Publicly-Funded Live-in Addiction Recovery Services in BC

A Snapshot of the Sector

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Executive Summary

The Live-in Addiction Recovery project provides a snapshot of live-in addiction recovery services (also described as residential substance use services). The primary goal of the project was to provide a foundation to better understand the capacity of this sector and to characterize it on a number of dimensions.

In BC, these programs are broadly categorized as supportive residential programs or residential treatment and are appropriate for those who require a level of care that cannot be provided on an outpatient basis. Ideally a sustainable system of live-in services operates within a tiered service framework in complement with lower levels of services such as family physicians and community-based substance use programs.

A solid understanding of addiction recovery needs and effective interventions for people with severe and complex mental health and addiction issues (those most likely to need residential services) is lacking. Little is known about the capacity of the BC care system to effectively serve this population. Focusing specifically on publicly funded live-in addiction services, the project sought to estimate service capacity across BC, to explore clients and program characteristics, the provision of services for concurrent disorders, and key issues/concerns of residential service providers. Twenty-four BC -based facilities providing live-in addictions recovery services with a minimum 30-day program that receive health authority funding for designated beds responded to a survey, representing a subset of the sector.

Live-in addiction recovery services in BC are funded and delivered provincially through the Provincial Health Services Authority, the five regional health authorities, and the First Nation Health Authority. Programs in most of the regional health authorities are operated through contractual arrangements with licensed community care facilities owned by not-for-profit agencies. Estimating publicly funded live-in addiction recovery bed capacity in BC relied on information beyond the sector survey, yielding a count of 436 residential treatment beds and 303 supportive residential beds.

The study revealed considerable ambiguity regarding the different levels of live-in addiction services in terms of the criteria that differentiate support recovery and intensive residential treatment beds, which agencies are providing what type of service, and the mechanisms for program access. It was noted that centralized access/intake processes are not consistently in place across health authorities. Further confusion arises from the fact that certain health authorities have redefined their specifications for contracted services as Stabilization and Transitional Living Residences to distinguish them from standard supportive recovery programs.

With regard to the nature of the population served in live-in settings, mental health presentations are reported as very common among clients. It was evident, however, that

specialist support is limited in terms of access to psychiatrists, psychologists, and psychiatric nurses. Provincial complexity-enhanced services offer mental health specialist support but this is not routine in other programs.

Medical support may also be insufficient in residential settings despite reports of an array of acute and chronic health conditions among clients. Only a fraction of intensive residential treatment and support recovery services indicated a formal arrangement with a general practitioner. Other programs may secure client medical services through fee-for service physicians in the community. Less than half of programs surveyed reported formal salaried or contractual arrangements with specialists in addiction medicine.

A substantial proportion of clients in live-in addiction services are reported to have unstable housing, unemployment and criminal justice system involvement. The large majority of programs address housing as part of their transitional planning for residents.

Low completion rates are common in residential substance use services through dropouts and automatic discharges for noncompliance (typically related to substance use). A minority of programs conduct formal program follow-up. Service providers noted that more support is needed for pre and post-treatment beds, transition from detox, and aftercare.

These preliminary findings have implications for the planning and delivery of live-in addiction recovery services.

Clarity around Levels of Residential Care

In BC, there appears to be a blurring of functions across residential treatment services and supportive residential services as both share therapeutic and social stabilizing goals. Formal criteria and centralized intake are lacking to determine appropriate referral pathways and the core elements or interventions unique to each. Efficient utilization management of the most costly tier of service is not possible if clients are not matched to the appropriate intensity of care.

Clinical Capacity to Address Concurrent Disorders

Mental health problems are common in residential substance use service settings. On the basis of the data available through this project, including service provider perspectives, the ability to provide specialized services in live-in addiction recovery programs to residents with *both* substance use and mental disorders who also have multiple social needs appears to be profoundly insufficient.

Degree of Medical Support

Medical support appears limited in residential substance use service settings despite reports of an array of acute and chronic health conditions in these populations and a BC standard requiring

physician access for residents. In terms of access to specialists in addiction medicine, less than half of programs reported formal arrangements with these physicians.

Service Models that Recognize the Chronic Nature of Substance Use Disorders

As a proportion of admissions to residential programs, failures to complete appear to be substantial. Further, formal follow-up with discharged clients is not routine. It would appear that the chronic care paradigm and the accepted practice of monitoring and provision of long-term support have not been adopted across all residential service providers in BC.

1. Project Overview and Purpose

The intent of this project was to examine live-in addiction recovery programs.[2] In British Columbia (BC), these programs are broadly categorized as supportive residential programs or residential treatment, corresponding to Tiers 4 and 5 of the National Treatment Strategy Model (2008). Tiers 4 and 5 represent specialized care functions for individuals with chronic, severe and/or complex substance use disorders.

The key project objectives were to:

- Estimate publicly funded live-in addiction recovery service capacity across BC
- Explore the extent to which these services address concurrent disorders
- Better understand the socio-demographic profile of live-in recovery services residents
- Characterize services on key parameters
- Examine issues/concerns of residential service providers.

The work was commissioned by the *StreetoHome* Foundation and involved a survey of 24 agencies in BC offering residential substance use services and receiving public health authority funds. The survey and related research was completed by the Centre for Applied Research in Mental Health and Addictions (CARMHA) and guided by an Advisory Committee with representation from St. Paul's Hospital, *Streetohome* Foundation, First Nations Health Authority, Vancouver Police Department, Vancouver Coastal Health, Turning Point Recovery Society, and the City of Vancouver.

It is estimated that 3% of BC's population have severe addictions and/or mental health conditions requiring specialized treatment services (Patterson et al., 2008). This represents approximately 138,000 people in the province. In 2014, a Mayor's task force established a set of priority actions to respond to the high numbers of Vancouver residents with severe untreated mental health and addictions concentrated in the downtown eastside (City of Vancouver, 2014). The very significant concerns regarding supports and services for this vulnerable population have been amplified by the surge in illicit drug overdose deaths in BC, largely due to Fentanyl, declared a public health emergency[3] in the spring of 2016. The Office of the Chief Coroner reported that accidental illicit drug overdose deaths in BC in 2016 were almost 80% higher than in 2015 (BC Ministry of Public Safety, 2017).

Currently, there are a number of publicly funded live-in addiction recovery services available in British Columbia provided in licensed residential facilities. All licensed residential care facilities

[2] The terms "live-in addiction recovery services" and "residential substance use services" are used interchangeably in this paper. The latter reflects the nomenclature used in the Provincial Standards for Adult Residential Substance Use Services (2011).

[3] https://news.gov.bc.ca/releases/2016HLTH0026-000568

must adhere to the *Community Care and Assisted Living Act*[4] and standards of practice. A service model and standards specific to residential substance use services were issued by the Province of BC in 2011.[5]

Most residential services are delivered via contractual agreements with non-government community agencies; others are owned and operated by regional health authorities and two are funded and managed provincially through the Provincial Health Services Authority. In addition, some residential treatment services are delivered through the National Native Alcohol and Drug Abuse (NNADAP) program under the auspices of the First Nations Health Authority (FNHA).

The project scope included facilities providing residential services within the top two tiers of accepted tiered service frameworks (Rush, 2010) including complexity-enhanced residential programs, intensive residential treatment (IRT) programs, stabilization and transitional living residential (STLR) programs, and those providing other forms of supportive recovery (SR) residential services. Withdrawal management services (detox), a pre-admission requirement for many residential programs, were not included. Supported housing was also not within the scope of this project.

Contracted live-in recovery services may involve health authority funding for a portion of beds within a given facility or funding for all beds within that facility. While this project's original focus was on live-in "treatment" services, the demarcation between *bona fide* treatment facilities and those that offer low to moderate intensity services and supports in live-in settings in BC was difficult to ascertain. Several agencies contracted to provide supportive residential services in fact describe themselves as treatment programs.

[4] http://www2.gov.bc.ca/gov/content/health/accessing-health-care/finding-assisted-living-or-residential-care/residential-care-facilities

[5] http://www.health.gov.bc.ca/library/publications/year/2011/adult-residential-treatment-standards.pdf

2. Contemporary Perspectives on Substance Use Treatment

2.1 Tiered Model

The widely adopted Tiered Model of services and supports represents a conceptual approach to both population and clinical substance use needs (Canadian Centre on Substance Abuse, 2009; Rush, 2010; Rush & Nadeau, 2011). The model underpins Canada's National Treatment Strategy (2008) and has served to inform service planning efforts across the country. Five tiers in the model outline different functions that correspond to the continuum of problem severity in the population served and increasing levels of specialization in the functions provided. Individuals may access services and supports within different tiers based on need simultaneously or at different points in their recovery. The integrated tiered framework envisions linkages across tiers and with other service systems (Rush, Tremblay, Behrooz et al., 2012).

In the development of its *Service Model and Provincial Standards for Adult Residential Substance Use Services* (BC Ministry of Health, 2011), BC adapted the tiered model, characterizing the tiers more in terms of types of services than functions. The adapted tiered framework is presented in Figure 1.

Although slightly different as conceptual models, overall the tiered model offers an approach to care planning that shares features with the continuum of care for substance use treatment established by American Society of Addiction Medicine (ASAM).[6] Of note is that the ASAM five levels can be subdivided into further gradations of service intensity. Each level defines assessment criteria for placement of individuals in care for health insurance coverage purposes. Table 1 compares the models.

The tiered model is designed to match individuals to appropriate services and supports, recognizing that while a client has the right to choose between options to meet his or her needs, access to higher tiers in which services are both more specialized and more costly should be restricted to those with the most severe and complex conditions (National Treatment Strategy Working Group, 2008). Residential services that offer live-in treatment and support are a component of Tier 4 and 5 service functions, determined by service intensity and specialization.

