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An evaluation of the use of Community Transition Teams to improve health outcomes for individuals with an opioid use disorder following release from British Columbia Corrections (The OPAC Corrections Study)

February 19th, 2023



Land Acknowledgement

We would like to respectfully acknowledge that the land on which we work is the unceded territory of the Coast Salish peoples, including the traditional territories of xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səílwətał (Tsleil-Waututh) Nations.

We recognize that the ongoing criminalization, institutionalization, and discrimination against people who use drugs disproportionately harm Indigenous peoples, and that continuous efforts are needed to dismantle colonial systems of oppression. We are committed to the process of reconciliation with Indigenous peoples, and recognize that it requires significant and ongoing changes to the health care system.



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The Outcomes for Patients Accessing Addiction Care in a Correctional Setting (OPAC Corrections) Study – Results

Authors: Dr. Seonaid Nolan and Eisha Lehal

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Contact:

British Columbia Centre on Substance Use
400-1045 Howe Street, Vancouver, BC V6Z 2A9
inquiries@bccsu.ubc.ca



About the British Columbia Centre on Substance Use

The **BC Centre on Substance Use (BCCSU)** is a provincially networked resource with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction. The BCCSU's focus is on three strategic areas including research and evaluation, education and training, and clinical care guidance. With the support of the province of British Columbia, the BCCSU aims to help establish world leading educational, research and public health, and clinical practices across the spectrum of substance use. Although physically located in Vancouver, the BCCSU is a provincially networked resource for researchers, educators, and care providers as well as people who use substances, family advocates, support groups, and the recovery community.



About the Study Team

This study was led by Dr. Seonaid Nolan who is an Assistant Professor in the Department of Medicine at the University of British Columbia (UBC), a Michael Smith Foundation for Health Research Scholar, a Clinician Scientist with the British Columbia Centre on Substance Use and the holder of UBC's Steven Diamond Professorship in Addiction Care Innovation. Dr. Nolan oversaw all study activities. Eisha Lehal was the study's clinical research coordinator and oversaw the implementation and ongoing management of the study. She conducted all of the qualitative interviews with CTT staff members and carried out its thematic analysis. Jonah Hamilton was the clinical research assistant and supported the study in several capacities including contributing to liaising with sites, reviewing consent forms with CTT clients prior to the questionnaire, and contributing to study materials such as interview guides. Chiarine Stuart assisted across the study by providing administrative support and coordination.

About This Report

The administration of health care services in British Columbia (BC) Correctional Centres was absorbed from the Ministry of Public Safety & Solicitor General into the governance of the Ministry of Health in 2017.¹ Community Transition Teams (CTTs) began as a pilot project in 2019 under the provision of Correctional Health Services, which operates as a program of Provincial Health Services Authority (PHSA) and BC Mental Health and Substance Use Services (BCMHSUS), to support the vulnerable period faced by people living with opioid use disorder (OUD) as they transition from a BC Correctional Centre back into their communities. This innovative pilot took a holistic and individualized approach to care, whereby a social worker, peer with lived experience, and access/transition nurse provided support to clients living with OUD for 30 days after they were released from a BC correctional centre. In the pilot's infancy, it was implemented at five BC correctional centres and was anticipated to be rigorously evaluated by the study team to inform future improvements and its eventual scale up across the province. However, in March 2020, the global Coronavirus disease 2019 pandemic was declared which significantly impacted the progress of the proposed evaluation. Moreover, correctional health care staff that were continuing to oversee medical and addiction care in BC correctional centers faced a severely challenging time responding to the pandemic. Accordingly, adaptations were made to the proposed evaluation in an effort to capture data that would serve as a starting point for a more robust evaluation in the future. Specifically, this study changed its intended study sample to CTT staff members and ascertained their perspectives on the pilot through a series of qualitative interviews.

This report describes the proposed evaluation methodology and the changes that were made in response to the COVID-19 pandemic, sociodemographics of CTT eligible clients were able to be collected (please refer to Limitations section), findings from the qualitative interviews with CTT staff, as well recommendations for further inquiry should a more robust evaluation take place in the future.

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Executive Summary

The opioid overdose crisis and the COVID-19 pandemic continue to be dual public health emergencies in British Columbia (BC), that are still unfortunately claiming the lives of individuals across the province. Among these decedents are a significant and disproportionate amount of individuals who had previous involvement with BC Corrections. Correctional Health Services, which operates as a program of British Columbia Mental Health and Substance Use Services (BCMHSUS), implemented a pilot program for Community Transition Teams (CTTs) in 2019 to support individuals with an OUD leaving a correctional centre and aimed to connect them to addiction supports in their communities. The focus of this evaluation is to highlight the interim success of the pilot program, distinguish areas for advancement, and advise on further evaluation efforts that will inform expansion and scale up of the program.

Given the declaration of the COVID-19 pandemic in March 2020, the progress of this evaluation was no longer feasible, and the scope of evaluation efforts was reduced in order to comply with public health safety measures. This report will present the sociodemographic data from participant administered questionnaires from Nanaimo Correctional Centre and Kamloops Regional Correctional Centre, as well as recommendations for further inquire from a series of qualitative interviews conducted from CTT staff from all five of the correctional centres that were a part of the pilot program.

Summary of Sociodemographic Data

Of the 20 participants from Nanaimo Correctional Centre and Kamloops Regional Correctional Centre who completed the questionnaire:

- All participants identified as male.
- 95% identified as heterosexual and 5% as bisexual.
- A majority of participants identified as white, while the second largest majority identified as indigenous.
- Almost half of the participants did not have a partner, roughly a quarter were married, roughly a quarter had a regular partner, and one participant identified as “poly”.
- A majority of participants had previously experienced incarceration prior to this episode at a provincial correctional centre.
- Almost two-thirds had completed high school or its equivalent.



- 80% had experienced homelessness in the 6 months prior to their incarceration, and about half described their financial situation as “cannot make ends meet”.
- Income sources for participants in the sample included: Disability/Persons with Disability (28%), financial assistance from friend, partner, or relative (22%), selling drugs or binning (39%).

Summary of Recommendations for Further Inquire

The participants in the qualitative interviews were composed of CTT staff from each of the 5 BC provincial correctional centres that were part of the pilot program; specifically, Surrey Pretrial Services Centre, Nanaimo Correctional Centre, Fraser Regional Correctional Centre, Kamloops Regional Correctional Centre, and Prince George Regional Correctional Centre. A total number of 10 qualitative interviews were conducted with peer support workers, access/transition nurses, and social workers within the CTT program. At least one CTT staff was interviewed from each of the different BC Correctional Centres.

