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Providence HEALTH CARE
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OUD Management For Clients With A Criminal Conviction

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Community Transition Team Correctional Health Services – BOOST Team
Darcy Long, *ASK Wellness Support Worker*
Community Transition Team Correctional Health Services – BOOST Team
Virginia Reynolds, *Social Worker*
Community Transition Team Correctional Health Services – BOOST Team
David Towers, *Peer Worker*
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“ I kicked it the hard way. I got incarcerated.” - Opioid Agonist Treatment and Individuals with Criminal Justice Involvement

Angela Russolillo, PhD, MSc

Nov 21, 2019

Provincial BOOST Closing Congress

Disclosures

Presenter: Angela Russolillo

- No Disclosures
- No Disclosure of Commercial Support
- No Conflicts of Interest to Report
- Mitigating Potential Bias - All funds for research were administered by Simon Fraser University.

Objectives

- Review what is known about the health of individuals in contact with the criminal justice system;
- Identify links between opioid agonist treatment and improved health, social and criminal outcomes; and
- Consider ways to reduce barriers and improve OAT adherence and retention

Overview

- Introduction
  - Opioid use: epidemiology, health and economic burden
  - Opioid use and other substance use in the criminal justice population
- Research –BC Offender Population
  - Methadone and crime
  - Methadone and mortality
  - Methadone and hospitalization
- Discussion and Policy/Practice Implications
- Final Remarks

Introduction

350k people met the criteria for OUD in Canada (2015)

$70M in opioid related hospitalizations costs in Canada (2014)

80% of people who died from drug poisoning in BC **accessed healthcare** in the year prior to their death (2016/2017)

32% of people who initiated (new start) methadone in BC were **retained in treatment** at 12 months (2014/2015)

Introduction

11M people imprisoned globally

117K adult offenders in custody or community on any given day in Canada

less than 50% of federally-sentenced inmates reported **accessing substance use treatment in their lifetime**

75% of deaths following incarceration **involved opioids**

Methods

- Survival Analysis
- Cox Proportional Hazards Regression
- *Medicated (*methadone was dispensed*)* and *non-medicated* periods (methadone was not dispensed)
  - Pharmacy fillings transaction dates
- Hazard Ratios and 95% Confidence Intervals
- Sensitivity and subgroup analyses

Offenders Included in Study

Population Level Administrative Data

Eligible sample for hospitalization study

n= 11,401

Research Evidence

ADDICTION
SSA SOCIETY FOR THE STUDY OF ADDICTION
RESEARCH REPORT
doi:10.1111/add.14059

Associations between methadone maintenance treatment and crime: a 17-year longitudinal cohort study of Canadian provincial offenders

Angela Russolillo, Akm Moniruzzaman, Lawrence C. McCandless, Michelle Patterson & Julian M. Somers

Faculty of Health Sciences, Simon Fraser University, Burnaby, BC, Canada

Aim: To estimate the hazard and risk difference associated with methadone treatment (medicated period) for **violent** and **non-violent** offending

Characteristics of methadone treatment and crime	*Mean (SD)/n (%)*
No. of offences in the year prior to enrollment, mean (SD)	1.1 (2.3)
Any offence in the year prior to enrollment, *n* (%)	5498 (37.8)
Any jail sentence in the year prior to enrollment, *n* (%)	2824 (19.4)
Violent offences in follow-up period	
Mean no. of offences (SD)	0.5 (1.3)
Median no. of offences (min, max)	0 (0, 21)
Total no. of violent events in the entire cohort	6541
Rate (per 100 PYs)	5.7
Non-violent offences in follow-up period	
Mean no. of offences (SD)	4.2 (8.3)
Median no. of offences (min, max)	4 (1, 116)
Total no. of non-violent events in the entire cohort	61 283
Rate (per 100 PYs)	53.6

Research Evidence

Table 2 Extended Cox regression analysis estimating the hazard associated with methadone for violent crimes among 14 530 offenders from British Columbia, 1998–2015.