[6] http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria

Figure 1: BC Ministry of Health, Adaptation of Tiered Framework

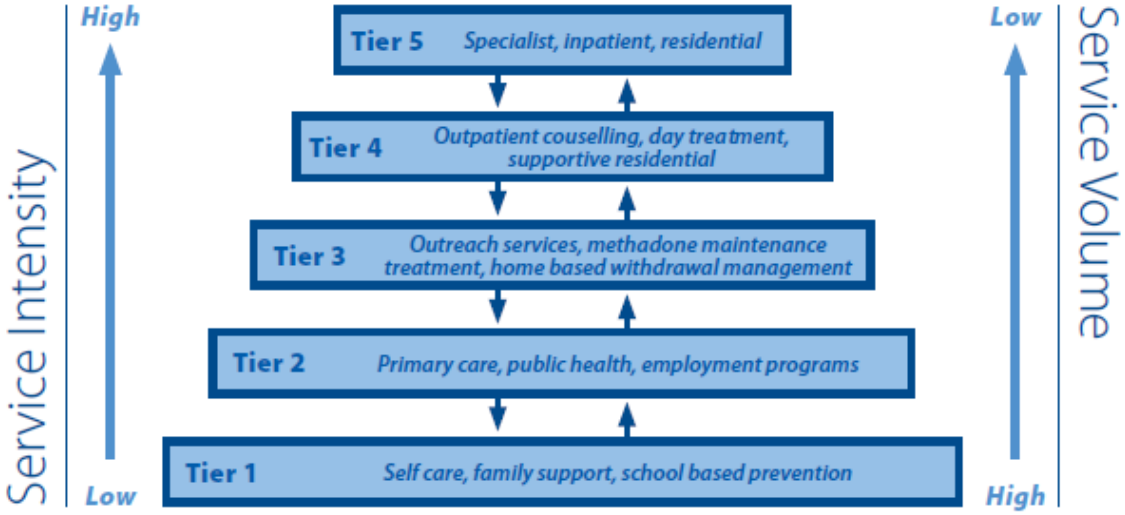

Figure is from the BC Ministry of Health Service Model and Provincial Standards for Adult Residential Substance Use Services (2011, p. 6).

Table 1: Comparison of the Tiered Model and the ASAM Levels of Care

Tiered Model (National Treatment Strategy)	**BC Adaptation of Tiered Model (in Provincial Standards)**	**ASAM Continuum**
Tier 1: Population based health promotion and prevention targeted to the general population	Tier 1: Self-care, family support, school based prevention	Level 0.5: Early intervention services
Tier 2: Early intervention and self-management functions targeted to individuals at risk	Tier 2. Primary care, public health, employment programs	Level 1: Outpatient services
Tier 3: Treatment planning, risk and crisis management, and support functions targeted to individuals with identified problems	Tier 3: Outreach services, methadone maintenance treatment, home based withdrawal management	Level 2: Intensive outpatient/partial hospitalization services (two sub-levels)
Tier 4: Specialized care functions targeted to people assessed or diagnosed as in need of more intensive or specialized care	Tier 4: Outpatient counseling, day treatment, supportive residential	Level 3: Residential/inpatient services (four sub-levels)
Tier 5: Highly specialized care functions targeted to individuals with complex problems	Tier 5: Specialist, inpatient, residential	Level 4: Medically managed intensive inpatient services

2.2 Chronic and Collaborative Care

The need for a shift away from episodic substance treatment to approaches that recognize the chronic and relapsing nature of alcohol and drug disorders is now evident (Canadian Centre on Substance Abuse, 2014a; U.S. Department of Health and Human Services, 2016). Moreover, it is generally acknowledged that the longer the engagement with treatment and support, the greater the likelihood of recovery (Millette, 2013; NIDA, 2012). Chronic disease management has been advocated as a means of engaging individuals with addictions in treatment, providing a continuity of treatment, addressing comorbid health concerns, promoting self-management and improving outcomes (Saitz, Larson, & LaBelle, 2011; White & Kelly, 2011). The Institute of Behaviour and Health (2014) describes a *New Paradigm for Recovery* as a model of long-term, active care management for substance use disorders comparable to the care standard for other chronic conditions. Under this paradigm, it is recommended that individuals undergoing treatment are monitored and supported for five years to achieve long-term recovery. In BC, some health authorities have endorsed the value of a chronic care approach, acknowledging that multiple service episodes over time represent a common pattern for many affected individuals (e.g., Virgo Consulting and Island Health, 2014).

In highly vulnerable populations, medical, psychiatric, addictions, housing, employment and social needs frequently coexist and contribute to the complexity of need. Collaborative care models offer whole person approaches in which multiple providers have distinct but coordinated roles (Institute of Medicine, 2006). Collaboration at the practice level is critical for providers of live-in addiction recovery services where residents are likely to experience comorbid mental illness and carry a higher risk for physical health conditions and homelessness (Krausz, 2009).

Specialized care and integrated provision of services are necessary to effectively meet the needs of comorbid individuals (Rush et al., 2012). Concurrent treatment provided by the same practitioner or by a team of practitioners ideally within the same agency represents best practice in addressing comorbidity and contributes to improved outcomes (SAMHSA, 2002). BC's service model for adult residential care recommends screening for concurrent disorders at intake and provision of simultaneous, rather than parallel, treatment of co-existing substance use and mental health disorders (BC Ministry of Health, 2011). A further important aspect of integrated treatment, highlighted by Krausz (2009), is that hard to treat individuals with concurrent disorders may use a number of different substances dictating a move away from a

Box 1. Features in Common Specific to Collaborative Efforts

- A need for effective linkages
- A high level of trust and reciprocity among participants
- A focus on a broad continuum of severity
- Multi-sectoral involvement
- Multiple levels of collaboration that align with different types of needs and levels of severity
- A distinction between service- and system-level initiatives

From: *Addiction and Mental Health Collaborative Project Steering Committee (2014)*

"single substance, single disorder" approach to one that accommodates a more complex picture of multiple substances and coexisting mental illness.

In an effort to summarize "best advice" on collaboration for addiction and mental health care, the Canadian Executive Council on Addictions (CECA), the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Abuse (CCSA) partnered to establish common features of collaborative care models (Addiction and Mental Health Collaborative Project Steering Committee, 2014). The six key features identified are presented in Box 1.

2.3 Recognizing the Link to Housing Instability

Chronic substance use may contribute to housing instability and/or may occur as a consequence of losing one's housing (National Coalition for the Homeless, 2009). While not all homeless people struggle with addictions, as a group they exhibit much higher rates of substance use and mental disorders compared to the general population. Citing findings from a Greater Victoria survey of homeless individuals, the Centre for Addiction Research of BC (CAR-BC) (2011) noted that 41% considered alcohol and drug use as a contributing factor in their lack of housing. Thomson (2016) reported that among the homeless in Vancouver, 53% reported addictions and substance use problems, 42% indicated that they had a medical condition and 40% reported mental health challenges. Homeless individuals with concurrent disorders are higher users of emergency services and are more likely to be involved with the justice system (Pearson & Linz, 2011).

There is no precise count of the number of homeless individuals in the province of BC. The Government of Canada's Homelessness Partnering Strategy has provided support to 61 communities across Canada to conduct a coordinated *Point-in-Time Count* of the homeless population. In BC, the highest numbers of homeless, unsheltered, sheltered and provisionally accommodated individuals are found in Vancouver and Victoria.

A failure to effectively treat individuals with severe substance use disorders may limit the ability to secure and maintain stable housing. Research shows that homeless people with concurrent disorders, in particular, who receive no additional supports have difficulty maintaining housing, which often results in cycling through shelters, the streets and emergency services (Patterson et al., 2014). Hence, it is crucial that live-in addiction recovery programs are effective in addressing the medical, psychiatric and social needs of those who come from precarious living arrangements.

3. Live-In Services as a Component of the Care Continuum

3.1 Residential Care Models

While the Tiered Framework covers the continuum of substance use services to address both population health and individual clinical need, residential care is a specialized care function, typically captured in Tiers 4 and 5 (as shown in Figure 1). Live-in services are appropriate for individuals who require a level of care that cannot be provided on an outpatient or non-residential basis.

Levels of residential addiction recovery services are defined differently by different agencies. In general, they refer to services that provide structured support and treatment in a 24-hour setting outside of hospital to individuals (U.S. Department of Health and Human Services, 2016).

The National Institute on Drug Abuse (NIDA, 2016) identifies three common types of residential treatment settings:

- Therapeutic communities in which the entire community of residents and staff act as agents of change through highly structured programming, typically 6 to 12 months in duration;
- Shorter-term residential treatment providing detoxification and intensive counseling as preparation for outpatient treatment;
- Recovery housing, which provides supervised accommodation following inpatient or residential treatment with support provided for transition to independent living.

Although designed for placement of health insurance clients, it is nonetheless instructive to consider the American Society for Addiction Medicine (ASAM) levels of residential/inpatient services. ASAM delineates greater separation among types of residential services than other systems, as follows:

- Clinically managed low-intensity residential services;
- Clinically managed population-specific high-intensity residential services;
- Clinically managed high-intensity residential services;
- Medically monitored intensive inpatient services;
- Medically managed intensive inpatient services.

In Canada, the Canadian Centre on Substance Abuse, as part of its system mapping tools (CCSA, 2014a) articulates three levels of residential services, differing in terms of structure and intensity:

- Supportive recovery providing a substance-free, stable environment with programming such as life skills coaching and mutual aid;
- Residential treatment providing structured, specialized programming on-site;
- Complexity-enhanced providing structured programming including individualized medical or psychiatric services for clients with concurrent mental health or co-morbid medical conditions.

In its *Service Model and Provincial Standards for Adult Residential Substance Use Services* (2011), British Columbia differentiates supportive residential programs from residential treatment (see description of each service type in Appendix B). The standards apply to residential programs in both service types/levels. It is not known if or how compliance with the standards is monitored.

Residential services funded and operated by the Provincial Health Services Authority exclusively represent complexity-enhanced or highly specialized services within the residential treatment category.

Regional health authorities also classify their residential services based on service intensity. The Fraser Health Authority (FH) formally distinguishes intensive residential treatment (IRT) from low to moderate intensity services and supports provided in stabilization and transitional living residences (STLR). The latter category differs from traditional support recovery homes because the STLR model emphasizes services and supports over housing.[7] Vancouver Coastal Health Authority (VCH) has also adopted the FH STLR model for contracting low to moderate intensity residential treatment beds. While a similar refinement of supportive recovery services may be present in the other regional health authorities, it has not been made explicit.

