Journal of
Alcoholism & Drug Dependence

McPherson and Boyne, J Alcohol Drug Depend
2017, 5:4
DOI: 10.4172/2329-6488.1000277

Commantary Open Access

Access to Substance Use Disorder Treatment Services in Canada

Carson McPherson[1,2] **and Holly Boyne**[1,3]

[1]*Cedars Cobble Hill, V0R 1L0, Canada*

[2]*Royal Roads University, BC V9B 5Y2, Canada*

[3]*University of Guelph-Humber, Toronto, ON M9W 5L7, Canada*

[*]**Corresponding author:** Carson McPherson, Cedars Cobble Hill, Box 250, 3741 Holland Ave, Cobble Hill BC, V0R 1L0, Canada, Tel: 866-716-2006; E-mail: carson@cedarscobblehill.com

Received date: August 04, 2017; **Accepted date:** August 17, 2017; **Published date:** August 21, 2017

Copyright: © 2017 McPherson C, et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Substance use disorder is an increasingly challenging and widespread issue throughout Canada with significant barriers negatively impacting access for treatment seekers. This paper seeks to examine the salient factors prohibiting equitable access for these individuals, while exploring a series of pragmatic considerations for policymakers to advance system efficacy. Increasing demand, treatment availability, funding prioritization, and marginalized subgroups were identified as central factors impacting treatment access. A review of the current intervention programs to enhance access is discussed, in addition to areas for system improvement and methodological considerations for future research.

Keywords: Substance use disorder; Access; Treatment

Introduction

There are over 47,000 deaths linked to psychoactive substances in Canada each year [1]. Annual Canadian estimates for the cost of substance use disorder exceed 40 billion [1]. More recently, the introduction of powerful opioid analgesics such as fentanyl have marred national headlines with tragedy [2]. From coast to coast, the addiction epidemic has affected millions of Canadians with increasing devastation [3]. The addiction treatment enterprise in Canada continues to struggle to effectively meet the needs of treatment seekers with a fragmented system of care, lack of services in rural areas, long wait times, and an undersupply of detox facilities [4]. Among other factors, insufficient standards of care, ambiguity over population needs and a shortfall of services in the community has led to inconsistent access to mental-health and addiction services [5]. The purpose of this paper is to identify and navigate some of the salient barriers negatively impacting access to various addiction treatment programs across Canada, along with the exploration of considerations for policymakers.

Access to Addiction Treatment Services

'Access' can be defined as a general concept representing the degree of 'fit' between the client and the system [6]. Penchansky and Thomas view access as a general concept that summarizes specific fundamental areas of this fit between the individual and the health care system: affordability, acceptability, accommodation, accessibility, and availability. Others posit five corollary dimensions of access including: 1) Ability to perceive; 2) Ability to seek; 3) Ability to reach; 4) Ability to pay; and 5) Ability to engage [7].

It is important to first establish the understanding of equal access and equitable access, ultimately establishing which the priority is for policy makers in Canada. Often equal and equitable access is used interchangeably in literature, though there are stark differences between the two [8]. To clarify, the goal of equitable access differs from equal access in that it looks to ensure distribution of health services based on need [9]. In contrast, equal access, however, is defined as aiming to ensure that everyone gets the same things in order to enjoy full, healthy lives [10]. As addiction disproportionately affects population subgroups in Canada, a health equity approach is needed to ensure the effective provision of services for marginalized subgroups of the Canadian population [2,11,12].

System Factors Affecting Equitable Access to Addiction Treatment

Increasing demand on the health system

In the province of Ontario, "the burden of illness from mental health and addictions has been calculated to be more than 1.5 times that of all cancers and more than seven times that of all infectious diseases" [13]. Between 2000-2010, there was a 203% increase in the use of prescription opioids in Canada [14]. One study looking at treatment admissions for prescription opioids alone found a 60% increase between 2004-2009 [15]. A Health Canada (2015) report looking at Canadians aged 15 and older found that 22% reported using a psychoactive prescription drug in that past year. In Ontario, deaths related to prescription opioids doubled from 13.7 deaths per million to 27.2 per million from 1991 to 2004, more than twice the mortality rate from HIV [16,17]. British Columbia was the first to issue a provincial state of emergency after opiate overdoses killed more than 200 people during the first three months of 2016 [18]. Subsequently, according to the media, British Columbians took home 220% more naloxone kits, the powerful opiate overdose antidote, in 2016 than the previous three years combined [19]. Despite the opiate crisis, it is important to remember that alcohol and tobacco remain the deadliest and most impactful substances experienced in the Canadian health care system, with the most recent estimates showing these two substances accounting for almost 80% of the aggregate system costs in Canada [20].