Time segment (years)[a]	*Dispensed methadone*	*Total events*	*Total PYs*	*Incidence per 100 PYs*	*Unadjusted HR*[b] *(95% CI)*[c]	*Adjusted HR*[d] *(95% CI)*	*Risk difference*[e] *per 100 PYs (95% CI)*
≤ 2.0	No	1412	13 037.5	10.8	Ref	Ref	−3.6 (−4.4, −2.6)
	Yes	985	13 927.1	7.1	0.61 (0.54, 0.69)	0.67 (0.59, 0.76)	
2.0 to ≤ 5.0	No	1473	19 745.5	7.5	Ref	Ref	−1.9 (−2.5, −1.0)
	Yes	638	12 824.3	5.0	0.66 (0.58, 0.76)	0.75 (0.66, 0.86)	
5.0 to ≤ 10.0	No	1053	21 573.1	4.9	Ref	Ref	−0.7 (−1.3, −0.0)
	Yes	488	13 013.4	3.7	0.77 (0.66, 0.90)	0.85 (0.73, 0.99)	
> 10.0	No	313	12 205.9	2.6	Ref	Ref	−0.2 (−0.8, 0.4)
	Yes	179	7917.0	2.3	0.88 (0.68, 1.14)	0.91 (0.70 1.17)	
Overall	No	4251	66 562.0	6.4			
	Yes	2290	47 681.7	4.8			

33% lower rate of violent crime

Table 3 Extended Cox regression analysis estimating the hazard associated with methadone for non-violent crimes among 14 530 offenders from British Columbia, 1998–2015.

Time segment (years)[a]	*Dispensed methadone*	*Total events*	*Total PYs*	*Incidence per 100 PYs*	*Unadjusted HR*[b] *(95% CI)*[c]	*Adjusted HR*[d] *(95% CI)*	*Risk difference*[e] *per 100 PYs (95% CI)*
≤ 2.0	No	13 874	13 037.5	106.4	Ref	Ref	−37.2 (−40.4, −33.0)
	Yes	9663	13 927.1	69.4	0.61 (0.57, 0.65)	0.65 (0.62, 0.69)	
2.0 to ≤ 5.0	No	13 336	19 745.5	67.5	Ref	Ref	−18.2 (−21.6, −14.9)
	Yes	5813	12 824.3	45.3	0.67 (0.62, 0.71)	0.73 (0.68, 0.78)	
5.0 to ≤ 10.0	No	9331	21 573.1	43.3	Ref	Ref	−5.2 (−8.2, −2.2)
	Yes	4666	13 013.4	35.9	0.83 (0.76, 0.90)	0.88 (0.81, 0.95)	
> 10.0	No	2717	12 205.9	22.3	Ref	Ref	−0.7 (−2.2, 4.0)
	Yes	1883	7917.0	23.8	1.07 (0.93, 1.22)	1.03 (0.90, 1.18)	
Overall	No	39 258	66 562.0	59.0			
	Yes	22 025	47 681.7	46.2			

35% lower rate of non-violent crime

Research Evidence


PLOS | MEDICINE

RESEARCH ARTICLE

Methadone maintenance treatment and mortality in people with criminal convictions: A population-based retrospective cohort study from Canada

Angela Russolillo*, Akm Moniruzzaman, Julian M. Somers

Somers Research Group, Faculty of Health Sciences, Simon Fraser University, Burnaby, British Columbia, Canada

Research Questions:

- Is the risk of **all-cause mortality** lower during periods of dispensed methadone compared with non-dispensed periods?
- Is the risk of **overdose mortality** lower during periods of dispensed methadone?