What is apparent is that both residential treatment and supportive residential program settings are therapeutic in nature, differing in degree of program intensity, specialization and the availability of on-site professional services. In some cases, the two settings serve unique individuals based on levels of severity and complexity. In other cases, the same client may move from supportive residential programs to residential treatment or move into supportive residential environment on completion of treatment. Hence, some agencies label the two programs as 1st and 2nd stage recovery (e.g. Chrysalis Society). This is consistent with the *Provincial Standards* (BC Ministry of Health, 2011) which state that "people do not reside in any one tier but may move up and/or down the tiers in accordance with their changing needs, strengths and preferences" (p. 7).

[7] Email correspondence, Sherry Mumford, Fraser Health Authority, December 2016.

3.2 Who Needs Residential/Live-In Care?

Residential care is designed to serve individuals in need of intensive or specialized care that corresponds to problem severity (Rush et al., 2012). Highly specialized residential services are required to support individuals with complex problems, including those with comorbid conditions. It has long been recognized that live-in addiction recovery services have social stabilizing goals as well as therapeutic goals (Health Canada, 1999). Hence, assessment of need for residential settings must take into account both clinical and functional circumstances. The US Surgeon General defines the population in need of residential care as "physically and emotionally stabilized individuals who may not have a living situation that supports recovery, may have a history of relapse, or have co-occurring physical and/ or mental illnesses" (U.S. Department of Health and Human Services, 2016, pp. 4-18).

BC's 2011 service model and standards do not provide specific criteria for assignment to its two levels of residential services: residential treatment and supportive residential programs. Rather, the province proposes foundational criteria for admission to residential service settings of either type. These include:

- The individual's readiness, willingness, and ability to look at the impact of his/her substance use;
- Evidence of negative effects of substance use on the individual's life in terms of health, functioning, family, work, education, and housing;
- The individual cannot be realistically served in an outpatient setting and requires an environment away from his or her living situation.

While the residential service standards specify the required elements of screening and assessment to inform what type of substance use services an individual needs, there is no provincial algorithm or guideline to determine assignment to each of the two levels of intensity in residential care. Some regional health authorities, however, do outline client eligibility characteristics in their contractual arrangements with residential service providers.

3.3 Live-In Addiction Recovery Services in BC

Residential addiction recovery services in BC are funded and delivered provincially and through regional health authorities and the First Nations Health Authority. The Ministry of Social Development and Innovation may provide financial support for client per diem fees charged by residential programs for individuals who are receiving income assistance.

Currently, there are just two[8] provincially managed live-in addiction recovery programs funded by the Provincial Health Services Authority: the Burnaby Centre for Mental Health and Addiction and the Heartwood Centre for Women. The Burnaby Centre offers a specialized inpatient treatment setting for individuals over age 19 experiencing severe and complex concurrent substance addiction and mental health disorders. The Burnaby Centre serves the needs of persons who are homeless or living in unstable housing. Heartwood operates as a provincial resource providing treatment for adult women with substance dependence who are independent in activities of daily living.

The five regional health authorities also provide funding for provincially licensed live-in addiction recovery beds. As noted above, the BC Ministry of Health classifies these beds as residential treatment or supportive residential services. At least two regional health authorities have relabelled the latter as stabilization and transitional living residences (STLR) reflecting the fact that the services and supports provided by these facilities represent a level of "treatment" for individuals who have low to moderate levels of severity. The renaming of the STLR beds also served to differentiate the provincially licensed, registered services from the unlicensed, unregistered facilities offering supported recovery.[9]

Publicly funded residential substance use services beds are largely operated through contractual arrangements with licensed community care facilities owned by private not-for-profit agencies. The exceptions to this include the Maple Ridge Treatment Centre, owned and operated by the Fraser Health Authority, and three facilities, Seven Sisters, Birchwood, and Nechako Youth Treatment Program, delivered as direct services by the Northern Health Authority. The majority of live-in addiction recovery beds are in the Fraser Region.

As noted earlier, several residential treatment services are funded through the National Native Alcohol and Drug Abuse (NNADAP) program and delivered under the auspices of the First Nations Health Authority (FNHA). The program began at a national level in 1982, and evolved from a joint initiative between Department of Indian and Northern Development and Health and Welfare (now known as Health Canada) (Government of Canada, 1998). Under the Tripartite Framework Agreement on First Nation Health Governance (2011), responsibility for design, delivery and accountability of NNADAP services was transferred from the Federal government to the First Nations Health Authority in BC. There are currently eleven NNADAP facilities operating in BC. NNADAP programs may also accept non-Native Canadians, particularly in smaller, isolated communities.[10]

[8] Note: The Crossing at Keremeos is a residential treatment program for youth and young adults, operated and funded by PHSA which re-opened in early 2017. The Crossing is not included in our report because the facility re-opened after our data collection period ended in November 2016.

[9] Personal correspondence, Sherry Mumford, Fraser Health Authority, December 2016.

[10] http://www.canadadrugrehab.ca/BC/British-Columbia-Outpatient-Alcohol-Drug-Rehab-Programs.html

Subsequent to the launch of this project, it was learned that the Ministry of Health requires health authorities to report twice a year on community substance use beds for four different types of facilities. The provincial definitions for the four facility types, of interest in this project are presented in Table 2. These definitions are slightly different from those documented in the *Provincial Standards* (2011).

Table 2: provincial Definitions of Four Residential Facility Types

Facility Type	BC Adaptation of Tiered Model in BC
Adult Residential Treatment	Adult facilities are safe, structured, substance-free settings, usually licensed under the Community Care and Assisted Living Act (CCALA), and are funded by the health authorities. Residential substance use services provide time-limited, live-in intensive treatment for individuals who are experiencing substance use problems, and whose assessment indicates that they will be effectively served through intensive treatment. Professional practitioners provide assessment, structured individual, group counselling and may include family counselling/therapy, as well as psychosocial education and life-skills training. Some programs may also provide medical, nursing or psychiatric support. Staff are on-site 24 hours a day. Programs generally range from 30-90 days.
Youth Residential Treatment	Youth facilities are safe, structured, substance-free settings, usually licensed under the Community Care and Assisted Living Act (CCALA), and are funded by the health authorities. Residential substance use services provide time-limited, live-in intensive treatment for individuals who are experiencing substance use problems, and whose assessment indicates that they will be effectively served through intensive treatment. Professional practitioners provide assessment, structured individual, group counselling and may include family counselling/therapy, as well as psychosocial education and life-skills training. Some programs may also provide medical, nursing or psychiatric support. Staff are on-site 24 hours a day. Programs generally range from 30-90 days.
Adult Supportive Residential Services (Supportive Recovery)	A temporary residential, substance-free setting for adults, funded by health authorities to provide a safe, supportive environment for individuals who are experiencing substance use problems. Support recovery programs deliver low to moderate, time-limited supports and services for clients. They meet the needs of individuals who are preparing to enter residential treatment or those who have left more intensive residential treatment but who require additional support to reintegrate into the community, or for those requiring a longer term structured environment while preparing to transition into a more stable lifestyle. Activities may include coaching for daily living, community reintegration, vocational and educational planning, participating in mutual aid supports, and some counselling and case management. Individuals access outpatient and other community treatment services and supports. Services may be provided in facilities that are registered under the Community Care and Assisted Living Act (CCALA). Programs generally range from 30-90 days.

Youth Supportive Residential Services (Supportive Recovery)	A temporary residential, substance-free setting for youth, funded by health authorities to provide a safe, supportive environment for individuals who are substance use problems. Support recovery programs deliver moderate, time-limited supports and services for clients. They meet the needs of individuals who are preparing to enter residential treatment or those who have left more intensive residential treatment but who require additional support to reintegrate into the community, or for those requiring a longer term structured environment while preparing to transition into a more stable lifestyle. Activities may include coaching for daily living, community reintegration, vocational and educational planning, participating in mutual aid supports, and counselling and case management, and wrap-around services. Individuals access outpatient and other community treatment services and supports. Services may be provided in facilities that are registered under the Community Care and Assisted Living Act (CCALA). Programs generally range from 30-90 days.

It is difficult to obtain an up-to-date figure on the number of publicly funded beds in any given programs as treatment centres are, on an ongoing basis, converting beds (treatment, detox, supported recovery) and adjusting contractual arrangements. In 2013, the Province of BC made a commitment to open 500 new substance use treatment beds by 2017. On January 18, 2017, the BC Ministry of Health announced another 60 new beds (in addition to the 500) for intensive residential treatment.[11] As such, bed availability around the province is regularly changing in response to government funding and initiatives.

In attempt to provide an accurate count of publicly funded live-in addiction recovery beds in the province, we sought the most recent official reports (September 30, 2016) from regional health authorities. Spreadsheets with detailed bed counts were provided by Fraser Health, Interior Health and Vancouver Island Health Authority. The BC Ministry of Health provided a summary bed count by health authority, but not by facility. As such, we were unable to confirm the bed counts by facility using the BC Ministry of Health report.

Some bed count discrepancies were resolved through discussions with the regional health authority managers. For example, the BC Ministry of Health reported 168 Adult SR and IRT beds in VCH, whereas VCH reported 105 contracted beds for the purposes of the project. We learned that the BC Ministry of Health report includes beds which can *be accessed* by VCH clients but do not necessarily reflect a contractual arrangement. VCH has contractual agreements for 105 beds, but they report to the BC Ministry of Health the total number of beds that they have

[11] https://archive.news.gov.bc.ca/releases/news_releases_2013-2017/2015HLTH0108-002166.pdf

access to and are able to fund. The complexity of the contractual arrangements and reporting practice poses a challenge for determining an accurate count of publicly-funded beds.

After the data collection and analyses, the project team also learned that the BC Ministry of Health does not include the Burnaby Centre for Mental Health and Addictions in the *Community Substance Use* bed count. The Burnaby Centre is reported as Tertiary Substance Use/Concurrent Services, which is another category of services. Despite the fact that the Burnaby centre is reported in a separate category from the others facilities, we have chosen to include the Burnaby Centre in our results.

Based on data that was accessible to the CARMHA research team along with information obtained from personal communication with PHSA, regional health authorities, and the BC Ministry of Health, Table 3 provides an **estimate** of publicly funded live-in addiction recovery beds in BC at the time of the survey.