Funding prioritization

There are multiple economic issues related to improving the system. Of the billions spent on health care in Canada, only about 7% is allocated to mental illness [21]. Further, only a portion of the funding allocated to mental illness is set aside for addiction. Of the $999.4 million of long-term care annual spending of mental health and addictions in Ontario, only 13.8% was allocated to addictions [22]. In 2004, it was estimated that as much as 94% of the $500 million allocated for illicit drug reduction in Canada was directed towards enforcement based strategies, negatively affecting treatment funding [23]. Another study found that an overwhelming amount of Canadian public funds are allocated to supply measures, with 70% of funds allocated to law enforcement, and just 17% for treatment, 4% for prevention and 2% for harm reduction [24]. From 2007-2011, $311 million was spent on the enforcement action plan, while only $91.3 million was spent on the treatment action plan [25]. In the 2012 budget, the Government of Canada announced significant cuts to health portfolio allocations. While some cuts were internally absorbed by Health Canada, the major programmatic cuts were targeted at programs preventing addiction and psychoactive substances [26]. Health Canada's Controlled Substances and Tobacco Program, the Canadian Centre on Substance Abuse, the Drug Treatment Funding Program, and the Drug Strategy Community Initiatives Fund saw a 35%, 5%, 49%, and >16% reduction in funding, respectively [26]. Increasing the funding allocated to mental health programs and practices in Canada is essential to address the burden imposed by mental illness across the country [13].

Treatment availability

In the case of addictions, common factors associated with barriers to access include treatment availability (e.g., wait lists), cost, stringent admission requirements, and stigma [27]. Estimates show that as few as one in three individuals suffering from addiction are able to access effective treatment [28,29]. A study from the University of Alberta found that almost 50% of participants surveyed who met criteria for a past-year addiction or mental health problems reported unmet service needs [30]. Treatment initiation is an incredibly sensitive time for individuals, as motivation to follow through is continuously shifting. Numerous studies cite the marked attrition rate of treatment initiation for individuals who are first placed on wait lists [31-33]. Pharmacologically, provinces such as British Columbia have made naloxone widely available through the Take Home Naloxone Program, which has surely prevented instances of mortality [34]. However, for treatment seekers looking to acquire suboxone, a combination of buprenorphine and naloxone capable of mitigating opiate cravings, the cost of up to $12/day can both impose a treatment barrier and instigate demotivation in the individual [35]. A study by West et al. found that 80.6% of psychiatrists were uncomfortable providing office-based opiate agonist treatment, indicating barriers at the practitioner level for individuals looking to access buprenorphine treatment.

Marginalized subgroups

Certain subgroups of the population face even more pressing challenges. At-risk Canadian youth often face a barrage of difficulties in accessing care that meets the level of risk they present [36]. Indigenous peoples have some of the highest rates of substance use disorder in Canada, and face both barriers to accessing general treatment options, as well as programs that incorporate traditional healing practices [29,37]. The Truth and Reconciliation Commission (TRC) recommends closing the gaps in health outcomes between Indigenous and non-Indigenous communities, particularly in regards to the issues of suicide, mental health, and addictions. McCormick identified two cultural barriers for the treatment of alcohol and substance use disorder among Indigenous peoples: shame of disclosing substance use disorder, and developing intimacy and trust with strangers. People who are LGBTQ, women, women with children, people in poverty, people who are incarcerated, and members of minority racial or ethnic groups all experience a range of barriers in accessing treatment in accordance with their need [38-41]. Rural communities have lower availability of substance use disorder services and use these services less frequently, with little known about the accommodation and acceptability of substance use disorder programs compared to their urban counterparts [42]. Additionally, rural areas struggle with resource availability, which influences their treatment quality [43]. Addressing our rural communities is an important step towards mitigating systems level health disparities, as 18.5% of Canadians live in non-urban areas [44]. Additional studies have highlighted the need to expand services for homeless persons in light of elevated rates of mental health comorbidity encompassing a variety of debilitating disorders [45].

