.

Before the client is "discharged", case workers work collaboratively to support the client, and/or those supporting the client, to connect to post-withdrawal management services (e.g., treatment, housing, other supports).

Staffing includes regular access to a physician, RNs and/or RPNs, LPNs, health care workers, social workers (RSW or RCSW) or addictions counsellors/case managers.

Concurrent disorders

CD-Capable

Examples:

- Creekside Withdrawal Management Services [adults/youth]
- Vancouver Coastal Health Detox Centre

- Onsite Detox [Vancouver]
- Community Medical Detox Vancouver Island Health
- The Bridge Youth and Family Services Adult Withdrawal Management Services [Kelowna]

10. HOSPITAL BED-BASED WITHDRAWAL MANAGEMENT SERVICES

Definition:

Clients reside on-site in a health care setting for stabilization, withdrawal management and psychosocial supports in preparation for additional substance use treatment and support. Clients participate in a structured, scheduled program of interventions and activities with access to 24-hour support and an alcohol and drug-free residential treatment milieu. While many community bed-based WMS services offer medical supports, these hospital-based services provide access to a high level of individualized medical and mental health treatment and support. Medication management is a normative element of interventions offered and this may include tapering from opioids with a goal being to transition to in-house or externally offered Opioid Agonist Treatment, other pharmacotherapies, or other treatment and support depending on client choice for that option. Before the client is discharged, case workers ensure that the client and/or those supporting the client are connected to other substance use treatment services.

Length of stay is typically less than seven days, but this can be quite variable. The focus is on support in managing an acute situation with the goal being to safely transition the individual to the next appropriate level of treatment and support based on individual strengths and needs (e.g., bed-based or non-bed-based substance use treatment).

The WMS beds are often organized as a specific hospital unit and staffed with an inter-disciplinary team (e.g., addiction medicine, psychiatry, nursing professionals, social work, and others). Coordination with other hospital services provide additional resources and expertise as required (e.g., pharmacy, occupational health, peer and family support, and others).

There may be some overlap with Hospital Bed-based Intensive Substance Use Treatment (see below) to the extent that WMS is an initial phase of a multi-phased treatment and support program operated by the same facility.

Concurrent disorders

CD-Enhanced

Examples

- Withdrawal Management – Inpatient Services, Richmond Hospital
- Adult Withdrawal Management Unit, Prince George
- Medically supervised detox service in acute care departments across Northern Health

11. SUPPORTIVE HOUSING

Definition:

Supportive housing refers to the construction and assigned usage of buildings for the purpose of providing housing for people who are experiencing or are at risk of homelessness. The social issue is ensuring that members of society have a home in which to live, whether this an apartment-style building, or a unit in the private rental market.

Supportive housing is a subsidized housing option with a combination of housing and support services to promote housing stability and help improve quality of life. There is a range of housing options that fall under the umbrella of supportive housing. It may provide self-contained, subsidized units, or single room units, governed by the Residential Tenancy Act in a building. Supportive housing also may include scattered-site housing in the private rental market, with added supports. Supportive housing can be targeted to different groups, for example Indigenous peoples. Supportive housing is an option for people who are at risk of homelessness or who experienced homelessness. Generally, supportive housing is based on the Housing First approach, where housing is provided and there is no requirement for the person to be abstinent from substance use or involved in treatment to access this housing. Access to supportive housing may be facilitated through housing service providers and/or health authorities through joint partnership tables.

Homelessness exacerbates physical health, mental health, and substance use issues. In supportive housing, onsite or off-site supports (e.g., connection to community services, peer support, financial management, health support) are coordinated through a community support worker, or in some cases, a case manager or case management team to support clients at risk of homelessness. Complex Care Housing (CCH) is one model that provides intensive in-reach services for people with complex mental health and substance use challenges. Supportive housing services may also incorporate onsite overdose prevention services, often referred to as Housing Overdose Prevention Services (HOPS).

Persons living in supportive housing can also be linked to a wide variety of social services such as employment, life skills, community support services (e.g., educational and recreational programs, support groups). Supportive housing is an affordable housing option for people who require additional supports to maintain housing and provides opportunity to improve health, well-being, and community integration. Access to supportive housing is typically though a coordinated access process within the provincially funded housing system, not the healthcare system.