Table 3: Publicly-funded Live-in Addiction Recovery Beds as of November 30, 2016

RESIDENTIAL TREATMENT SERVICES				
FACILITY NAME	**REGION**	**OWNERSHIP**	**POPULATION FOCUS**	**BEDS**
Burnaby Centre for Mental Health and Addiction**	Provincial	Provincial Health Services Authority	Adults	94
Heartwood Centre for Women	Provincial	Provincial Health Services Authority	Adult females	28
Maple Ridge Treatment Centre	Fraser	Fraser Health Authority	Adult males	50
Peardonville House	Fraser	Kinghaven Peardonville House Society	Adult females	28
Kinghaven Treatment Centre	Fraser	Kinghaven Peardonville House Society	Adults	52
Pacifica	Vancouver Coastal	Pacifica Treatment Centre	Adults	27
Round Lake Treatment Centre	Interior/FNHA	Round Lake Alcohol and Drug Treatment Society	Adults, Indigenous	36
The Bridge Assisted Living Residential Program	Interior	The Bridge Youth and Family Services Society	Adults	20
Seven Sisters	North	Northern Health Authority	Adults	20
Birchwood	North	Northern Health Authority	Adults	5
Nechako Youth Treatment Program	North	Northern Health Authority	Youth	7
NNADAP Residential Treatment Services				
Namgis Treatment Centre	FNHA	First Nations Health Authority	Adults, Indigenous	15
North Wind Healing Centre	FNHA	North Wind Healing Centre Society	Adults, Indigenous	10
Tsow-Tun Le Lum	FNHA/Island	Tsow-Tun Le Lum Society	Adults, Indigenous	19
Kackaamin Family Development Centre	FNHA/Island	Kackaamin Family Development Centre Association	Adults, Indigenous	9
Gya'wa'tlaab Healing Centre	FNHA/North	Gya'wa'tlaab Healing Centre Society	Adult Males, Indigenous	16

Nenqayni	FNHA/Interior	Nenqayni Wellness Centre	Adults & Youth, Indigenous	10
Total Residential Treatment Beds				**446**
**The Burnaby Centre is reported by the BC Ministry of Health as a Tertiary Service, not a Community Substance Use Service				

SUPPORTIVE RESIDENTIAL SERVICES				
FACILITY NAME	**REGION**	**OWNERSHIP**	**POPULATION FOCUS**	**BEDS**
Charlford House	Fraser	Charlford House Society for Women	Adult females	13
Last Door Recovery Centre	Fraser	Last Door Recovery Society	Adult males	20
Last Door Youth Program	Fraser	Last Door Recovery Society	Youth males	4
Phoenix Drug and Alcohol Centre	Fraser	Phoenix Drug & Alcohol Recovery & Education Society	Adult males	28
Westminster House	Fraser	Julien House Society	Adult females	10
Ellendale Place	Fraser	Elizabeth Fry Society of Greater Vancouver	Adult females and pregnant females	22
Prairie House	Fraser	Inner Visions Support Recovery Society	Adult males	15
Path to Freedom	Fraser	Path to Freedom Recovery Centre Ltd.	Adult males	5
Valley House	Fraser	Kinghaven Peardonville House Society	Adult males	6
Mollies Place	Fraser	Kinghaven Peardonville House Society	Adult females	6
Hannah House	Fraser	Inner Visions Support Recovery Society	Adult females	10
New Beginnings	Fraser	Elizabeth Fry Society of Greater Vancouver	Pregnant females	4
Central City Lodge	Vancouver Coastal	City Centre Care Society	Adult males	22
New Dawn	Vancouver Coastal	Chrysalis Society	Adult females	10
Together We Can	Vancouver Coastal	Together We Can Addiction Recovery and Education Society	Adult males	16

Turning Point	Vancouver Coastal	Turning Point Recovery Society	Adults	30
Transitions	VIHA	NARSF Programs LTD	Youth	3
Comox Valley Recovery Centre	VIHA	Comox Valley Recovery Centre Society	Adults	20
Second Chance	VIHA	North Island Supportive Recovery Society	Adults	6
180	VIHA	John Howard Society of North Island	Youth	1
Beacon of Hope House (Salvation Army)	VIHA	Salvation Army	Youth	4
Ann Elmore House	VIHA	Campbell River and North Island Transition Society	Adults	2
Amethyst House	VIHA	Comox Valley Transition Society	Adults	6
New Leaf	VIHA	Vancouver Island Mental Health Society	Adults	5
The Grove	VIHA	Vancouver Island Health Authority	Adults	10
Holly Place	VIHA	Vancouver Island Health Authority	Adults	5
Lilac Place	VIHA	Vancouver Island Health Authority	Adults	6
Her Way Home	VIHA	Vancouver Island Health Authority	Youth	4
Comerford Apartments	VIHA	Vancouver Island Health Authority	Adults	10
Total Supportive Residential Service Beds				**303**

4. Survey of BC Live-In Addiction Recovery Services with Publicly Funded Beds

4.1 Survey Approach and Methods

Identifying the survey sample of providers

The survey sampling strategy attempted to capture all BC-based facilities providing live-in addictions recovery services with a minimum 30-day program that receive health authority funding for designated beds. All facilities providing publicly funded residential services are licensed under the *Community Care and Assisted Living Act*. The sample selection involved a web search and consultation with provincial and regional health authority leads responsible for substance use planning and service delivery to identify relevant facilities.

The project Advisory Committee was helpful in identifying residential treatment facilities, particularly in Vancouver Coastal Health Authority area. Contact information for the Fraser Health Authority organizations were obtained from a document provided by the manager that oversees substance use services. The list of residential addictions programs in the North was readily available as such programs are operated as direct services by the Northern Health Authority. Obtaining lists of residential programs with publicly funded beds in the Interior Health Authority and Vancouver Island Health Authority proved more challenging initially; therefore, the Drug Rehab & Addiction Services Canada[12] and the Canada Drug Rehab[13] websites were used as a secondary source to identify live-in addiction recovery services. Additionally, identified facilities in each region were contacted by phone or email to verify that they received public funding. In January, Vancouver Island Health Authority and First Nations Health Authority provided a comprehensive list of facilities that included a number of agencies that were not discovered during our search. Many of these facilities were not contacted until *after* the data collection period (September – November, 2016) and so the survey data are not included in the analyses. Unfortunately, this meant that several of the facilities listed in Table 3 were not included in the survey sample pool.

Through this process, a list of 29 potential organizations was identified. In terms of the total pool of organizations, this number differs from that (provided in Table 3) subsequently determined from the health authority reports and correspondence.

[12] http://www.canadadrugrehab.ca/

[13] http://www.drugrehab.ca/

The sample includes two provincial programs, categorized by PHSA as "complexity- enhanced" residential treatment: the Burnaby Centre for Mental Health and Addictions (BCMHA) and the Heartwood Centre for Women. BCMHA, in particular, serves a population that is considered more complex than that served by any other treatment facilities in the province. As mentioned, the BC Ministry of Health does not include BCMHA beds in their count of Community Substance Use beds – they are reported as Tertiary Substance Use/Concurrent Services.

Survey Development

The survey content was developed around domains of interest determined by the project Advisory Committee. These domains included program parameters, client characteristics, inclusion/exclusion criteria, staffing, specialized service provision, programming, funding and fees, data and accountability. See Appendix C for a copy of the survey template.

Administering the Surveys

Surveys were distributed via email to 29 organizations identified as providing publicly funded treatment beds. Each facility was instructed to either complete the survey and return it via email or schedule an interview with the research assistant to complete the survey over the phone. Of the 24 facilities that responded, 14 facilities opted to do the phone interview. A research assistant reviewed each survey and followed up with the organizations in instances where there were missing or unclear responses. For a list of the 24 facilities that responded to the survey, see Appendix A.

Caveats and Limitations

The sample includes both residential treatment programs and supportive residential programs. The websites of many of the latter describe themselves as providing treatment yet they are not classified as such for health authority reporting purposes. In this project, the assignment of programs to the two categories was based on the information provided by the health authorities.

It was apparent that some survey respondents completed the survey in terms of their agency and *total* beds and not specifically pertaining to those beds that are publicly-funded. As a result, certain data including client volumes cannot be compiled and other data may not uniquely characterize public beds.

In instances, where survey data appeared questionable or incomplete, cross-referencing with agency websites was undertaken to obtain more accurate information.

4.2 Survey Results

Many facilities in the province have a long history of providing live-in addiction recovery services, spanning several decades. Some organizations provide both supportive residential services and intensive residential treatment at different facilities or sites. Where possible, results are presented by facility type.

4.2.1. Facility profiles

Location

Table 4 provides a geographic breakdown of the 24 facilities that responded to the survey. While only two facilities are funded and managed as provincial services by the Provincial Health Services Authority (PHSA), most programs within regional health authorities accept out-of-region referrals. The large majority of facilities operate within the Fraser Health Region. Three facilities receiving public funding from the Island Health Region were invited to participate in the survey but none responded during the data collection period of the project.

Table 4: Facility Location

Region	# (%) of Programs	
	Residential Treatment	Supportive Residential
Fraser	3(25%)	8(66.7%)
Vancouver Coastal	1(8.3%)	4(33.3%)
Northern	4(33.3%)	0
Interior	2(16.7%)	0
Island	n/a	n/a
Provincial	2 (16.7%)	0
Total	12(100%)	12(100%)

Population Focus

Eight of the 24 facilities surveyed are open to both males and females; eight serve men only and seven serve women only. While only one program reported that it had designated beds for transgendered individuals, several noted that they do accept transgendered clients and in some instances this was made explicit on the agency website (i.e., Heartwood Centre for Women).

Twenty-two facilities exclusively serve adults, one facility serves both youth and adults and only one program, Nechako, is youth-specific.

Two of the surveyed agencies – Gya'wa'tlaab Healing Centre and Round Lake Treatment Centre serve First Nations, Aboriginal and Metis people using holistic and traditional healing approaches. It should be noted that there are other live-in addiction recovery programs in BC with a focus on Indigenous people that are not included in this survey (see Table 1Table 3 for list of FNHA/NNADAP facilities).