What do we know about Improving Access?

There are a variety of pragmatic approaches to positively affect access for treatment seekers in Canada. In light of the recent opioid crisis in British Columbia, the Canadian Research Initiative in Substance Misuse recommends collective action to remove barriers to safe and effective treatment. Across the country, there is innovative work to improve the quality, accessibility, and range of options for addressing substance use disorder [4]. In a review of recent literature, there are recurring programs and processes currently in place within various jurisdictions, organizations, and treatment agencies that merit consideration.

Workplace intervention and wellness programs

Workplaces provide an inimitable advantage to access difficult to reach and high risk populations, such as young males and high risk drinkers [46]. In a literature review of ten papers analyzing the effectiveness of workplace intervention strategies, Webb et al. [46] found seven studies with significant reductions in alcohol consumption or related problems. Hermansson et al. [47] found considerably positive results of a routine health and lifestyle check-up including alcohol screening at a large transport company. Of the nearly 1,000 employees who volunteered for substance use disorder screening as part of their routine check-up, approximately 20% met the criteria for hazardous or harmful consumption, allowing the company to engage employee assistance programs and other resources [47]. Education and awareness in workplace settings, beyond standard policy protocols have proven effective as well [48]. One organization with over 3,000 employees implemented a team awareness training program with skills training in peer referral, team building, and stress management along with education in company policy, employee assistance, and drug testing [48]. The company conducted employee assessments at three intervals during the year following the training, and found an overall reduction in problem drinking from 20% to 11% of those surveyed, and a reduction in individuals missing work due to substance related issues from 16% to 6% of all absenteeism [48].

SBIRT programs for health care delivery centres

Screening brief intervention and referral to treatment initiatives (SBIRT) have shown to be effective in improving access across numerous regions [49]. SBIRT has been defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as:

A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

A significant strength of the SBIRT model is the premise that clinicians screen all their patients regardless of whether the individual has disclosed a diagnosis of substance use disorder [50]. By doing so, health care professionals in a variety of settings can address a range of behavioural health problems despite that the individual is not actively seeking an intervention or treatment. Thus, many patients initiating treatment as a result of SBIRT programs are considered early intervention, which numerous studies attribute as a critical factor in increased long-term success [51,52]. Similar programs used in emergency departments, such as Project ASSERT, have shown significant results towards identifying current or potential individuals with substance use disorder and providing appropriate treatment referrals [53]. Often times, SBIRT programs are integrated with counselling sessions to develop and channel patient motivation. There are numerous studies on the effectiveness of strengths-based counselling and motivational interviewing sessions for the period of time individuals are placed on wait lists [49,54,55].

Family programs

There is an extensive amount of literature supporting family involvement to help engage individuals with substance use disorder in treatment [56-58]. As health care professionals typically focus on the addicted individual, families are often not included in the creation of treatment goals, and affects to the family system are often not considered, despite the vast impact families have on the individual with the substance use disorder [59]. As addiction dramatically affects all family members, treating the family can be viewed as a first step, both from a biopsychosocial and educational perspective as a means of enhancing treatment initiation and retention for their loved ones [60-63]. A recent study looking at a therapeutic psychosocial program offered to family members of a primary residential patient found a 9.62% increased retention rate for those individuals [64]. Other studies have shown the effectiveness of familial involvement to prevent relapse post treatment [65,66]. A literature review of family intervention strategies found three critical areas of focus for continued research, noted as: "(1) Working with family members to promote the entry and engagement of misusers into treatment; (2) The joint involvement of family members and misusing relatives in the treatment of the misuser; and (3) Responding to the needs of the family members in their own right" [67]. As addiction is a disease that affects entire family systems, treating only the individual with an active substance use disorder is limiting and an overly narrow orientation for enhancing both family and community health [63,68].