All-cause mortality rate
11.2 per 1000 PYs

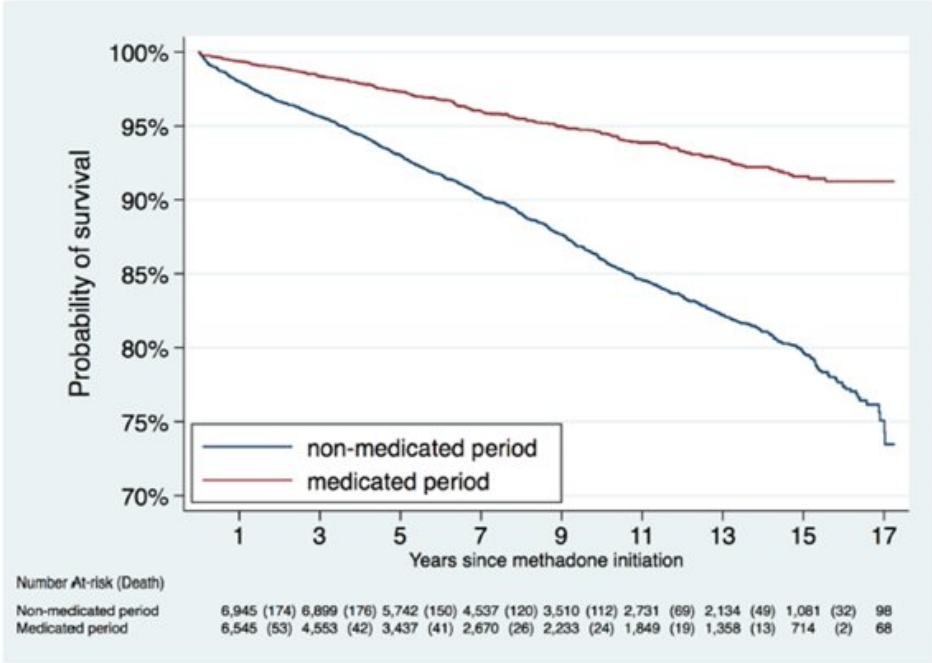

Fig 2. Kaplan-Meier curve for all-cause mortality among 14,530 convicted offenders from BC, 1998–2015. BC, British Columbia.

Research Evidence

Table 3. HR estimates of dispensed methadone on mortality among 14,530 convicted offenders from BC, 1998–2015.

Cause of Death	Medicated Methadone Period	Number of Deaths	Total PYs	Death Rate per 1,000 PYs (95% CI)	UHR (95% CI)[1]	AHR[2] (95% CI)
All-cause mortality[3]	No	996	66,562.0	15.0 (14.1–15.9)	Reference	Reference
	Yes	279	47,681.7	5.9 (5.2–6.6)	**0.37 (0.32–0.42)**[5]	**0.32 (0.28–0.37)**
	Total[4]	1,275	114,243.7	11.2 (10.6–11.8)		
Nonexternal causes	No	623	66,562.0	9.4 (8.7–10.1)	Reference	Reference
	Yes	148	47,681.7	3.1 (2.6–3.7)	**0.32 (0.26–0.38)**	**0.27 (0.23–0.33)**
	Total	771	114,243.7	6.8 (6.3–7.2)		
Infectious diseases	No	162	66,562.0	2.4 (2.1–2.8)	Reference	Reference
	Yes	28	47,681.7	0.6 (0.4–0.9)	**0.23 (0.15–0.35)**	**0.20 (0.13–0.30)**
	Total	190	114,243.7	1.7 (1.4–1.9)		
Other nonexternal causes	No	461	66,562.0	6.9 (6.3–7.6)	Reference	Reference
	Yes	120	47,681.7	2.5 (2.1–3.0)	**0.35 (0.28–0.43)**	**0.30 (0.25–0.37)**
	Total	581	114,243.7	5.1 (4.7–5.5)		
External causes	No	373	66,562.0	5.6 (5.1–6.2)	Reference	Reference
	Yes	131	47,681.7	2.8 (2.3–3.3)	**0.45 (0.37–0.55)**	**0.41 (0.33–0.51)**
	Total	504	114,243.7	4.4 (4.0–4.8)		
Accidental poisoning	No	266	66,562.0	4.0 (3.5–4.5)	Reference	Reference
	Yes	89	47,681.7	2.0 (1.9–2.3)	**0.43 (0.33–0.55)**	**0.39 (0.30–0.50)**
	Total	355	114,243.7	3.1 (2.8–3.5)		
Intentional self-harm	No	41	66,562.0	0.6 (0.5–0.8	Reference	Reference
	Yes	12	47,681.7	0.3 (0.1–0.4)	**0.40 (0.21–0.77)**	**0.36 (0.18–0.70)**
	Total	53	114,243.7	0.5 (0.4–0.6)		
Other external causes	No	66	66,562.0	1.0 (0.8–1.3)	Reference	Reference
	Yes	30	47,681.7	0.6 (0.4–0.9)	**0.57 (0.37–0.90)**	**0.54 (0.34–0.85)**
	Total	96	114,243.7	0.8 (0.7–1.03)		