Table 5: Population Focus

	Residential Treatment			Supportive Residential			
	Youth	Adult	All Ages	Youth	Adult	All Ages	Total
Males only		2			5	1	8
Females only		2			5		7
Male & Female	1	7			1		8
Total	1	11			11	1	24

Accreditation

Less than half (46%) of facilities responding to the survey are accredited (Table 6). One agency reported that they are undergoing an accreditation process. The most common accrediting body was *Accreditation Canada* (6 agencies) followed by the *Commission for Accreditation of Rehabilitation Facilities Canada* (3 agencies) and the *Council on Accreditation* (1 agency). Residential treatment programs were much more likely to be accredited than supportive residential programs.

Table 6: Accreditation Status

	# (%) of Programs		
	Residential Treatment	Supportive Residential	All programs
Accredited	8 (66.7%)	3 (25.0%)	11 (45.8%)
Not accredited	3 (25.0%)	9 (75.0%)	12 (50%)
In progress	1 (8.3%)	0	1 (4.2%)

4.2.2. Program Parameters

Eligibility/Admission Criteria

With the exception of questions concerning detox requirements, survey questions did not systematically address specific inclusion/exclusion criteria. Rather, respondents were asked to list criteria in an open-ended question. Hence, the data is not sufficiently comprehensive to present an accurate description of program eligibility criteria.

The large majority of live-in recovery programs require that clients be fully detoxed before admission. Only two programs (Heartwood Centre and Burnaby Center) do not require prior detoxification because detox is provided on site. In addition, most specify a period of non-use between detox and recovery program entry. Table 7 illustrates the range of requirements.

Table 7: Detoxification Requirements

Required?	0 to 3 days	4 to 7 days	+ 7 days	Variable
Yes (22)	11	7	1	3
No (2)	n/a	n/a	n/a	n/a

With respect to other eligibility criteria, four of twelve residential treatment programs and four of twelve supportive residential programs specified that clients with opiate addiction must be stabilized on opiate substitution therapy prior to program entry. One-quarter of supportive residential service providers reported that individuals on opiates or psychotropic drugs were not eligible to receive treatment. Three programs do not provide opiate replacement therapy (ORT). Among those that do, four limit the number of residents on ORT due to licensing.

One program reported that clients cannot be accepted if they are addicted to benzodiazepines, amphetamines or opiate controlled substances, another does not accept people with a dependence on benzodiazepines or Zoplicone, and another reported refusal of people on "certain medications."

Most respondents noted that clients must be willing to participate is all aspects of the live-in recovery program. One program requires clients to have completed six pre-treatment counseling sessions.

Half (50%) of programs responding to the survey indicated that clients entering treatment must be psychiatrically and medically stable. Consistent with this is the finding that all twelve supportive residential programs reported that individuals with severe and/or untreated mental or psychiatric conditions are ineligible. Exclusion of people with serious mental health problems was much less frequent among residential treatment providers. Reported exclusionary criteria

included active suicidal ideation, eating disorders, and personality disorders but this was not consistent across programs. Overall, sixty percent of programs do not accept people with severe mental health or developmental difficulties and three-quarters noted that they do not accept high-risk individuals – e.g. those who may be sexual offenders or violent. Ten programs listed 'current involvement with the criminal justice system' as exclusionary criteria.

Referral Pathways

It was learned that while Vancouver Coastal Health Authority has a central addiction intake referral process for its supportive transitional living residences (STLRs) and treatment facilities, questions exist as to whether it is region-wide. Fraser Health Authority does not have centralized intake but is working towards implementation of such. Northern Health Authority controls access only to its owned and operated residential programs. In the Interior, access occurs through different routes although it is known that The Bridge requires Interior Health screening prior to admission. Vancouver Island has a community-based referral system where individuals would need to access outpatient mental health centres and meet with a counsellor who then determines what services would be appropriate for them. An extensive list of referral sources was evident from survey sources. Surprisingly, 15 agencies included self-referrals in their list of referral pathways. The project sought additional information to ascertain whether access to these higher tier services was controlled through mechanisms for centralized intake and placement. This was found to be the case for PHSA funded provincial programs. The Burnaby Centre and the Heartwood Centre for Women require that community-based addictions services in the individual's regional health authority must have been exhausted. The referral pathways appear to differ substantially across the health authorities.

Waitlists

At the time of the survey, all but two programs indicated that all of their available beds were full. Only three programs reported no waitlist. The number of clients who are waitlisted ranged from 2 to 53. Three programs reported waitlists in excess of 50 people (Maple Ridge Treatment Centre, Phoenix Recovery Society, and Turning Point Recovery Society).

Table 8: Waitlist Breakdown

	# of Support Recovery programs	# of Residential Treatment Programs
1-25 people	8	8
26- 50 people	1	0
50+	2	1

Program duration

The survey asked respondents about length of stay, which can be different than program duration insofar as some facilities have flexible completion criteria. Agency websites were consulted to obtain information about program length at residential treatment facilities which theoretically offer time-limited intensive programming (Table 9). The Burnaby Centre provides longer treatment stays given the complexity of its residents. Supportive residential services are less structured than residential treatment programs and most offer long-term support to residents as they transition to community living. While some do specify a fixed program length (e.g., Central City Lodge – 90 days), others report variable lengths of stay -- in some cases up to one-year. As a result, program lengths for supportive residential services could not be tabulated.

Table 9: Residential Treatment Program Duration

	# of Programs
30 to 60 days	7
60 to 90 days	4
90 to 120 days	0
120 days or longer	1

Completion Rates

It was very difficult to determine the volume of clients entering and completing live-in treatment programs given that most survey respondents provided data for their facility as a whole and not unique to their publicly funded beds. What was apparent is that the proportion of clients who drop out prior to program completion is substantial as is the number who are asked to leave for non-compliance reasons – typically a failure to remain alcohol or drug free. Table 10 illustrates how the two service categories compare in responding to resident alcohol and/or drug use. It is apparent that supportive residential programs are less tolerant of client substance use or relapse.

Table 10: Consequences of Alcohol/Drug Use

	# of Programs	
	Residential Treatment	Supportive Residential
Immediate Discharge	2	5
Discharge only if use on site	1	2
Other provisions/possible restrictions	8	7

Follow-Up

The large majority (10/12) supportive residential programs reported formal follow-up practices with clients after discharge. Surprisingly, only five of the 12 residential treatment programs noted that they conduct formal follow-up activities.

Staffing

Survey respondents were asked whether the live-in recovery services they provide have access to different types of human resources, secured under different funding arrangements. Table 11 shows the number of programs that have formal support from different professionals, defined as staff or contract (including sessional) arrangements. Physician services that were provided via other arrangements (which may include MSP fee-for-service, or staff provided by funder) were not considered to represent a formal arrangement.

Due to the higher level of specialization in the two PHSA programs, practitioner type is shown separately for these complexity-enhanced programs. It should be noted that not all professionals are secured on a full-time basis. The majority provides part-time services and support.

Table 11: Staffing by Professional

Provider	Programs # (%)		
	Complexity Enhanced n = 2	Residential Treatment n = 10	Supportive Residential n= 12
Addiction Medicine Specialist	2 (100%)	3 (30%)	5 (42%)
General Practitioner	1 (50%)	1 (10%)	1 (8%)
Psychiatrist	2 (100%)	4 (40%)	1 (8%)
Psychologist	1 (50%)	2 (20%)	1 (8%)
Counsellor	2 (100%)	8 (80%)	11 (92%)
Social worker	2 (100%)	4 (40%)	2 (17%)
Psychiatric Nurse	2 (100%)	1 (10%)	1 (8%)
Registered Nurse	2(100%)	4 (40%)	1 (8%)

Less than half of all residential programs report staff or contractual access to physician services. Opiate replacement therapy was reported as available at all supportive residential facilities but only 9 of 12 residential treatment facilities.

Ten programs reported physicians with specialized training in addictions were part of their staffing mix. Aside from provincial programs, addiction medicine support in residential

treatment programs was not higher than in supportive residential services. In most cases, the degree of specialized medical involvement was limited to once per week. Two residential treatment programs reported that they had access to Addiction Medicine Physicians through MSP fee-for-service, and one program's funder provided an Addiction Medicine Physician once per week. Four residential treatment programs reported that did not have access to an addiction medicine specialist. It should be noted that there is no way of knowing whether these physicians are certified with the American Board of Addiction Medicine (ABAM) or other body.[14]

Only three reported formal general practitioner (GP) arrangements. However, addiction medicine physicians are also GPs. A few programs noted that their access to physician services was via other arrangements such as through their funder or MSP fee-for-service billing and therefore not part of their program budget. Furthermore, less than half of programs employ registered nurses.

Mental health specialist support in live-in addiction recovery services is very limited in terms of access to psychiatrists, psychologists, and psychiatric nurses. Complexity-enhanced residential settings include mental health professionals in their staff mix and residential treatment programs tend to use psychiatrists more than supportive residential services. Nearly all programs employ counsellors but it cannot necessarily be concluded that they are registered clinical counsellors. Unlike "psychologists" for whom use of the professional title is regulated, no regulation protects the use of the title for counsellors. The title appears to describe staff with different levels of education and experience. Some residential service provider websites noted that they employ addictions counsellors that have certification through the Canadian Addiction Counsellors Certification Federation (CACCF).[15] Survey respondents also listed many other administrative and non-specialist workers as part of their staffing. All but one program reported employing staff with lived experience.

Scope of Specialized Services

Survey respondents were asked to indicate whether they provided in-house specialized services for specific clients' needs (shown in Table 12). Of interest here is that a high proportion of supportive residential service programs report in-house services for clients with mental health concerns including mood or anxiety disorders, eating disorders, and concurrent disorders. This is an unexpected finding given the very limited number of mental health specialists working in these settings according to the results in Table 11. However, as noted earlier, supportive

[14] The Canadian Society of Addiction Medicine presently offers a certificate process which is based on the successful completion of either the American Board of Addiction Medicine or International Society of Addiction Medicine examination.

[15] http://www.caccf.ca

residential programs report that they do not admit individuals with severe or untreated mental illness.