Indigenous housing providers play a particularly critical role in the substance use system of care as they support stability and improved housing and health outcomes for Indigenous peoples who use substances. They provide and refer to a range of culturally safe services, including but not limited to substance use supports, serving a population that is highly overrepresented in experiencing harms related to substance use and homelessness.

Concurrent disorders

Varies from CD-Informed to CD-Capable, depending on nature of supports. Housing First model: CD-Enhanced.

Examples:

- Orca Place
- Budzey Building
- McCurdy Place
- New Gate Apartments

12. SUBSTANCE USE-SPECIFIC DAY OR EVENING TREATMENT SERVICES

Definition:

Day/Evening treatment is an intensive type of non-bed-based services for individuals whose needs are more complex than can be managed through standard outpatient services, yet do not require an inpatient stay. A structured, scheduled program of treatment and support activities is provided for a certain number of days or evenings per week and a certain number of hours per day/evening (e.g., 3-4 hours per day), while the client resides at home or in another setting such as a multi-function bed-based service. These services typically consist of a minimum of nine or more hours of structured activities a week for adults. There is, however, considerable variability in total number of hours per week.

Services and supports include a range of individual or group options, including counselling, psycho-educational supports, relapse prevention, stress management, and skills development programs.

These services may be delivered by a hospital or community-based organization and, therefore, offer varying levels of, or access to, medical and mental health supports. The distinguishing feature, however, is that there is no live-in component, although arrangements may be made with other services for accommodation while the person participates in the day/evening treatment services and supports. Staffing is comprised of an inter-disciplinary team (e.g., psychology, psychiatry, psychiatric and other nursing professionals, addiction counsellors, social workers, peer and family support, and others). Coordination with other hospital or community services would provide additional resources and expertise as required (e.g., pharmacy and others).

Concurrent disorders

CD-Capable or CD-Enhanced

Examples:

- Day, Evening, Weekend [DEW] program
- Intensive Day Treatment Program

13. ADDICTION MEDICINE SERVICES

Definition:

Addiction medicine is a medical specialty that deals with the assessment, diagnosis, prevention, evaluation, treatment, and recovery of persons with addiction, of those with substance-related and addictive disorders, and of people who show unhealthy use of substances including alcohol, nicotine, prescription medicine and other illicit and licit drugs. The medical specialty often crosses over into other areas, since various aspects of addiction fall within the fields of public health, primary care, psychology, social work, mental health counseling, psychiatry, and internal medicine, among others. Access to addiction medicine can occur in a range of care locations (e.g., in-patient services, virtually, emergency departments, physician's office Rapid Access Addictions Clinic (RAAC), etc.).

Addiction specialists may work independently or be part of another core service such as RAAC and prescribed safer supply.

Addiction Medicine Services may provide a range of supports:

Medication-assisted treatment: provides access to evidence-based pharmacotherapies through a licensed provider. This includes OAT and injectable OAT (iOAT), which specifically supports individuals with opioid use disorder by starting and maintaining clients on opioid agonist (replacement) therapy (Buprenorphine/Naloxone [Suboxone]/Methadone/Kadian) under the care of a designated licensed physician or other licensed prescriber such as a Nurse Practitioner, Registered Nurse, or Registered Psychiatric Nurse. This also includes medications for alcohol use disorders, such as naltrexone or acamprosate.

Prescribed safe supply: disconnects people from the highly toxic illicit drug supply by providing a pharmaceutical grade alternative to those who are risk of drug toxicity events and death. Safe supply can help reduce drug-related harms, including toxicity injuries and deaths, enhance connection to health and

social supports, and improve overall health and wellness for people receiving these medications.

Managed alcohol programs: a harm reduction approach where clients are prescribed or otherwise provided a daily dose of alcohol to assist in the management of the addiction to alcohol and to prevent severe withdrawal from happening. MAPs may be delivered in a range of settings, including community agencies, hospitals, health care, or housing services, including some community-led models. Medical oversight by a prescriber supports safe dispensing and doses of alcohol to clients. Staffing includes a physician, regulated health professionals (e.g., nurses) and other members such as outreach workers, and has strong linkages to other services such as mental health and other substance use services.