- Regular meetings should be held between all CTTs and Correctional Health Services Leadership.
- The CTT mandate should be expanded to include clients with substance use disorders outside of OUD. Consideration should also be given to include significant mental health diagnoses in the intake criteria.
- Increase networking with housing supports to provide CTTs with housing specific resources to refer clients to. Advocacy efforts including calls to government should be pursued to address the housing crisis.
- Publicly available outputs such as media, reports, and presentations should be available to heighten awareness of CTTs and their services in communities.
- Contingency planning should be actively underway so that CTT staff can take vacations and sick time, and know that they have reliable coverage of their workload.
- Specific on-boarding materials and training plans should be in place for new CTT staff.
- Infrastructural support and IT support should be in place for CTT staff to facilitate their daily work.
- Video Court should be considered as a modality to prevent challenges associated with last minute releases.
- Advancement in coordination and communication should be prioritized to ensure CTT staff are well positioned to support clients.

Introduction

Canada is in the midst of a worsening overdose (OD) crisis with approximately 26,690 Canadians having lost their lives as a result of opioid toxicity between January 2016 and September 2021.² Compared to other parts of the country, British Columbia (BC) is at the epicentre having experienced the second highest rate of provincial OD deaths.² More specifically, in January 2022, there were 207 British Columbians who died as a result of a suspected illicit drug toxicity, which is a 10% increase since January 2021.³

Correctional populations are at significant risk for OD and death following release. A BC-based death review panel demonstrated two-thirds of the 1,854 illicit drug overdose death cases reviewed between 2016 and 2017 to have had previous involvement with BC Corrections or were currently under their supervision.⁴ Consistent with other studies, the death review panel reported the period immediately following release from a correctional facility to be one of greatest risk for OD and mortality among this population. The main causes of increased mortality among released clients with opioid use disorder (OUD) has been attributed to loss of tolerance and erroneous judgement of dose when an individual returns to opiate use following a period of abstinence.⁵ These findings emphasize the urgent need that exists for enhanced support to individuals with an OUD while incarcerated and as they navigate the vulnerable time of transition back to community.

Under the current model, BC Corrections oversees custody for individuals who are serving sentences that are less than two years and those awaiting trial. Prior to 2017, the provision of health care services in BC Correctional Centres was under the governance of the BC Ministry of Justice.¹ In 2017, Correctional Health Services, which is a program of Provincial Health Services Authority (PHSA) and British Columbia Mental Health and Substance Use Services (BCMHSUS), was incorporated into the provision of the overarching BC health care system, which is ultimately overseen by the Ministry of Health.¹ PHSA and BCMHSUS operate as a separate entity from BC Corrections. Notably, BC was one of the first provinces in Canada to transfer the responsibility of health care services in correctional centres from the Ministry of Justice to the Ministry of Health.¹ As previously described, many of the clients of BC Corrections have an OUD, and therefore require specialized addiction treatment services as part of their care provision while incarcerated. . Given the unprecedented number of ODs that have been observed in the post-release period, Correctional Health Services (CHS) (which is a program of BCMHSUS) implemented a pilot for

Community Transition Teams (CTTs) in 2019. CTTs aim to adopt a client-centered approach to case management for individuals living with OUD during their transition out of a BC Correctional Centre and back into their community. Broadly, CTTs connect with clients while they are incarcerated and collaboratively work with them to develop a discharge plan for their anticipated release date. Furthermore, CTTs help to connect clients to different addiction and social support services in the community subsequent to their release. CTTs attempt to stay connected with clients for approximately 30 days after their release date to continue to provide support.

In March 2022, BC Coroners Service released their death review panel which undertook a review of illicit drug toxicity deaths between August 1st 2017 and July 31st 2021. The findings reinforce the results of the 2016-2017 report, specifically the data brought forward about decedents' employment, poverty and housing instability. The period following release from a correctional centre is often characterized by challenges securing housing and employment, and these barriers are compounded when individuals are living with an OUD. According to the most recent review in March 2022, 44% of all decedents were receiving social assistance within a month of their passing.⁶ Moreover, 19% of decedents had lived in subsidized housing, hotel, motel, or shelter, and 12% of decedents were homeless.⁶ Notably, 72% of decedents had been in contact with a health care professional within 3 months prior to their passing.⁶ This further emphasizes the critical need for CTTs, specifically their specialized understanding of addiction management and geographic-specific resource knowledge. Furthermore, compared to a referral to addiction support, the report highlights the prioritization of outreach activities for individuals at risk of an OD,⁵ which is an important element of the current CTT mandate.

To our knowledge, an evaluation of this novel program has not been undertaken. An evaluation of the use of CTTs to improve health outcomes for individuals with an OUD following release from British Columbia Corrections (The OPAC Corrections Study) study aimed to assess the CTT program, identify implementation barriers, operational challenges and opportunities for improvement. Additionally, findings from this study will be used to review the interim success of the pilot program, recognize areas for improvement, and apprise further evaluation efforts that will inform expansion and scale up of the program.

Methods

The initial study design was based on the methodology employed in the Principal Investigator's existing research study at St. Paul's Hospital in Vancouver BC: the Outcomes for Patients Accessing Addiction Care (OPAC) study. Building off of the original OPAC study design, the OPAC Corrections Study began its pre-implementation phase in 2019 where it was anticipated that 400 participants recruited from Surrey Pre-Trial Services Centre (SPSC), Fraser Regional Correctional Centre (FRCC), Nanaimo Correctional Centre (NCC), Kamloops Regional Correctional Centre (KRCC), and Prince George Regional Correctional Centre (PGRCC) would be enrolled into the study. Prospective participants were eligible for inclusion in the study if: they had an OUD; were within 30 days of release; were able to communicate in English and provide written informed consent; were a resident of BC; and were eligible to participate in the CTT program. Eligible participants would be informed about the study activities by a CTT member at the correctional centre during their routine medical care prior to release. Notably, participants were eligible for study inclusion even if they decided not to partake in the CTT program (as long as they were deemed eligible for participation by a CTT member). Inclusion of both willing and unwilling groups was intended to compare health and social outcomes between groups. If they were interested, a phone call with a member of the study team would be arranged. After providing informed consent, the participant would complete an interviewer-administered questionnaire soliciting information on: demographics, substance use (both prior and during incarceration), mental health, previous hospitalizations, overdose history, and addiction treatment history. Then, participants would consent to provide personal details such as their personal health number (PHN), correctional services number and birth date, for database linkages to a number of health administrative databases (see Appendix A). As part of this original proposed methodology, data linkage was intended to occur annually over a five year follow up period to prospectively monitor the health and social outcomes of participants as they utilized health care and addiction treatment services post release. Additionally, using a purposive sampling strategy, 30 participants would be invited to take part in an in-depth qualitative interview one month after completion of the CTT program. This would allow for a more comprehensive understanding of both facilitators and challenges associated with their experiences with CTT, which would ultimately inform scale up and expansion of the CTT program.