Table 12: In-House Provision of Specialized Services

Client Need	Complexity Enhanced n = 2	Residential Treatment n = 10	Supportive Residential n= 12
Concurrent Disorders	2 (100%)	9 (90%)	9 (75%)
Intellectual/ Developmental Disorder	2 (100%)	9 (90%)	7 (58%)
Wheelchair accessibility	2 (100%)	9 (90%)	6 (50%)
Visual/Hearing Impairment	2 (100%)	5 (50%)	7 (58%)
Eating Disorders	2 (100%)	7 (70%)	10 (83%)
Mood or Anxiety Disorders	2 (100%)	9 (90%)	12 (100%)
Survivors of Violence	2 (100%)	9 (90%)	11 (92%)
Residential School Experience	2 (100%)	9 (90%)	10 (83%)

Program Activities

Table 13 provides a picture of the weekly program components reported by agencies competing the survey. Complexity-enhanced programs have been included in the residential treatment category as there were no obvious programming differences in this list that set provincial programs apart. As is evident, there are no major differences in the nature of programming offered between residential treatment and supportive residential services. Both offered multi-faceted programs. Supportive residential facilities are slightly more likely to provide vocational training as a component of programming. Unfortunately, the survey did not capture specialized clinical activities that may differentiate programming across types of residential services.

Table 13: Program Activities

Activity	Residential Treatment n = 12	Supportive Residential n = 12
Life skills	11 (92%)	12 (100%)
Educational training	9 (75%)	8 (67%)
Vocational training	3 (17%)	5 (42%)
Art therapy	11 (92%)	9 (75%)
Yoga/meditation	10 (83%)	10 (83%)
Support Groups	10 (83%)	12 (100%)
12-Step	11 (92%)	12 (100%)
Group therapy	11 (92%)	11 (92%)
Physical education	10 (75%)	8 (67%)

Outdoor recreation	11 (92%)	7 (58%)
Musical activities	8 (67%)	6 (50%)
First Nations	7 (58%)	7 (58%)
SMART recovery	8 (67%)	6 (50%)
Community events	11 (92%)	11 (92%)
Faith based	4 (33%)	2 (17%)

4.2.3. Client Characteristics

Physical and Mental Health

The survey does not provide a client profile compiled from individual client data. Rather, survey respondents provided an aggregate description of clients in terms of certain key characteristics.

Clients of residential services, irrespective of service level, were described as being affected by multiple physical health conditions. Common resident medical problems include but are not limited to:

- Diabetes
- Heart disease
- Liver disease
- HIV-AIDS
- Kidney disease
- Arthritis
- Chronic Pain
- Trauma wounds/injuries
- Sleep disorders
- Asthma
- Malnutrition
- Sexually transmitted infections
- Tuberculosis
- Seizure disorders
- Dermatological conditions (eczema, psoriasis)
- Hepatitis
- Crohn's disease

The most commonly reported concurrent psychiatric conditions across all agencies were depression and anxiety. Residential treatment facilities were more likely to report schizoaffective, bipolar disorders and personality disorders than supportive residential facilities. Schizophrenia, schizoaffective disorder and other psychotic conditions were noted as the primary mental health diagnoses among residents of the Burnaby Centre for Mental Health and Addictions. The Heartwood Centre for Women identified post-traumatic stress disorder as the most common concurrent disorder followed by depression, anxiety and bipolar disorder.

Housing, Employment and Criminal Justice Status

Nine of the 24 programs surveyed indicated that they track housing status at intake. This finding was at odds which other information provided by survey respondents showing that 83% of supportive residential programs and 73% of residential treatment programs address housing as part of clients' transitional planning. Employment status and criminal involvement were more difficult to determine because five out of twelve residential treatment facilities simply do not track these data and therefore, it is difficult to make comparisons between the two treatment levels on these client outcomes.

The majority of programs report improvements in housing status over the course of the client's stay. Given the wide range and variation in the figures, it is difficult to interpret the client status data in a meaningful way.

Table 14: Housing Status

Housing Status	Range (%)	
	Residential Treatment	Supportive Residential
Homeless at intake	5% – 50%	0% - 88%
Homeless at discharge	0% - 10%	0% - 66%
Precariously housed at intake	50% - 80%	5% - 70%
Precariously housed at discharge	10% - 75%	5% - 50%

Table 15: Criminal Justice Involvement

	Range (%)	
	Residential Treatment	Supportive Residential
Criminal Justice Involvement	20% – 60%	15%-80%

Table 16: Employment Status

Employment Status	Range (%)	
	Residential Treatment	Supportive Residential
Employed at intake	5% – 50%	1%-50%
Employed at discharge	1%-24%	1%-24%

4.2.4. Provider Perspectives

Survey respondents were given the opportunity, in open-ended questions to:

- Identify the most significant barriers to access to live-in addiction recovery services in BC;
- Identify needed supports to better serve the population of people with substance use and mental health challenges;
- Make recommendations to policy-makers and decision-makers in BC to improve addiction recovery services in the province.

There was considerable overlap in the nature of responses across the three questions. In terms of barriers to access, the most common issues were wait-times for services, client fees, and insufficient detox services. Some agencies identified pre-existing medical and psychiatric conditions as well as poly-pharmacy as a factor in clients being able to access residential services.

Survey respondents offered very specific suggestions in terms of better support for residents with concurrent mental disorders. These included:

- Better links with primary health care;
- Additional resources to secure mental health specialists;
- Greater collaboration with health authority mental health services;
- More training for program staff;
- Increased availability of addiction medicine specialists;
- Aftercare support for clients with concurrent disorders.

Recommendations to decision-makers centered on the need for additional funding to address a variety of service and support needs. These included:

- Transition support for clients who have completed detoxification and are awaiting facility placement;
- Consistent medical care through on-site physician and nurses;
- An increase in residential treatment beds;
- More detox capacity in community;
- Pre- and post-treatment recovery beds, and targeted programs;
- Funding for individuals who cannot afford treatment but do not quality for MSDI support;
- More transitional housing for women and their children;
- Better support and resources for people returning to small rural and remote communities.

5. Key Findings and Implications for Live-in Addiction Recovery Services Planning & Delivery

This project consulted key information sources through web searches, relevant document reviews, and drew from a voluntary survey of providers and other data sources to construct a picture of live-in addiction recovery services in BC. While this does *not* reflect a systematic or comprehensive review of the sector, the project identified a number of issues that have implications for the planning and delivery of residential substance use services going forward. The findings are timely in light of the recent BC Government announcement of a major investment to address opioid addiction that will include 60 new residential treatment beds. Expanded bed capacity must occur in the context of care quality, clinical capacity issues and continuity of care throughout the spectrum of detox through to residential treatment and aftercare.

The attempt to quantify publicly funded live-in addiction recovery bed capacity in BC yielded a count of 446 residential treatment beds (352 when BCMHA is excluded) and 303 supportive residential beds. There are currently no accepted service planning benchmarks for residential substance use treatment beds in Canada. It is difficult to determine system needs by looking at residential services alone (tiers 4 and 5) because the optimal number of residential service beds is contingent upon there being adequate services and supports at lower tiers of the tiered framework to support affected individuals at all levels of severity. Earlier and lower-intensity interventions may help prevent or delay the progression to more severe and complex conditions that require more intensive treatments in residential settings.

The results of this survey suggest that clients admitted to live-in addiction recovery services in BC, both supportive residential programs and residential treatment programs, have multi-faceted needs. In addition to substance use disorders, residents appear to suffer from a myriad of medical conditions, many chronic in nature, as well as concurrent psychiatric problems. Further, a substantial percent have unstable housing, unemployment and a history with criminal justice system involvement. Those who are homeless may come from more marginalized and disadvantaged backgrounds (greater accumulation of risk factors with less protective factors) over the life course contributing to adverse trajectories and persistent health inequalities. Due to these factors and the increasing awareness of substance-related harms and poly-drug use, improvements in the delivery of residential substance use services are warranted.

5.1 Clarity around Levels of Residential Care

Higher tiers of service are designed to provide specialized care functions to the subset of individuals in need of intensive interventions in alignment with the severity and complexity of their conditions. In BC, there appears to be a blurring of functions across these tiers as both

residential treatment services and supportive residential services share therapeutic and social stabilizing goals. While provincial standards describe two levels of residential services, in reality, further subtyping exists. Two health authorities in BC contract for "upgraded" supportive residential services in the form of STLRs, facilities that are recognized as providing low to moderate intensity treatment, distinguishing them from traditional supportive recovery services. Indeed, the websites of a number of supportive residential services advertise their services as "treatment." Within the category of residential treatment, the two provincial complexity-enhanced programs offer higher level of service intensity and specialization than health authority funded live-in treatment programs. Hence, four levels of service actually exist in BC.

At the systems level, formal criteria are lacking to determine which clients are best served at what levels, appropriate referral pathways and the core elements or interventions that are unique to different levels of service intensity. Without regional barrier-free centralized access mechanisms and adequate avenues of client funding, the matching of clients to the appropriate intensity of care and the array of needed supports is difficult, precluding efficient utilization management of the most costly tiers of service.

It is recommended that consideration be given to:

- A clearer articulation of the factors that differentiate levels of residential substance use service, and the clients they are intended to serve;
- Explicit referral criteria and centralized intake/standardized placement;
- A utilization review to better understand the clinical and social characteristics of clients using residential treatment services.

5.2 Clinical Capacity to Address Concurrent Disorders

Although most supportive residential facilities and some residential treatment facilities identify severe and untreated mental disorders as an exclusion criteria for program admission, it is evident that mental health concerns among residents of live-in addiction recovery services are common. What is not obvious is the clinical capability to provide specialized treatment for concurrent disorders within these settings. Many residential programs claim to provide specialized services but in the absence of formal arrangements with mental health specialist practitioners.[16] Provincial complexity-enhanced services offer mental health specialist support but this is not routine outside of provincial programs. Like elsewhere in North America, substance use treatment in residential programs in BC appears to be provided primarily by

[16] Subsequent to the survey, it was learned that Fraser Health does employ Adult Youth Concurrent Disorders Therapists who work across the Fraser Region and may do consults or assessments of clients in residential facilities.

practitioners who likely have varying levels of formal training but who are not always mental health professionals. Further, as one member of the project advisory group noted in addition to variations in certification requirements, continuing education requirements (and educational provisions) for staff for non-regulated professions vary greatly by centre.

The CCSA (2014b) has published the technical and behavioural skills and competencies for Canada's substance abuse workforce as a means of promoting professionalism in the field. In BC, it is known that staff working in the substance use treatment system, including employees of contracted agencies have been encouraged to take the Core Addiction Practice (CAP) training to encourage best practice among addictions recovery practitioners. As noted earlier, some counsellors have attained CACCF certification and those with Masters' level training may be registered with the BC Association of Clinical Counsellors.