Conclusion

Access to evidence-based treatment for SUD remains a crucial issue in Canada. Although there is effective treatment modalities available, treatment seekers are often unable to access the treatment required. Factors such as increasing demand on the health care system, funding prioritization, treatment availability, and additional barriers for marginalized subgroups are salient challenges in Canada. However, there are a variety of pragmatic approaches that may improve access to treatment for substance use disorder. Workplace intervention and wellness programs, SBIRT programs within health care delivery centres and family programs are just a few ways with empirical support that may improve access for Canadians [69-74]. As a national issue, access should be combated with collective, national action employing practical solutions, such as those evidenced here, in order to increase the amount of individuals in treatment and ultimately, strengthen Canadian society as a whole.

References

1. Rehm J, Baliunas D, Brochu S, Fischer B, Gnam W, et al. (2006) The costs of substance abuse in Canada 2002. Canadian Centre for Substance Abuse.
2. Howlett K, Giovannetti J, Vanderklippe N, Perreaux L (2017) How Canada got addicted to fentanyl. The Globe and Mail.
3. Statistics Canada (2015) Health at a glance.
4. http://www.cclt.ca/eng/pages/default.aspx
5. Woo A (2016) Mental health and addiction services lacking in B.C., report says.
6. Penchansky R, Thomas JW (1981) The concept of access: definition and relationship to consumer satisfaction. Medical Care 19: 127-140.
7. Levesque JF, Harris MF, Russell G (2013) Patient-centred access to health care: conceptualising access at the interface of health systems and populations. Int J Equity Healh 12: 18.
8. Milken Institute School of Public Health (2016) What's the difference between equity and equality?
9. Andersen RM, Davidson PL, Baumeister SE (2014) Improving access to care. Changing the US health care system: key issues in health services policy and management. San Francisco, CA: Jossey-Bass, pp: 33-65.
10. Clow B, Pederson A, Haworth-Brockman M, Bernier J (2009) Distinguish between equity and equality.
11. Firestone M, Tyndall M, Fischer B (2015) Substance use and related harms among aboriginal people in Canada: a comprehensive review. J Health Care Poor Underserved 26: 1110-1131.
12. Banerjee A, Duflo E (2011) Poor economics: A radical rethinking of the way to fight global poverty. PublicAffairs.
13. Mental Health Commission of Canada (2015) Funding for mental health.
14. International Narcotics Control Board (2011) Narcotics drugs: estimated world requirements for 2012; Statistics for 2010. New York: United Nations.
15. Fischer B, Nakamura N, Rush B, Rehm J, Urbanoski K (2010) Changes in and characteristics of admissions to treatment related to problematic prescription opioid use in Ontario, 2004-2009. Drug and Alcohol Dependence 109: 257-260.
16. Fischer B, Argento E (2012) Prescription opioid related misuse, harms, diversion and interventions in Canada: A review. Pain Physician 15: ES191-ES203.
17. Canadian Centre on Substance Abuse (2013) First, do no harm: Responding to Canada's prescription drug crisis.
18. Ellis E, Lindsay B (2016) B.C. declares public health emergency after fentanyl overdoses kill 200 people in three months. National Post.
19. Schmunk R (2017) B.C. program handed out 220% more naloxone kits in 2016 than last 3 years combined.