However, the declaration of the global Coronavirus disease 2019 (COVID-19) pandemic in March 2020 created several challenges for implementation of study activities within BC Correctional Centres. Health care staff at BC Correctional Centres were extremely agile as their responsibilities and roles were rapidly changing in response to constantly evolving provincial guidance and response strategies to the global pandemic. Many health care staff were re-allocated from their typical roles into different positions as part of adaptations and risk mitigation tactics. Firstly, new social distancing guidelines at the correctional centres posed issues for connecting with prospective participants. Health care staff emphasized that it was imperative to minimize movement of clients within the correctional centre, which created obstacles for scheduling clients into interview rooms for private, confidential study phone calls with the study team to obtain informed consent and administer the questionnaire. Through conversations with correctional health staff, the study team became aware through anecdotal means that the justice system was sentencing fewer clients to some of the participating correctional centres, as a way to reduce the number of clients in the confined spaces of the correctional centres. CTT staff observed that they had lower than usual numbers of CTT eligible clients compared to pre-pandemic, therefore limiting the number of prospective participants for enrollment. Moreover, visitations were suspended, which meant that the study team was unable to visit correctional centres and instead had to rely heavily on health care staff to refer and facilitate study activities. Despite the measures put in place in the correctional centres (by the province's Medical Health Officers), several sites experienced COVID-19 outbreaks and were immediately placed into restricted movement which continued to stall study activities. Finally, when the COVID-19 vaccine rollout took place at correctional centres, health care staff became inundated with training on vaccine administration and allergy responses. The study team was cognizant of pandemic fatigue of health care staff and made an effort to pivot study activities to remove the onus and burden on them.

The study team adapted to the challenges posed by the COVID-19 pandemic by switching to a participant-administered questionnaire for clients to complete while in their living units. This was meant to mitigate movement needed for participants to complete an hour long interview on the phone in a private space. The study team created a study package, which was a self-sealing envelope that contained two copies of the informed consent form and a copy of the questionnaire to complete. On the front of the envelope was a checklist that had the study team's phone number. The recruitment strategy was also adapted to accommodate the new study design. Accordingly, when CTT staff were seeing clients as part

of their ongoing care, eligible clients would be given a study envelope to take with them to the units. Clients could then call the phone number on the envelope from shared phones in the living unit to go over the consent form with a member of the study team. Then, participants could complete their questionnaire and place it in the self-sealing envelope for confidentiality until a health care member could pick up the package. The health care staff would be able to go through the checklist on the envelope to make sure they were collecting both a signed consent form and a completed questionnaire. On a monthly basis, the study team would arrange for batch mailing of completed questionnaires and consent forms back to their office in Vancouver, BC.

Despite the adapted study plans, the study team continued to face challenges. More specifically, clients would end up not calling once they returned to their units, envelopes would get lost, fewer clients were being seen in-person in health care settings at the site, and also some clients did not have the literacy to complete the questionnaires on their own. As well, even though the phone calls were only meant to explain the study and the consent, the shared space the phones were located in may have been a deterrence for some prospective participants as individuals may have wanted more privacy when speaking with the study team. The study team were also unable to call the prospective participant back if they were disconnected. Moreover, as COVID-19 cases continued to rise between 2020 and 2021, CHS continued to limit the number of in-person visits to health care. Additionally, staffing shortages due to the pandemic created correspondence challenges with CTT staff, as many were assigned to different roles outside of CTT and were unable to assist with study activities. Additionally, when health care staff would try to see clients, some clients had to be escorted which resulted in increased coordination with correctional officers which was challenging to navigate amidst a staffing shortage. Unforeseen circumstances such as increased wildfires in the Kamloops region in BC in 2021 meant that KRCC was on evacuation alert, further stalling study activities. Successful completion of the consent form and questionnaires ultimately occurred when a CTT member was able to have the client in their office again to facilitate the consent phone call with the study team and go through the questionnaire with them. By the end of the study period, we were able to collect 20 questionnaires from two different BC Correctional Centres.

In an effort to meet the research objectives of the study, the study team undertook a series of qualitative interviews with CTT staff in addition to the participant-administered questionnaires. These interviews took place between November 2021 and March 2022. More specifically, all CTT staff were

invited to participate in a one-hour long semi-structured qualitative interview between November 2021 and February 2022, and were compensated for their time. Using a research ethics board (REB) approved email script, the research coordinator emailed CTT staff about the opportunity to participate in the qualitative interview. During some of the interviews, CTT staff suggested colleagues that may be interested in participating as well. In these instances, the research coordinator would obtain their email and follow up with the same script. The only eligibility criteria for participation in the study was either current or prior employment with the CTT program. Interviews were scheduled at the discretion of CTT members, and occasionally were completed at times before or after their work hours to minimize disruption to their existing workflow.

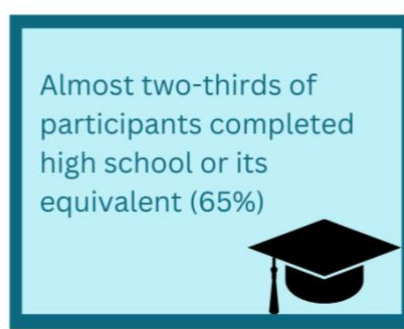
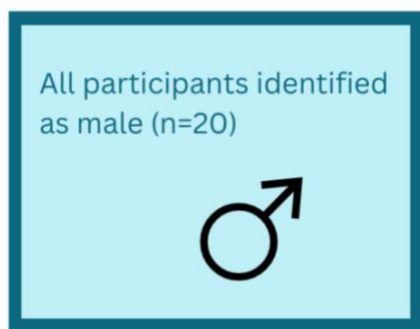
CTT members (referred to as study participants) were recruited to reflect a variety of geographic sites and roles (access/transition nurses, social workers, and peer support workers). The study sample consisted of at least one participant from each of the five CTT-operational sites (Nanaimo Correctional Centre [NCC], Fraser Regional Correctional Centre [FRCC], Surrey Pre-Trial Services Centre [SPSC], Kamloops Regional Correctional Centre [KRCC], and Prince George Regional Correctional Centre [PGRCC]), and contained at least two study participants from each CTT role (peer support worker, social worker and access/transition nurse). The interviews were conducted over the phone and discussed: roles and responsibilities of CTT staff, training, challenges and facilitators to program operations, recommendations for change, and challenges related to the COVID-19 pandemic. Audio recordings of the interviews were then de-identified and transcribed verbatim. To ensure timely dissemination of study results, a rapid qualitative analysis framework was adopted for this project.⁷ The transcripts were first summarized using a template derived from the interviewer guide.⁷ The template consisted of 3 columns: (1) Section of the interview guide; (2) Key points and; (3) Exemplar quotes. The research coordinator reviewed the interview transcripts, then transferred pertinent information to the template to aid in extracting key information from the transcripts. Quotes were chosen at the discretion of the research coordinator based on what best captured the key points. Notably, summaries were consolidated by type of CTT staff (e.g., access/transition nurse, social worker, peer support worker) within the matrix.⁷ Then, in an excel document, separate sheets were created for each section of the interview guide, specifically role characterization, facilitators, challenges, and training. Within each sheet, themes began to emerge as the summaries were entered into the matrix. As each summary was entered into the matrix, key points were coded according to the list of emerging themes, alongside supporting details and any exemplar quotes.