On the basis of the data available through this project, including service provider perspectives, the ability to provide specialized services to residents with *both* substance use and mental disorders in live-in addiction recovery programs appears to be profoundly insufficient. As such, efforts should be directed to:

- Enhance provision of mental health specialist support in both supportive residential facilities and residential treatment facilities.

5.3 Degree of Medical Support

Medical support, in terms of the availability of general practitioners and nurses, also appears limited in residential substance use service settings despite reports of an array of acute and chronic health conditions in these populations. BC's *Provincial Standards* specify that *each residential facility ensures that individuals have access to a physician while in the program* (Standard 6) in recognition of the generally poor health of people with severe substance use conditions. For those programs without staff medical support, it will be important to understand if and how residents' medical and pharmacological needs are being met through other arrangements with physicians in the community.

In terms of access to specialists in addiction medicine, less than half of the programs surveyed reported formal salaried or contractual arrangements with these physicians. While many of the physicians identified as addiction physicians by residential service providers in BC may be fully certified, it is also possible that others may not be certified but have taken additional training such as the Methadone Maintenance Treatment training and/or have extensive experience working with substance dependent populations.

Although efforts are underway, addiction medicine is not officially recognized as a sub-specialty in Canada and there is shortage of physicians qualified to provide evidence-based treatment for substance use disorders (McEachern, Ahamad, Nolan et al., 2016).

The McEachern (2016) study estimated that as of July 2015, there were 25 ABAM certified physicians in good standing in BC. The study concluded that investments in addiction medicine training and education as well as remuneration are needed to increase the numbers of skilled addiction medicine providers particularly in the Island and Northern regions where they are no certified physicians.

While this survey does not provide a comprehensive picture of physician support in the live-in substance use treatment sector, there is sufficient evidence to recommend:

- Improved medical coverage, inclusive of specialized addiction medicine care, in both supportive residential facilities and residential treatment facilities;
- Better links to patient medical homes to ensure on-going medical support for individuals with severe substance use and mental disorders.

5.4 Service Models that Recognize the Chronic Nature of Substance Use Disorders

High dropout rates characterize residential substance use services. Compounding this, in many facilities, is the automatic discharge of residents who are non-compliant with program rules and restrictions, typically related to use of substances. While the survey did not provide specific data on failures to complete residential programs, reports indicated that as a proportion of admissions, these are substantial. Staiger et al. (2014) noted that retention rates in residential care are lower among individuals with concurrent disorders. Severe substance dependence disorders as well as many mental health disorders are now recognized as chronic in nature. Further, relapse rates for addiction are believed similar to those for other chronic conditions such as diabetes, asthmas and hyptertension (NIDA, 2012).

In this project, fewer than half of residential treatment programs reported conducting formal follow-up with clients, a practice that is inconsistent with a chronic care paradigm. Lack of follow-up does not allow for post-discharge monitoring or the ability to characterize predictors of success. This limits optimal provision of recovery support, making the likelihood of relapse high. The Institute of Behavioural Health (2014) has argued that substance use disorders must be seen as serious chronic illnesses requiring long-term care and has recommend a five-year recovery standard to monitor what happens to clients after discharge from treatment. It is not clear that the chronic care approach and the implications for monitoring and long-term support have been adopted across all residential service providers in BC.

As a result, it will be important to pursue:

- Strategies to improve the low completion rates in residential treatment programs;
- Mandated follow-up for clients leaving residential programs to better understand the impact of services on client functioning.

Finally, on the basis of the literature and overall information yield from this project, a few additional considerations are put forward as important steps in improving residential substance use services in BC.

- Support for accreditation across all residential substance use service settings;
- Improved transition support between detoxification and admission to residential support;
- Support for a data repository to inform planning and delivery of live-in addiction recovery service.

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7. Appendix A

Residential Services Categories from BC's Service Model and Provincial Standards for Adult Residential Substance Use Services (2011)

<u>Supportive Residential Programs</u> (e.g., Supportive Recovery, Stabilization and Transitional Living Residences)

Supportive residential programs are suitable for people who require low-moderate intensity of services. They meet the needs of individuals who are preparing to enter residential treatment or those who have left more intensive residential treatment but who require additional stabilization and support to reintegrate into the community. They are also suitable for individuals who do not require intensive residential treatment, but who need a safe, supportive environment, away from their usual living situation, to deal with their substance use. Supportive residential programs provide safe, substance-free accommodation and a level of support appropriate for longer-term recovery from problematic substance use. Typically, supportive residential programs are less intensive than residential treatment. Support is generally provided through a combination of peer mentoring, group work and structured activities. Some programs also offer individual counselling from qualified staff. Supportive residential programs focus on education and life-skills training that will help the participant to reintegrate successfully into the community. Individuals in supportive residential programs may also access outpatient centres or day treatment programs and other community services and supports, including mutual aid groups.

<u>Residential Treatment</u>

Residential Treatment facilities provide time-limited treatment in structured, substance-free, live-in environments. Individuals accessing these services are most likely to be those with more complex and/or chronic substance use for whom community-based treatment services have not been effective. Treatment includes individual, group and family counselling/therapy, as well as psycho-social education and life-skills training. Staff at residential programs generally have a higher level of training than staff at supportive residential programs. In addition, there are staff onsite 24 hours a day. Some programs may also provide medical, nursing or psychiatric support. Residential treatment programs provide daily programming that supports participants to examine and work in depth on the underlying causes of their substance use (such as trauma, grief and family of origin issues). There is also a focus on identifying and practising skills to deal with issues such as boundary setting, co-dependency, communications, anger management, and relapse prevention.

8. Appendix B

The following table includes the 24 services that responded to the survey and were included in this report. The brief program descriptions are based on information from the programs' websites and survey responses. For a full list of publicly residential treatment facilities in BC, see Table 3.

Facility	**Brief Description**
Birchwood Place	Eight bed facility offering 5 short-stay beds to Northwest Mental Health and Addiction clients, and 3 beds for regional tertiary specialized housing. The facility offers 24-hour staffing providing life skills to residents based upon the principles of psychosocial rehabilitation and best practices, in order to promote independence of individuals with mental illness.
Burnaby Centre for Mental Health and Addictions	A provincial resource providing specialized inpatient treatment services for BC adults (over 19 years) with severe and complex concurrent substance addiction and mental health disorders. Length of treatment depends on individual needs, the maximum length of stay is 9 months. The average length of stay for most clients is 5-6 months.
Central City Lodge	Provides treatment for adult men experiencing problems with substance use. Length of program is 90 days and primarily serves clients living in the Vancouver Coastal Health region.
Charlford House	Provides a supportive recovery home for adult women with addictions.

	Length of treatment is minimum of 90 days.
Chrysalis	Provides treatment for women and pregnant mothers experiencing addiction related issues. The length of treatment for the first stage stabilization program is minimum 30 days however clients can stay up to 18 months.
Ellendale	Provides treatment for women and pregnant mothers experiencing addiction related issues and who have been involved with the criminal justice system. The maximum length of stay is 3 months.
Gya' Wa' Tlaab Healing Centre	Provides treatment that incorporates holistic First Nations teachings for adult males and females experiencing problems with substance use. Length of program is 7-8 weeks.
Hannah House	Provides treatment for women experiencing problems with substance use. Length of treatment is 60 days and primarily serves clients in the Fraser Health region.
Heartwood Centre for Women	A provincial resource that provides treatment for women and pregnant mothers experiencing addiction related issues. Length of treatment is 10 weeks.
InnerVisions – Prairie House	Provides treatment for adult men experiencing problems with substance use. Length of treatment is 60 days and primarily serves clients in the Fraser Health region.

Kinghaven Treatment Centre	Provides an intensive treatment program for adult men experiencing substance use issues. Length of treatment is 70 days and primarily serves clients in the Fraser Health regions.
Last Door	Provides treatment for youth and adults who are experiencing addiction related issues Program is 90 days long and is located in New Westminster.
Maple Ridge Treatment Center	Provides treatment for adult males experiencing problems with substance use. Length of program is 35 days and primarily serves clients living in the Fraser Health region.
Nechako Youth Treatment Program (NYTP)	Provides substance misuse management, detox and treatment, as well as mental health assessments for youth ages 13 - 18. The program does not have a fixed time limit; each client's length of stay is based on their individual treatment needs.
Pacifica Treatment Centre	Provides treatment for adult men and women experiencing problems with substance use issues. Length of treatment is 12 weeks long and primarily serves clients in the Vancouver Coastal health region.
Path to Freedom	Provides treatment for adult males experiencing problems with substance use. Length of program is 90 days and primarily serves clients living in the Fraser Health region.
Peardonville	Provides treatment for women and pregnant mothers experiencing addiction related issues.

	The length of treatment is 10 weeks long and primarily serves clients in the Fraser Health region.
Phoenix	Provides a treatment program for adult men experiencing substance use issues. Length of treatment is 90 days and primarily serves clients in the Fraser Health region.
Round Lake	Provides treatment that incorporates holistic First Nations teachings for adult males and females experiencing problems with substance use. Length of the program is 35-42 days and the program is based in the Okanagan.
The Bridge Family Services	Provides treatment for men and women experiencing problems with substance use. Length of treatment is 6 weeks long and primarily serves clients in the Interior health region.
Together We Can	Provides treatment for adult men experiencing problems with substance use. Length of treatment is 90 days and the program primarily serves clients in the Vancouver Coastal Health region.
Turning Point	Provides treatment for adult men and women experiencing problems with substance use. Length of treatment is 90-120 days.
Westminster House	Provides treatment for women experiencing problems with substance use. Length of treatment is a minimum 90 days and primarily serves clients in the Fraser Health region.

7 Sisters	Provides adult tertiary rehabilitation and residential services for adults with severe or persistent mental illness. Clients can receive treatment for up to 2 years.

9. Appendix C

Live-in Addiction Recovery Services in BC Survey

On behalf of the research team at the Centre for Applied Research in Mental Health and Addiction (CARMHA), we sincerely thank you for taking the time to fill out this survey. Please use as much room as you require to answer the questions. You are also welcomed and encouraged to submit supplementary documents and reports that may help the research team to fully understanding the important work of your organization. The survey will take approximately 30 minutes to complete, but this will depend on the level of detail provided in response to the open-ended questions.