20. Canadian Centre on Substance Abuse (2017) Costs of substance abuse.
21. The Canadian Press (2016) Mental illness afflicts about 20% of Canadians, gets 7% of health funding.
22. Ontario's Mental Health & Addictions Leadership Advisory Council (2015) Annual report.
23. Wood E, Spittal P, Li K, Kerr T, Miller CL, et al. (2004) Inability to access addiction treatment and risk of HIV infection among injection drug users. JAIDS 36: 750-754.
24. DeBeck K, Wood E, Montaner J, Kerr T (2009) Canada's new federal 'National Anti-Drug Strategy': An informal audit of reported funding allocation. Int J Drug Policy 20: 188-191.
25. Department of Justice (2016) National anti-drug strategy evaluation. Government of Canada.
26. CPHA (2013) Analysis: The 2013 federal budget from the public health perspective.
27. Milloy MJ, Kerr T, Zhang R, Tyndall M, Montaner J, et al. (2009) Inability to access addiction treatment and risk of HIV infection among injection drug users recruited from a supervised injection facility. J Public Health fdp089.
28. Cunningham JA, Breslin FC (2004) Only one in three people with alcohol abuse or dependence ever seek treatment. Addict Behav 29: 221-223.
29. Wood E, Li K, Palepu A, Marsh DC, Schechter MT, et al. (2005) Sociodemographic disparities in access to addiction treatment among a cohort of Vancouver injection drug users. Subst Use Misuse 40: 1153-1167.
30. Wild TC, Wolfe J, Wang J, Ohinmaa A (2014) Gap Analysis of Public Mental Health and Addictions Programs (GAP-MAP) final report. Government of Alberta.
31. Redko C, Rapp RC, Carlson RG (2006) Waiting time as a barrier to treatment entry: Perceptions of substance users. J Drug Issues 36: 831-852.
32. Hser Y, Maglione M, Polinksy ML, Anglin MD (1998) Predicting drug treatment entry among treatment-seeking individuals. Journal of Substance Abuse Treatment 15: 213-220.
33. Chawdhary A, Sayre SL, Green C, Schmitz JM, Grabowski J, et al. (2007) Moderators of delay tolerance in treatment-seeking cocaine users. Addict Behav 32: 370-376.
34. Toward the Heart (n.d.) General information about the BC Take Home the Naloxone Program.
35. Clancy N (2016) "A major barrier": Make drugs that prevent fentanyl deaths free, families and experts say.
36. Hadland SE, Kerr T, Li K, Montaner JS, Wood E (2009) Access to drug and alcohol treatment among a cohort of street-involved youth. Drug Alcohol Depend 101: 1-7.
37. DeVerteuil G, Wilson K (2010) Reconciling indigenous need with the urban welfare state? Evidence of culturally-appropriate services and spaces for Aboriginals in Winnipeg, Canada. Geoforum 41: 498-507.
38. Ontario HIV Treatment Network (2014) Rapid response: Facilitators and barriers to health care for lesbian, gay, and bisexual (LGB) people.
39. Marsh JC, D'Aunno TA, Smith BD (2000) Increasing access and providing social services to improve drug abuse treatment for women with children. Addiction 95: 1237-1247.
40. Nunn A, Zaller N, Dickman S, Nijhawan A, Rich JD (2010) Improving access to opiate addiction treatment for prisoners. Addict 105: 1312-1313.
41. Bobinsky M (2002) Women, poverty, access to health care, and the perils of symbolic reform. The Journal of Gender, Race, and Justice 5: 233.
42. Borders TF, Booth BM (2007) Research on rural residence and access to drug abuse services: Where are we and where do we go? J Rural Health 23: 79-83.
43. Edmond MB, Aletraris L, Roman PM (2015) Rural substance use treatment centers in the united states: An assessment of treatment quality by location. The American J Drug Alcohol Abuse 41: 449-457.
44. http://www12.statcan.gc.ca/census-recensement/2011/as-sa/98-310-x/98-310-x2011003_2-eng.cfm
45. Palepu A, Gadermann A, Hubley AM, Farrell S, Gogosis E, et al. (2013) Substance use and access to health care and addiction treatment among homeless and vulnerably housed persons in three Canadian cities. PloS ONE 8: e75133.
46. Webb G, Shakeshaft A, SansonFisher R, Havard A (2009) A systematic review of workplace interventions for alcoholrelated problems. Addict 104: 365-377.
47. Hermansson U, Helander A, Brandt L, Huss A, Rönnberg S (2010) Screening and brief intervention for risky alcohol consumption in the workplace: Results of a 1-year randomized controlled study. Alcohol and Alcoholism 45: 252-257.
48. Bennett JB, Patterson CR, Reynolds GS, Wiitala WL, Lehman WE (2004) Team awareness, problem drinking, and drinking climate: workplace social health promotion in a policy context. American J Health Promotion 19: 103-113.
49. Madras BK, Compton WM, Avula D, Stegbauer T, Stein JB, et al. (2009) Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: comparison at intake and 6 months later. Drug Alcohol Depend 99: 280-295.
50. Agerwala SM, McCance-Katz EF (2012) Integrating screening, brief intervention, and referral to treatment (SBIRT) into clinical practice settings: A brief review. J Psychoactive Drugs 44: 307-317.
51. Liddle HA, Rowe CL, Dakof GA, Ungaro RA, Henderson CE (2004) Early intervention for adolescent substance abuse: pretreatment to posttreatment outcomes of a randomized clinical trial comparing multidimensional family therapy and peer group treatment. J Psychoactive Drugs 36: 49-63.
52. Moyer A, Finney JW, Swearingen CE, Vergun P (2002) Brief interventions for alcohol problems: a metaanalytic review of controlled investigations in treatmentseeking and nontreatmentseeking populations. Addicti 97: 279-292.
53. Bernstein E, Bernstein J, Levenson S (1997) Project ASSERT: an ED-based intervention to increase access to primary care, preventive services, and the substance abuse treatment system. Annals Emergency Medicine 30: 181-189.
54. Mireau R, Inch R (2009) Brief solution-focused counseling: a practical effective strategy for dealing with wait lists in community-based mental health services. Social Work 54: 63-70.
55. Arkowitz H, Miller WR, Rollnick S (2015) Motivational interviewing in the treatment of psychological problems. Guilford Publications.
56. Meis LA, Griffin JM, Greer N, Jensen AC, MacDonald R, et al. (2013) Couple and family involvement in adult mental health treatment: A systematic review. Clin Psychol Rev 33: 275-286.
57. Roozen HG, de Waart R, van der Kroft P (2010) Community reinforcement and family training: An effective option to engage treatment-resistant substance-abusing individuals in treatment. Addict 105.
58. Matheson JL, Lukic L (2011) Family treatment of adolescents and young adults recovering from substance abuse. J Family Psychother 22: 232-246.
59. Center for Substance Abuse Treatment (2004) Substance abuse treatment and family therapy.
60. McCrady BS, Epstein EE, Hirsch LS (1999) Maintaining change after conjoint behavioral alcohol treatment for men: Outcomes at 6 months. Addict 94: 1381-1396.
61. Sisson RW, Azrin NH (1986) Family-member involvement to initiate and promote treatment of problem drinkers. J Behav Ther Exp Psychiatry 17: 15-21.
62. Liddle HA (2004) Family-based therapies for adolescent alcohol and drug use: research contributions and future research needs.
63. Csiernik R (2002) Counseling for the family: The neglected aspect of addiction treatment in Canada. J Social Work Prac Addict 2: 79-92.
64. McPherson C, Boyne H, Willis R (2016) The role of family in residential treatment patient retention. Int J Mental Health Addict pp: 1-9.
65. Nattala P, Leung KS, Nagarajaiah, Murthy P (2010) Family member involvement in relapse prevention improves alcohol dependence