Codes were derived as interviews progressed and were continually entered into the matrix. Furthermore, sub-themes within larger themes became evident and were also categorized accordingly. Once all of the summaries were entered into the matrix, themes that had the most supporting data and were within scope of this report on each sheet were highlighted as pertinent for inclusion in this report. This process provided the opportunity to filter and extract key themes related to challenges, facilitators, and recommendations for operations of the CTT program, thereby informing the recommendations on page 22 of this report. Additionally, given the delayed timeline of study and limited personnel, this methodology was the most feasible to deliver results that would be timely and accurately analyze and assess the data collected to meet the urgent need of expanding this pilot program.

Findings and Discussion

Sociodemographic questionnaire data from CTT clients¹

A total of 20 participants completed the participant-administered questionnaire while incarcerated at one of two BC Correctional Centres. A majority (80%) of participants had previously experienced incarceration prior to this current episode. 95% of participants identified as heterosexual.



When participants were asked about their relationships, roughly 47% did not have a partner, 22% were married or common law, and 26% identified they had a regular partner. Moreover, 80% of participants had experienced homelessness in the 6 months prior to incarceration. Also, 47% of participants described their financial situation as “cannot make ends meet”. Half of participants indicated

¹ Given inconsistent data collection, the study authors are unsure of how representative this cohort is compared to all clients accessing CTTs.

that income assistance and criminal activity was a source of income in the 6 months prior to incarceration (Figure 1). About 28% of participants indicated they received Disability/Persons with Disability, about 22% had financial assistance from a friend, parent, partner, or relative, and about 39% indicated that they sold drugs or participated in binning (recovering items that can be reused⁸) as a source of income (Figure 1). Finally, when participants were asked about which family background or ethnic group they identified with, a majority of participants (80%) identified as white and about 25% identified as Indigenous.

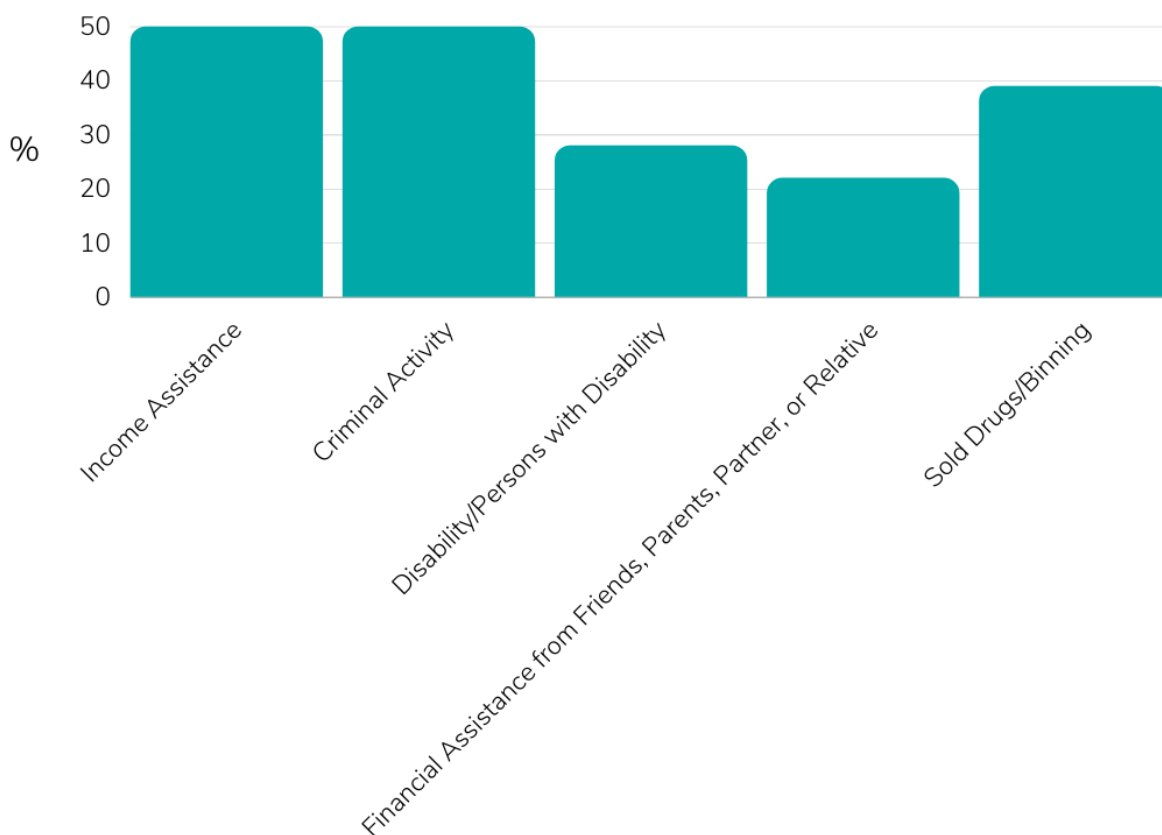


Figure 1: Participants' responses (%) when asked about sources of income in the 6 months prior to incarceration.

Qualitative interviews with CTT staff

A total of 10 CTT staff members agreed to participate in our study between November 2021 and February 2022. Rationale for participating included wanting to contribute to the growing body of knowledge on CTTs, and to shape improvements for the program moving forward. Participants also spoke



about continuing to advocate for the clients they support and building on the successes they've witnessed working in the CTT pilot:

"[The client] actually reached out to us. He's gotten on safe supply, and he maintains that himself. He maintains his OAT. He's just – you know, if we're talking about successes, I know it doesn't seem quite this, you know, like got a job and da-da-da, but it's the success that he keeping himself safe and reaching out to a services where he never would have done that in the past, which is a huge success for us" (Anonymous)

CTT roles and responsibilities

Each study participant was asked to broadly define their role within the CTT team and describe what their typical responsibilities entailed.

