Access to Substance Use Disorder Treatment Services in Canada

Carson McPherson1,2 and Holly Boyne1,3
1Cedars Cobble Hill, V0R 1L0, Canada
2Royal Roads University, BC V9B 5Y2, Canada
3University of Guelph-Humber, Toronto, ON M9W 5L7, Canada

1Corresponding 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

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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 Colombians 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.

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