outcomes: A prospective study at an addiction treatment facility in India. J Studies Alcohol Drugs 71: 581-587.

66. Walitzer KS, Dermen KH (2004) Alcohol-focused spouse involvement and behavioral couples therapy: evaluation of enhancements to drinking reduction treatment for male problem drinkers. J Consulting Clin Psychol 72: 944.
67. Copello AG, Copello AG, Velleman RD, Templeton LJ (2005) Family interventions in the treatment of alcohol and drug problems. Drug Alcohol Rev 24: 369-385.
68. Lander L, Howsare J, Byrne M (2013) The impact of substance use disorders on families and children: from theory to practice. Social Work in Public Health 28: 194-205.
69. Canadian Research Initiative in Substance Misuse (2016) Evidenced-based opioid addiction care.
70. Health Canada (2015) Funding for Addictions Prevention and Treatment Services in First Nations Communities across Canada.
71. McCormick RM (2000) Aboriginal traditions in the treatment of substance abuse. Canadian J Counselling 34: 25-32.
72. SAMHSA (2015) About Screening, Brief Intervention, and Referral to Treatment (SBIRT).
73. Truth and Reconciliation Commission (2015) Truth and reconciliation commission of Canada: calls to action.
74. West JC, Kosten TR, Wilk J, Svikis D, Triffleman E, et al. (2004) Challenges in increasing access to buprenorphine treatment for opiate addiction. The American J Addict 13: S8-S16.