Rapid access to addictions care (RAAC): These services can be connected to a hospital or other acute services (e.g., withdrawal management) or provided in the community. RAACs in acute care settings can be coordinated with the emergency department (ED) to rapidly connect patients by referral (or with embedded staff) to the RAAC, which provides outpatient medical support for people with substance use disorders. Connections may also be made to an outreach team, an existing service that connects people who have recently experienced and/or are at high risk for a drug poisoning event, to addictions care and support.

RAAC services also provide outpatient support with starting and managing any necessary changes to a person's OAT, for anywhere from two weeks up to two months (over the course of a year), until such time as they are stable and/or successfully referred to a longer-term service. RAAC services are optimal for individuals with severe opioid use disorders who have trouble maintaining contact with their primary care providers, and moderate cases who are not receiving wraparound by a community-based counsellor or case manager.

RAAC staffing includes a multi-disciplinary approach and/or team, generally led by an addictions trained physician; includes nurses and may include health care workers, socials workers, peer navigators and clinical counsellors.

Concurrent disorders

CD-Capable

Examples:

- OAT: Found in all BC Health Authority jurisdictions and include public and private services and provincial custody centres
- iOAT: Crosstown Clinic
- RAAC: Providence Health Care, St. Paul's Hospital; Fraser Health Creekside WMS
- MAP: GMAP Gwa'dzi Managed Alcohol Program run by Gwa'sala-'Nakwaxda'xw in partnership with the local RCMP detachment in Port Hardy
- First Nations Virtual Substance Use and Psychiatry Services: First Nations Health Authority

14. MULTI-FUNCTIONAL SUBSTANCE USE TRANSITION SERVICES

Definition:

These bed-based services offer a variable length stay up to a maximum of 30 days of support (as a guideline) for physical, social, and psychological stabilization. A key distinguishing characteristic is usually minimal in-house programming given the focus on rest and stabilization. This focus allows the resident to plan for entering a residential or non-residential treatment service (e.g., while on a wait list post-withdrawal management). Stabilization/transition beds may also be used to help the person make the transition from a residential service to a community non-residential service, for example when housing in the community has not yet stabilized. This may also be a distinct phase of treatment in some residential treatment services. In some cases, these beds can be part of a mobile detox or withdrawal management program (e.g., Short Term Access to Recovery (STAR) beds in Fraser Health).

Staffing typically includes persons with lived experiences who have completed a one-or two-year certificate or diploma. Staffing would be similar to a Supportive Recovery facility.

Concurrent disorders

CD-Informed

Examples:

- Short Term Access to Recovery (STAR) beds (Fraser Health)
- Step Up/Down Services (Vancouver Coastal Health)
- Stabilization (withdrawal management) (Island Health)

15. COMMUNITY SUBSTANCE USE BED-BASED TREATMENT

Definition:

These are substance-free settings, usually licensed under the Community Care and Assisted Living Act (CCALA) providing time-limited intensive treatment for individuals who are experiencing substance use related problems, and whose assessment indicates that they will be effectively served through intensive treatment. Clients reside on-site and participate in a structured, scheduled program of interventions and activities with access to 24-hour support and an alcohol and drug-free residential treatment milieu.

Program activities are specifically designed to treat substance use disorders and/or mild to moderate concurrent disorders. Treatment may include a combination of assessment, psychosocial treatment interventions, structured individual, group and family counselling/therapy and relapse prevention by clinical counsellors. Other services may include participation in mutual aid supports such as Alcoholics Anonymous/Narcotics Anonymous, SMART recovery, and/or other peer-based supports; life/employment skills training and education; culture-based activities such as sweat lodge and tobacco and other ceremonies, and recreation activities.

While some medical supports are provided, such as medication management, and the facilitation of medication-assisted treatment, the emphasis is on structured psychosocial treatment and often spiritual and/or cultural treatment and supports. Opioid Agonist Treatment and other pharmacotherapies for managing cravings and relapse (e.g., naltrexone, acamprosate) may be offered in-house or arrangements made for access to medication through a local pharmacy, and some health authorities may offer prescriber in-reach as needed. A variable length of stay is recommended based on client strengths and needs. Programs generally range from 30-90 days.