Date: [Click to select a date.]

Name: [Your Name]

Contact information: [Your email address and phone number]

BASIC INFORMATION

1. **How long has your organization been in operation?**

[Explanation]

2. **How many sites do you operate?**

[Explanation]

3. **In what Health Authority region(s) do you operate?**

☐Vancouver Coastal Health

☐Fraser Health

☐Interior Health

☐Island Health

☐Northern Health

☐Provincial Health Services

4. **What is the average length of stay for clients in your program?**

[Explanation]

5. **Are clients permitted to extend their stay? If so, for how long?**

☐ No ☐ Yes Explain: [Explanation]

6. **How many <u>total</u> beds do you have at your facility?** Click here to enter text.

   6.1. **How many of your beds are designated for MSDI clients (i.e. publically funded)?**Click here to enter text.

   6.2. **Of your MSDI beds, how many of these are also contracted by the Health Authority or BC Housing?**Click here to enter text.

Going forward, publicly-funded beds will refer to those which are designated for MSDI clients. This number should be <u>inclusive</u> of the Health Authority or BC Housing contracted beds.

7. **Are your publicly-funded beds currently full?**

☐ No ☐ Yes

8. **Do you have a wait list? If so, how many people are currently on the list?**

☐ No ☐ Yes Explain: [Explanation]

   8.1. **How is the list prioritized?**

[Explanation]

9. **How many paid staff positions do you have in your program:**

☐Full Time Equivalent Click here to enter text.

☐Part Time Click here to enter text.

☐ContractClick here to enter text.

10. **How many volunteer positions do you have? (Please provide estimate if exact # unknown)** Click here to enter text.

11. **What type of staff do you employ in your program? Click all that apply. Please also indicate the frequency of their site visits (daily, weekly, biweekly, by-appointment only, etc.)**

☐Addiction Physician (Specialized training in addiction)

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐General Practitioner

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:

Frequency of site visits: [Explanation]

☐Psychiatrist

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Psychologist

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Counsellor

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Case Manager

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Social Worker

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Occupational Therapist

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Site Manager/Director

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Psychiatric Nurse

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Registered Nurse

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

☐Other

☐Staff ☐Contract ☐Provided through funder ☐Sessional ☐Other:
Frequency of site visits: [Explanation]

12. **Do you have staff members with lived experience with addition recovery?**

☐ No ☐ Yes Explain: [Explanation]

13. **Who do you serve? Please click all that apply:**

☐Males

How many beds are designated for males?: Click here to enter text.

☐Females

How many beds are designated for females?: Click here to enter text.

☐Other (ex. transgender)

How many beds are designated for transgender?: Click here to enter text.

14. **Which age group(s) do you serve?**

☐Children (0-12)

☐Youth (13-18)

☐Young Adults (19-24)

☐Adults (25-54)

☐Older Adults (55+)

If your organization defines the age categories differently, please explain. Please also provide any details you wish to share about age/gender restrictions.

[Explanation]

15. **Will you accept clients from other regions? If so, under what circumstances would you accept a client in one of your publicly-funded beds?**

☐ No ☐ Yes [Explanation]

16. **What area(s) do you serve? Click all that apply.**

☐Large urban (100,000+)

☐Urban (25,000-100,000)

☐Small Urban (10,000-25,000)

☐Rural (<10,000)

☐On Reserve

17. **Does your organization provide specialized services for individuals who have experienced any of the following?**

	Yes – refer out	**Yes – in house**	**No – not provided**
Concurrent disorders	☐	☐	☐
Intellectual/Development disorders	☐	☐	☐
Individuals in wheelchairs	☐	☐	☐
Hearing or visually impaired	☐	☐	☐
Eating disorders	☐	☐	☐
Mood or anxiety disorders	☐	☐	☐
Survivors of violence	☐	☐	☐
Residential school survivors (First Nations)	☐	☐	☐

Please provide any additional information you wish to share: Click here to enter text.

18. **Do you charge any additional fees to clients in <u>publicly-funded</u> beds?**

☐ No ☐ Yes [Explanation]

19. **Do you provide a fee-waiving option for clients who do not qualify for publicly-funded beds but who cannot afford to pay the fees? If so, please explain.**

☐ No ☐ Yes [Explanation]

20. **How many <u>unique</u> individuals did your organization serve in the last fiscal[17] year?** Click here to enter text.

21. **How many people left voluntarily <u>before</u> fully completing the program in the last fiscal year?** Click here to enter text.

22. **How many people were discharged for noncompliance or other reasons before fully completing the program in the last fiscal year?** Click here to enter text.

GETTING IN AND OUT OF THE PROGRAM

23. **Where has your organization received referrals from in the last calendar year? Click all that apply.**

☐Detoxification/Withdrawal Management Centres

☐Community organizations

☐Corrections

☐Family

☐Churches

☐Health Authority

☐Community Health Centres (CHCs)/Community Addiction Counsellors

☐Ministry of Children & Family Development

☐Hospitals

☐Schools

☐Family Physicians

☐Residential treatment facilities/Other lived-in Addiction recovery programs

☐Employee Assistance Programs (EAPs)

☐Unions

☐Self-referrals

[17] **Last fiscal year refers to your 2015-2016 full fiscal year.**

☐Other [Please specify:Click here to enter text.]

24. How long do clients need to be detoxed or clean before entering the program?

[Explanation]

25. Do you provide or facilitate opiate replacement therapy (ORT) such as methadone?

☐ No ☐ Yes [Explanation]

25.1 If 'Yes', do you limit the number of clients you accept who are on opiate replacement therapy and/or how many of your beds are designated to ORT? Click here to enter text.

26. What are your criteria for inclusion in the program?

[Explanation]

27. What are your exclusion criteria? (i.e. what are common reasons for denying an application?)
[Explanation]

28. Do you offer alumni programs?

☐ No ☐ Yes [Explanation]

29. Do you conduct formal follow-up with clients?

☐ No ☐ Yes [Explanation]

29.1. If yes, for how long?
[Explanation]

30. Do you provide any other kinds of aftercare or continuing care?
☐ No ☐ Yes [Explanation]

PROGRAM STRUCTURE & CHARACTERISTICS

31. What does your programming include? Please check all that apply. [If possible, please provide a detailed weekly schedule when your submit the survey]

☐Life skills

☐Physical education

☐Educational training

☐Outdoor recreation/activities

☐Vocational training

☐Art therapy

☐Yoga/Meditation

☐Support groups

☐12-step (AA, NA, Al-Anon, etc.)

☐Group Therapy

☐Musical activities

☐First Nations traditional teaching/ceremonies

☐SMART Recovery ®

☐Community events/outings

☐Faith-based services

☐Other [please specify]

32. What is the protocol if someone is found using substances while in the program?

Explain: [Explanation]

33. Are families engaged in the recovery process of the clients? If so, how? (ex. family groups)

☐ No ☐ Yes Explain: [Explanation]

34. Do you offer transition planning? If yes, what does it include?

Explain: [Explanation]

35. Please describe your discharge planning process.

Explain: [Explanation]

36. Is vocational planning provided before a client exits the program?

☐ No ☐ Yes [Explanation]

37. Do you allow your clients to participate in paid employment while they are in the program?

☐ No ☐ Yes [Explanation]

DATA & ACCOUNTABILITY

38. What types of data are regularly collected by your organization?

[Explanation]

39. How often do you report on the program? To whom do you report?

[Explanation]

40. Is your organization currently accredited?

☐ No ☐ Yes

40.1. If yes, with which of the following?

☐Accreditation Canada

☐Council on Accreditation (COA)

☐Commission for Accreditation of Rehabilitation Facilities (CARF) Canada

☐Imagine Canada

☐Other [please specify]: Click here to enter text.

41. What were your sources of operating funding for your live-in addiction programs in the last fiscal year? Check all that apply.

☐BC Ministry of Social Development/Innovation

☐BC Ministry of Child & Family Development

☐Health Canada

☐Provincial Health Services Authority

☐BC Health Authority

☐Local Municipality

☐Membership Fees

☐Social Enterprise

☐Charitable Donations

☐Private Foundation

☐Self-Pay Client Fees

☐Other [please specify]: Click here to enter text.

41.1. **Please identify your <u>primary</u> source of funding:** Click here to enter text.

CLIENT CHARACTERISTICS

42. **Based on the last fiscal year, what percentage of people entering the program were employed at intake?** Click here to enter text.

43. **Based on the last fiscal year, what percentage of people entering the program were employed at discharge?** Click here to enter text.

44. **Based on the last fiscal year, what percentage of people were:**

    - **Precariously housed at intake?** Click here to enter text.
    - **Precariously housed at discharge?** Click here to enter text.
    - **Homeless at intake?** Click here to enter text.
    - **Homeless at discharge?** Click here to enter text.

45. **In your last fiscal year, what percentage of people exiting the program secured safe, stable housing?** Click here to enter text.

46. **What percentage of clients have previous criminal justice involvement?** Click here to enter text.

47. **Of the following, please rank in order of most commonly reported concurrent disorder conditions with 1 representing your most common condition. You <u>do not</u> need to put a number beside every disorder:**

Rank #	Disorder Category
	Depression
	Anxiety disorders
	Schizoaffective
	Bipolar
	Obsessive-compulsive
	Hoarding
	Personality Disorders
	Gambling
	Eating Disorders
	Sexual Disorders
	Other Click here to enter text.

	OtherClick here to enter text.

48. What types of other medical conditions do your clients report?

[Explanation]

HOW CAN SERVICES BE IMPROVED IN BC

49. What would you identify as the most significant barrier for people to access live-in addiction services in BC?

[Explanation]

50. What supports would help your organization to better serve the population of people with mental health and substance use challenges?

[Explanation]

51. What would you recommend to policy-makers and decision-makers in BC to improve addiction recovery services in the province?

[Explanation]

CONCLUSION

Thank you for taking the time to fill in the survey and contributing to this important project. You will be provided with a copy of the final report. If you have any follow-up questions or concerns, do not hesitate to contact the Project Manager, Amanda Butler, at albutler@sfu.ca or 778-782-9897.