Access/Transition nurses

Access/Transition Nurses (ATNs) meet with CTT eligible clients roughly a month before they are released. Eligible clients are clients who are in the Opioid Agonist Treatment (OAT) program, which means that the client is currently on methadone or suboxone™, and have no history of aggression towards health care. More recently, ATNs also now receive referrals for clients who may benefit from the CTT program from Correctional officers or forensics. ATNs meet with prospective CTT clients and complete a Discharge Assessment Form, which opens up a conversation about CTT and assesses the client's interest in the program. Participation in the CTT program offers the opportunity for enhanced support once the client is released. Some examples of this support include: assistance with getting identification (ID) cards so that they can access social services, accessing a car ride to appointments in the community, developing a plan for how and where clients will access their methadone or suboxone™ once in the community, re-establishing their income support by going to the income assistance office, help with applying for disability benefits, consenting to follow-up visits in community from social workers and peer support workers, and also support with individual goals (e.g., re-joining the workforce, connecting with children, school).



Additionally, if a client is interested, CTT can also facilitate a referral to addiction counsellors inside the correctional centre who may then facilitate referrals to addiction treatment in the community. If the client is interested, then the ATN would complete a referral form to the social worker and peer support workers (PSWs) with the aim of both seeing the client that same week. ATNs are primarily responsible for preliminary discharge planning such as setting up appointments at a community OAT clinic, sending a suboxone™ prescription to a local pharmacy, and completing naloxone training with clients. This provides a starting point for the social worker and PSWs to continue their discharge planning. Additionally, they are part of last-minute release clients, and will often arrange for the social worker and PSW to see the client to help support the client. Aside from their CTT discharge planning responsibilities, some ATNs also provide clinical care to clients living with hepatitis, HIV, or other chronic conditions.

Social workers

Social workers (SWs) meet clients who have been referred to them by ATNs roughly one month prior to release while they are incarcerated. SWs obtain consent to work with different agencies on the clients' behalf. Examples of this work might include: coordinating appointments and referrals to community supports in preparation for the client's upcoming release (e.g., housing appointments, addiction treatment supports, mental health intakes, residential treatment referrals, etc.). Additionally, SWs discuss how the client wants to address their OUD. SWs have observed that addressing a client's OUD typically falls into one of two streams. The first being the recovery stream where the client is wanting to go to a residential treatment centre. Typically, clients have a housing plan and are keen to engage in outpatient supports. Secondly, there is a harm reduction stream. These clients usually do not have a housing option and plan on staying in shelters or on the street, but opt to engage in substance use more safely. After the initial discussions about the client's goals, other duties include facilitating access to prescriptions in the community, providing one on one counseling, encouraging participation in different addiction support groups, facilitating referrals to mental health and addiction resources in the community, and providing emotional support. Importantly, even if a client is referred to a counsellor in the community, they may not feel comfortable sharing their thoughts with them. SWs are equipped to help clients navigate dealing with trauma and can provide counselling in community, and continue to build on the rapport that was developed inside the correctional centre. Moreover, they also discuss other personal goals the client may have such as reconnecting with children or loved ones, completing an education, or securing a job. Once the client is released, they continue to attempt to follow up with the client for roughly



30 days. The frequency of follow up can be variable and depends on the client's preference. During this time they provide counseling and act as a support system for clients to call if they are in need of help. During the follow up period, they also provide the clients with transportation to different appointments, accompany them to appointments, and to pharmacies where their addiction medications are provided via daily witnessed ingestions. SWs continue to act as a support system for clients once they are released, and often their roles involve a large amount of outreach work where they search for clients who have not continued to follow up at local hangout spots or community resource spaces.

Peer support workers

Working in partnership with social workers are peer support workers (PSWs), who have lived/living experience of addiction and/or incarceration. PSWs often make the client feel more comfortable with the services provided by CTT through their relatability. Often times, clients may view the SW as a more authoritative figure, and having the PSW may add familiarity and relatability to the services provided, particularly for a vulnerable population who may already have high levels of mistrust in the healthcare and correctional system. Additionally, the PSW's presence allows the clients to feel more comfortable which in turn may increase their level of engagement. The PSW and SW are responsible for discharge planning and community work together on tasks such as intake interviews, documentation, case planning, looking for clients in community, attending appointments, liaising with community organizations, and organizing referrals. Along with the social worker, the PSW acts as an important advocate for the client. Additionally, PSWs contribute an important comforting presence during clinical conversations with clients.

"Like clients definitely view social workers as authoritative or, you know, kind of that they come in kind of seeing it like that. And so having – having a peer there along with the social worker, and just kind of, you know, adds some credibility to the team, and it kind of puts the client at ease." (Anonymous)

Often there is an increased level of rapport and trust built through the PSW and clients, and this is built by PSWs engaging in comradery with the client (e.g., casual visits in the living units, going for coffee, etc.).



Facilitators of the CTT program

Study participants were asked to discuss facilitators of the programs, and identify strategies that have been working well since the implementation of the program in 2019.

“I think what’s really unique about CTT is that not only are we, yeah, filling those gaps and addressing those resources that they need, but we can also walk with them every step of the way” (Anonymous)

Transportation

The transportation services provided by CTT was consistently identified by study participants as a key attractor of the program for clients, particularly for unstably-housed clients. These car rides allow clients to be picked up from the correctional centre at reasonable hour when services are open so that they may carry out essential tasks (e.g., visiting the income assistance office). Some study participants noted that when clients are released from the correctional centres, they are in the clothes that they were initially arrested in. Having transportation means that the CTT can take the client to buy new clothes at local community resources (e.g., Value Village). Additionally, the car rides assist clients with basic needs that help them set the foundation for their transition into community (e.g., grocery runs). Furthermore, clients who are able to get a ride to treatment centres directly from the correctional centre were thought to have a higher chance of continuing with addiction treatment, as opposed to clients who may have to take a long bus ride to addiction treatment centres from the correctional centre. In addition to the direct benefits that transportation provides, study participants identified two indirect benefits of car rides. First, during the car rides are when relationships and rapport with clients is developed:

“We’re – sometimes like we’re a glorified taxi service, but I also find that in those moments when we are able to do those pickups, it’s, you know, it’s the best type of therapy. It’s – it’s very non-invasive. There’s no direct eye contact required. You’re just like sitting in the back of the car, staring out a window, chatting about your feelings, and you have some really good conversations. And so I think that sometimes, when we’re able to facilitate releases, I feel like those clients, unless they’re specifically using us for a ride, which some people do, I feel like those clients hang on a little bit longer”.
(Anonymous)



These relationships are key, particularly as CTTs work in community to support clients. Clients were thought to more likely stay in contact with CTTs post release when they had established a good relationship and rapport with members of the CTT. Therefore, the importance of transportation is that it builds strong rapport with the client, which encourages community follow up and lowers the risk of attrition.