Staffing should include individuals with post-secondary education in clinical counselling/therapy at a

Masters' degree level, wellness workers, addictions counsellors – generally at a Bachelors' level in a relevant discipline, and program support workers with varying education related to the health care/ substance use/mental health fields and generally, lived experience. In treatment facilities, staff are onsite 24 hours a day. Some programs may also have a nurse and/or social worker, with some access to a physician and minimal access to a psychiatrist.

Concurrent disorders

CD-Capable

Examples:

- Pacifica Treatment Centre
- Kinghaven Treatment Centre
- Peardonville House
- Phoenix Centre Treatment beds
- Round Lake Alcohol and Drug Treatment Society
- Nenqayni Wellness Centre
- Maple Ridge Treatment Centre

16. SUBSTANCE USE SUPPORTIVE RECOVERY SERVICES

Definition:

These services provide temporary accommodation in a supportive, recovery-oriented environment and may be a step down or step up from/to intensive bed-based treatment. They may also be used when there is a high risk of relapse. Although the large majority of such services are alcohol/drug free, "Harm Reduction Homes" or Residential Managed Alcohol Programs are also included in this grouping. Individuals may access outpatient and other community treatment services and supports. Programs generally range from 30-120 days, though some programs may run for longer than a year. Supportive recovery services can be licenced or registered under the Community Care and Assisted Living Act (CCALA), with the majority being registered.

Activities are directed at individuals whose substance use disorder has stabilized, typically include coaching for daily living focusing on eventual community reintegration, and participating in mutual aid supports (e.g., AA/NA, SMART Recovery). Recovery-oriented programming helps people build the internal and external resources necessary to start and maintain their recovery journey and maintain their quality of life. High-intensity structured interventions or programs are typically not offered in house, the exception perhaps being basic counselling and case management and, in some cases, low- to moderate intensity structured programming and medication management.

Staffing typically requires that people demonstrate the competencies required to do their job and have a minimum of 20 hours of training total across four key areas: counselling; crisis intervention and conflict resolution; psychosocial interventions for substance use disorders; and trauma informed practice. Many staff have lived experiences, and some facilities may also contract external clinical counsellors and/or physicians.

Concurrent disorders

CD-Informed

Examples:

- Stabilization and Transitional Living Residences (STLRs) in both Fraser Health and Vancouver Coastal Health Authorities
    - Last Door Recovery Centre, Turning Point, Phoenix Society, Mollies Place
- Supportive Recovery residences in Vancouver Island, Northern and Interior Health Authorities
    - Comox Valley Transition Society, A:yelexw Recovery Programs, Seabird Island (men's and women's), 333 Trinity Men's Recovery House [Prince Rupert]

17. BED-BASED INTENSIVE (TERTIARY) SUBSTANCE USE TREATMENT

Definition:

Commonly referred to as "Inpatient substance use treatment" or perhaps a "concurrent disorders unit" this involves a number of designated beds for stabilization, assessment, treatment, and psychosocial treatments and supports for people with severe substance use disorders. As noted above, this may be preceded by a period of medically supported withdrawal management. While many community bed-based WMS services and treatment also offer medical supports, including medication management, intensive (tertiary) bed-based services typically provide access to a higher level of individualized medical or psychiatric care. Thus, the distinguishing characteristic of these bed-based substance use treatment services is their capacity to offer in-house treatment of significant health, mental health, and other complex conditions.

A variable length of stay is recommended but is typically 90 to 270 days and as per clinical indication. The focus is on intensive treatment and support with the goal being to safely transition the individual to the next appropriate level of services based on individual strengths and needs, for example, "step-down" to bed-based supportive recovery services or non-bed-based substance use services in the community for continuing treatment and support.

These beds are often organized as a specific hospital unit or other specially designated facility and staffed with an inter-disciplinary team (e.g., psychiatry, psychiatric and other nursing professionals, social work, and others).

Concurrent disorders

CD-Enhanced

Examples:

- Red Fish Healing Centre
- Heartwood for Women
- Hope Centre