Second, some study participants emphasized the vulnerability and risk that initial release poses to clients. One study participant described how without a ride, clients are likely to return to substance use immediately after being released from a correctional centre. This risk is exacerbated when clients are forced to take a bus to either a court date or treatment centre post release:

“... we remove that chance for them to go back to the street again” (Anonymous)

Study participants have observed that even within a few hours of release, if a client does not have ample support, there is a high probability that they will return to using substances despite any goals developed inside the correctional centre during discharge planning. In one instance, one study participant had a client who was hesitant to go to a shelter post release because there was open substance use around the shelter. The client had identified that their goal was to continue not using substances, and an open use environment was not an ideal situation for the client to be placed in. In an effort to circumvent this, the CTT was able to leverage community connections to arrange for a motel room for the client to stay in temporarily. Remarkably, the CTT worked to also get the client an iPad where he was able to connect with his children who resided elsewhere. This served as inspiration as he continued on his recovery journey. Finally, the client was able to get into an addiction treatment centre. This exemplifies the critical need to immediately support individuals post release, particularly for clients who are unstably housed.

Community partnerships

Community partnerships (e.g., pharmacies, outreach groups, non-profits, ect.) are critical for clients to access as they transition back into the community. We asked study participants how they built these relationships. This information is important as the CTT program expands into different geographic areas, as future CTTs will need to curate similar relationships in their own communities. Actions taken to build community partnerships included visiting facilities, attending meetings, and attending overdose awareness group sessions. Moreover, attending conferences and networking, attending workshops, and calling different services and inquiring about the services that are offered also proved to be beneficial for



developing community partnerships. One study participant spoke about developing workflows with each community partner, and having frank discussions about expectations from the community partner and CTT as a means of informing concrete workflows with organizations to facilitate continuity of care of clients.

“I do find a chunk of my time is meeting with other professionals and, you know, sitting down over a coffee and chatting about work, as a way to really establish their understanding of our program, so that we’re not playing hot potato, essentially, with people in the community” (Anonymous)

One of the benefits of establishing these relationships is that aside from direct services provided to the client, some community resources can aid CTT with outreach efforts. For example, some CTTs have developed relationships with probation officers. If consent is provided from the client, the probation officer can let clients know that CTT is looking for them when they check in with probation officers. Additionally, one study participant found that many community partners have a peripheral understanding of what CTT does. Specifically, given how small the team is, and limited publicly available knowledge about the services CTT offers, community partners often refer any corrections-involved clients to CTT, a misconception that is partly attributed to limited understanding and public knowledge.

COVID-19 facilitators

An interesting finding was that due to the COVID-19 pandemic, court proceedings happened virtually at the correctional centre. In the event of last-minute releases, where typically CTTs are quickly attempting to pull together a discharge plan, having virtual court take place gave CTTs an opportunity to meet with the client to assess their need for support.

“Yeah, so video court, they stay here and do their video court, and then, you know, and then they’ll be here for a few – you know, a couple of hours, so we can get them a script then. We can talk, have a conversation with the client ... We can see them if they get released. But at court, they don’t come back here”. (Anonymous)

Additionally, one study participant found that since their client load was smaller during the onset of the COVID-19 pandemic, the CTT was able to expand who they received referrals from. Specifically, they worked with clients referred from mental health teams, community partners, forensics, as well as

other correctional centres that did not have a CTT. Many of these clients were not part of the OAT program, which was an opportunity to see the benefit the program has to clients who are not just living with an OUD.

Opportunities for improvement of the CTT program

More standardized training for CTT staff

All 10 of the study participants reported that besides Provincial Health Services Authority (PHSA) training modules (e.g., different therapy interventions and confidentiality courses), they received no CTT-specific training. Many study participants decided to participate in our study in an effort to contribute to the development of better onboarding in the future. Lack of training was coupled with a loosely defined job description, leaving one study participant feeling lost and stressed. The lack of definition of each CTT role, coupled with a lack of training and job expectations has resulted in ongoing stress:

“...and I think that is something that maybe will come over time, because the more experienced that I’ll be, the more I will be able to figure out those areas of doing my job. But having more literature about CTT, or about what the expectations are, would help, would really help”. (Anonymous)

Study participants were asked to reflect on what training would have been beneficial when they began as part of the CTTs. One study participant who had not come from a provincial corrections background, suggested that learning the organizational structure of PHSA, and particularly the structure of CHS would have been helpful. They found that a large part of navigating their role initially was learning how CHS operated, and it was challenging to learn this while concurrently trying to carry out their role. Another study participant did not have any overlap with their predecessor. To compensate for this lack of handover, they networked and relied heavily on speaking with other SWs from around the province to understand the job. They recommended that for future CTT staff, part of the training should include shadowing more seasoned CTT employees around the province. Additionally, they recommended creating a manual which includes a description of each role, as well as templates for documentation.



Additional support for CTT staff

Given the demands placed on CTT staff, specifically working within restrictive and limited resourced environments, adjusting to unpredictable hours (e.g., unforeseen release times), and the emotional toll (e.g., providing one on one counseling), it is imperative that staff feel supported to avoid burnout and also to be able to carry out their role to its maximal potential. Some participants described the need for contingency planning in case one of their team members is sick. Compared to clinicians, where patients can sometimes be re-scheduled, clients accessing CTT cannot re-schedule their release dates:

“You know, if one of us is sick, the whole team’s sort of kneecapped, so it presents some challenges, and we do the best we can, either using correctional staff or other staff from agencies, ... I can’t reschedule a release, so not having a strong and solid contingency plan for those days specifically creates quite a bit of stress. You never want to get sick on a release day, because you are really, really impeding someone’s plans, and it – yeah, it doesn’t feel good.”
(Anonymous)

This pressure placed on CTT workers, coupled with only having one CTT per correctional centre means that some CTT staff are left feeling guilty for taking time off. One participant mentioned their correctional centre intended to bring on a part time position that would work Friday to Monday with a cellphone to be on call, however this position was never able to be filled. This emphasizes a need for more weekend support to help facilitate weekend releases and assist in the management of the weekly workload for the CTT.

Enhanced infrastructural support

Many study participants described lack of office space and infrastructural support as a challenge in their work. Within the correctional centres, many study participants found it challenging to secure an office space. Office space was deemed critical to some study participants in order to have meaningful and honest meetings with clients. Offices offer confidentiality for clients to express their treatment goals, and



allow a comfortable environment to foster rapport between CTT staff and the client. Furthermore, unforeseen challenges with securing office or interviewing space has implications on workload planning for study participants:

"Yeah, because I mean, we're all professionals, and we all are fairly bright. We can figure out, you know, problem-solve things, but you can't problem-solve lack of space."

(Anonymous)

One study participant described that they may intend to visit with several clients in one day in an office, but if that space is no longer available, it backs up referrals for other clients. Some study participants have attempted to circumvent this challenge by visiting clients in the living units. However, study participants noted that it's challenging to have honest conversations with clients when they can easily be overheard by others in the units. Some study participants feel like clients prematurely dismiss the services offered by CTTs when approached in the units due to the presence of others. Moreover, there is no internet in the units, which means that if a CTT staff needs to look something up for a client, it is not feasible. These concerns and frustrations are exacerbated by lack of technological and IT support available in correctional centres. Particularly with the onset of COVID-19 where many appointments were switched to virtual platforms, facilitating virtual health within correctional centres with limited support has resulted in delays and feelings of frustration:

"...Everything I do is involving tech" (Anonymous)

These concerns regarding space and technological support also apply to CTT members working in community. Having a community office space exclusive to CTT was a recommendation by one study participant. The study participant noted that sharing this space with other organizations in the community poses challenges when on confidential calls. Additionally, another study participant recommended providing CTTs with petty cash or available funds (as many outreach programs have) for damage deposits, small rental subsidies, grocery cards, or transportation:

"And then not having funding. A lot of outreach programs run by other agencies that I know locally have, you know, kind of like petty funds, or even more funding to kind of



support clients in their transition whether that's possibly paying for a damage deposit or, you know, small rental subsidies, or funding for grocery cards or that kind of thing, or transportation. So our program doesn't really have funding dollars for that, but I think it'd be so beneficial to access funds more readily" (Anonymous).

This highlights the critical work that is being done as part of the CTT pilot, and increased funding could expand the quality of services provided to clients.

Inclusion of housing supports into the CTT resources

Securing stable and affordable housing for clients is currently outside of CTT's mandate and scope. However, many study participants elaborated on the challenges that lack of housing poses to clients following their release plans. Immediately after release from a correctional centre, many clients lack stable housing to transition into. Many study participants observed that in these instances, clients are unable to follow through on goals established while incarcerated because they lack the basic necessities for survival:

"It's tough to do other things when you're in survival mode, and that's what happens, is you're released and you have these good intentions, but then you get released and maybe you don't have housing, or you don't – you don't have anywhere to go, then – then it's just complete survival mode again, and your plans, you know, fall to the wayside, because now you just have to think about keeping yourself warm and fed and all of that kind of stuff". (Anonymous)

Additionally, many housing resources are hesitant to accept clients with a history of incarceration. One study participant described this as a consistent challenge when trying to secure clients a treatment or housing placement. At times, the calls are denied because it is coming from Corrections, or the placement is denied because the client is coming directly from a correctional centre. Services that are more open to accepting individuals with a history of incarceration are often unregistered treatment facilities. These unregistered facilities, though they provide shelter, can be dangerous, where open substance use may occur. They are often crowded, lack heat, can be infested with bugs and pests, and



some require access to individuals' welfare cheques as a payment mechanism. Moreover, some geographic areas lack transitional housing such a provincial halfway house. In Prince George, there are currently no provincial halfway houses. Having a provincial halfway house would allow clients a place to go immediately after release, and have an easier transition back into community with the aid of supports and services at the half way house.

According to several study participants, safe and stable housing has the potential to positively influence other health and social outcomes for clients. One study participant shared their experience working with an adult client who had lacked housing since he was a youth. After being stabilized on OAT, CTT assisted him with securing housing which was an eight-month advocacy process. Finally, CTT was able to get him and his partner a placement in a supportive housing complex, and since then, he has not been in custody again. Study participants recommended that because working on housing placements is time consuming, resources should be shared with CTT to support this process.

"Um, I think the program (CTT), the way it's designed, it's amazing. But the first thing, when a person gets released from Corrections, the first thing they need is housing, a stable housing where they can stay safe and that's missing"
(Anonymous)

For example, one study participant suggested that even assisting clients with temporary transitional housing for 1-2 weeks post release would allow the CTT and client to assess their options and would circumvent losing contact with clients immediately after release as is often seen. Or, one study participant suggested building partnerships with housing resources and having CTT more involved in the organization of placement processes would be helpful as well.

Identified challenges specific to the COVID-19 Pandemic

COVID-19 had implications on missing vulnerable client populations. The justice system adapted to the pandemic by try reducing the number of sentences to correctional centres and instead placing individuals on community supervision. One study participant observed that because of this, CTT was missing interacting with a large vulnerable population, since they initially connect with clients while they



were incarcerated. One CTTs pragmatic approach to this was to continue to foster relationships with probation officers who could advise on clients in the community. Additionally, CTTs were not able to see clients who had tested positive for COVID-19. In order to try to still provide services, one participant described their efforts with trying to get medications delivered to clients and also doing intakes over the phone. Similarly, one study participant described the process of sending letters to clients in their units to introduce them to the health care services provided at the correctional centre. This was challenging because many clients were challenged with their literacy. For clients who were able to be seen in person, some study participants found the wearing of Personal Protective Equipment (PPE) to be a barrier in developing rapport with clients. To circumvent this, often CTT would facilitate walks with clients outside where they could be in an open space and practice social distancing. Additionally, COVID-19 stalled the progress on several anticipated program launches within the correctional centres such as one on one counseling, schooling, work programs, life skills, behavioral management, and anger management. The implementation of these program has the potential to help clients adhere to the goals they determined in their release plans. At NCC, the Right Living Community, specifically the Therapeutic Community, is a separate living unit that clients may apply to, which is extremely program heavy with psychoeducational groups focusing on risk factors and how to reduce those factors. CTT clients who engage in these programs were thought to have a smooth integration back into the community according to one study participant.

COVID-19 also created challenges with connecting with community resources. Particularly working in a landscape with limited resources catered to the population CTT aims to serve, it has been challenging for study participants to continue their work. One study participant described an experience with a client where he lost his housing due to COVID-19. CTT called several shelters to get the client temporary shelter until his housing was re-secured, however shelters would not take the client. This happened the day before the client was scheduled to move into his housing placement:

“So we’re finding like having multiple backup plans for your plan is like the way to go, but even finding one plan is really difficult, so to have like two or three plans in the event that COVID kind of... yeah, gatekeeps that resource, it’s yeah, we have to be incredibly flexible, and incredibly resourceful in those times” (Anonymous)



Limitations

This evaluation has limitations. Firstly, the original study design proposed to collect both quantitative and qualitative data to critically evaluate BC's CTT pilot program. Given the onset of a global pandemic however, significant adaptations to the study's methodology had to be adopted which inherently limited the scope of the originally proposed evaluation. More specifically, the sociodemographics collected from clients were only collected from two BC Correctional Centres and the sample size was small (n=20). Accordingly, the study's client population are not representative of all CTT clients in BC. With respect to the qualitative interviews with CTT staff, while we were able to recruit participants from each of the five CTT operational sites the sample size was again small (n=10). Furthermore, for some sites it was challenging to reach CTT staff, which limited our ability to conduct more interviews with CTT staff from those sites to get a richer understanding of the challenges and potential opportunities associated with each geographic location. Additionally, some sites did not have certain CTT roles filled at the time of interviews, so we did not have the opportunity to gain those perspectives from those sites. The results described in this report are a preliminary evaluation of this pilot program, and present an opportunity for a more in-depth investigation to be conducted to critically discern the nuances of the challenges and facilitators of the existing program, which will overall inform the trajectory of the health and social outcomes for individuals at significant risk of OD post release from a BC Correctional centre.



Recommendations for Further Inquiry

Based on the findings from our research interviews, we propose the following recommendations to improve the existing operations of the CTT program:

- 1) **Regular monthly meetings:** should be considered between all of the CTTs and Correctional Health Services Leadership across the province to help support and work through challenges that CTT members might be experiencing. These meetings should provide a forum for CTT staff to articulate challenges experienced, safety concerns and identified opportunities for improvement.
- 2) **Expansion of the CTT mandate:** given the tremendous success of CTTs for clients with an OUD, consideration should be given expand that mandate of the CTT to support clients with other substance use disorders and/or mental health diagnoses.
- 3) **Inclusion of housing supports from BC Housing into the CTT resources:** given the integral role housing plays in shaping health and social outcomes for clients, resources or referrals to services that specialize in housing support should be incorporated into each CTTs resources. CTT teams should be equipped to refer clients to resources that can navigate the challenges of securing housing, particularly when subsidized housing options are already hesitant to accept individuals with a criminal history. Efforts may be allocated to expanding these partnerships and facilitate networking to ensure CTTs are well-positioned to engage with existing resources. Specifically, networking with BC Housing should be undertaken to curate resources specific to individuals who are unhoused and have a history of incarceration. It should be emphasized that the role of CHS is to bridge connections to housing, but CTTs cannot assume the sole responsibility of navigating the housing system. Importantly, concerted efforts should be made to ask for action from the government on the current housing crisis, particularly calls for action that benefit marginalized populations who face additional challenges securing affordable housing (e.g., people living with OUD and leaving correctional centers).
- 4) **Improved knowledge translation:** increased publicly available outputs (e.g., media, reports, presentations) from BCMHSUS and CHS about the role of CTTs and the services they provide would be beneficial to enhance the presence and awareness of CTTs in the community.
- 5) **Relief planning:** a plan should be developed that allows CTT staff to reliably take breaks/holidays whereby their workload can be managed by someone else.



- 6) **Development of onboarding materials and training plans:** specific on-boarding material should be developed for the CTTs at each site that outlines the responsibilities of each role, offers strategies for success, workflows, and key contacts both in CHS and the community.
- 7) **Infrastructural support:** interview space and IT support (e.g., unrestricted access to internet) should be secured for the CTTs both in each correctional centre but also in the community.
- 8) **Improved coordination and communication with BC Corrections Community Corrections Division (CCD):** In order to foster a continuum of care for clients, concerted efforts should be made to increase coordination between CTT staff and community corrections staff so as to ensure the CTTs can be well-positioned to support clients. Specifically, CTTs should liaise with probation officers that operate out of Community Corrections offices to assist with outreach efforts. Collaboration with Community Corrections may also increase accessibility for addiction health and social services for clients who are seeking support once they are released. CTT staff should also be well positioned to collaborate with BC Corrections Integrated Transitional and Release Planning (ITRP) to facilitate bridging clients to resources in their communities.



Expansion of CTTs 2022

On Monday October 22nd 2022, BC Ministry of Mental Health and Addictions announced the expansion of CTTs. This expansion is related to the scope of services offered and geographical distribution of CTTs across BC Correctional Centres. Importantly, an Indigenous Patient Navigator has been added to each CTT which was a role that was not part of the pilot program. In addition to the five Correctional Centres that were part of the pilot, five more Correctional Centres will now have CTTs; specifically Allouette Correctional Centre for Women, Ford Mountain Correctional Centre, North Fraser Pretrial Centre, Okanagan Correctional Centre, and Vancouver Island Regional Correctional Centre. Also, CTTs will now work with clients for 90 days following release, which is triple the amount time during the pilot. The size of all teams has also been increased. Eligibility of participation in the CTT program now includes individuals living with significant mental health challenges and is no longer limited to living with OUD. Furthermore, a centralized hub has been put in place to support and provide coordination for all 10 CTTs across BC. This centralized hub serves the province and includes, but is not limited to, a nurse, addictions doctor, system navigator, psychologist, social worker, and an Indigenous Patient Navigator.

The briefing from the BC Ministry of Mental Health and Addictions can be found [here](#).



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Appendix

Appendix A: List of proposed databases linkages

Database	Variables	Rationale
Primary Access Regional Information System (PARIS)	Community use of medical, mental health or addiction services	Healthcare & addiction treatment system utilization
Insite	Use of supervised consumption services	Addiction treatment system utilization
IntraHealth EMR	Use of primary care, and mental health community care services	Addiction treatment and healthcare utilization
National Ambulatory Care Reporting System (NACRS)	Uptake of emergency departments, outpatient and community-based clinics, and ambulatory care	Healthcare utilization & addiction treatment system utilization
Discharge Abstract Database (DAD)	Demographic, administrative, and clinical data for presentation to emergency departments and hospital discharges Uptake of in-patient acute, chronic, and rehabilitation health services	Healthcare utilization
Medical Services Plan (MSP)	Use of provincial medical services	Healthcare utilization
Residential Assessment Instrument	Use of continuing care and residential care services	Addiction treatment system utilization
Minimum Reporting Requirements	Use of mental health services	Addiction treatment system utilization
Canadian Primary Care Sentinel Surveillance Network (CPCSSN)	Use of primary health care and related addiction care services	Healthcare & addiction treatment system utilization
PharmaNet	Uptake of addiction medications (e.g. methadone, acamprosate, naltrexone)	Addiction treatment system utilization
British Columbia Centre for Excellence in HIV/AIDS Drug Treatment Program	Use of antiretroviral therapy for the treatment of HIV	Health outcomes
BC Cancer Agency	Uptake of cancer services	Health outcomes
	This information is important to collect as the use of many substances (e.g. nicotine, alcohol) can have significant adverse health outcomes resulting in the development of cancer.	
British Columbia Centre for Disease Control – Infectious disease testing	Test results for HIV, hepatitis C and sexually transmitted diseases	Health outcomes
Cardiac Services BC	Uptake of cardiac procedures	Health outcomes
	This information is important to collect as the use of many substances (e.g. alcohol, crack/cocaine) can have significant adverse health outcomes that affect the heart.	



Vital Statistics (Deaths)	Information about the date and circumstances surrounding death, should this unfortunately occur during the study period	Health outcomes
Community Transition Team database	Information about participation with CTT and access to medical care and compliance with this in the post-release period	Health outcomes
BC Corrections CORNET database	Legal hold status, offences and events.	Criminal justice outcomes
BC Corrections CORNET database	This information is important to collect to determine the frequency and nature of recidivism and to evaluate how this may relate to relapse to substance use in the post-release period	