5x lower risk

~2.75x lower risk

Research Evidence

JAMA Network Open

Original Investigation | Substance Use and Addiction

Association of Methadone Treatment With Substance-Related Hospital Admissions Among a Population in Canada With a History of Criminal Convictions

Angela Russolillo, MSc; Akm Moniruzzaman, PhD; Julian M. Somers, MSc, PhD

Research Questions:

- Is the risk of **hospital admission** lower during periods of dispensed methadone compared with non-dispensed methadone periods?
- Is the risk of **substance-related hospital admission** lower during periods of dispensed methadone relative to other reasons for admission (e.g., psychiatric or medical)?

19,160 acute hospital admissions **27.8** admissions per 100 PYs

Table 2. Extended Cox Proportional Hazards Regression Analysis Estimating the Hazards Associated With Methadone for Any-Cause Acute Hospitalizations Among 11 401 Patients With Convictions in British Columbia, 2001-2015, Who Were Receiving Methadone

Time Segment, y[a]	Period Receiving Methadone	Total Admissions, No.	Total PYs	Incidence per 100 PYs	HR (95% CI)		Risk Difference per 100 PYs (95% CI)[e]
					Unadjusted[b,c]	Adjusted[d]	
≤2.0	No	4129	9984.5	41.4	1 [Reference]	1 [Reference]	
	Yes	2416	10 612.5	22.8	0.52 (0.48 to 0.56)	0.50 (0.46 to 0.53)	−20.7 (−22.3 to −19.4)
2.1 to ≤5.0	No	4485	14 043.6	31.9	1 [Reference]	1 [Reference]	
	Yes	2057	9206.6	22.3	0.70 (0.65 to 0.76)	0.63 (0.59 to 0.69)	−11.8 (−13.1 to −9.9)
5.1 to ≤10.0	No	3228	12 020.6	26.9	1 [Reference]	1 [Reference]	
	Yes	1746	7889.5	22.1	0.82 (0.75 to 0.91)	0.75 (0.68 to 0.83)	−6.7 (−8.6 to −4.6)
>10.0	No	646	3101.8	20.8	1 [Reference]	1 [Reference]	
	Yes	453	1960.7	23.1	1.11 (0.92 to 1.34)	1.00 (0.83 to 1.21)	0.0 (−3.5 to 4.4)
Overall	No	12 488	39 150.5	31.9			
	Yes	6672	29 669.3	22.5	NA	NA	NA
	Total	19 160	68 819.8	27.8			

Research Evidence

Table 3. Extended Cox Proportional Hazards Regression Analysis Estimating the Hazards Associated With Methadone for SUD-, NSMD-, and MED-Related Hospitalizations Among 11 401 Patients With Convictions in British Columbia, 2001-2015, Who Were Receiving Methadone [a,b,c]

Time Segment, y[d]	Period Receiving Methadone	Total Admissions	Total PYs	Incidence per 100 PYs	HR (95% CI)		Risk Difference per 100 PYs (95% CI)[h]
					Unadjusted[e,f]	Adjusted[g]	
SUD							
≤2.0	No	850	9984.5	8.5	1 [Reference]	1 [Reference]	
	Yes	309	10 612.5	2.9	0.33 (0.28 to 0.38)	0.32 (0.27 to 0.38)	−5.8 (−6.2 to −5.3)
2.1 to ≤5.0	No	821	14 043.6	5.8	1 [Reference]	1 [Reference]	
	Yes	268	9206.6	2.9	0.50 (0.41 to 0.60)	0.43 (0.36 to 0.52)	−3.3 (−3.7 to −2.8)
5.1 to ≤10.0	No	586	12 020.6	4.9	1 [Reference]	1 [Reference]	
	Yes	214	7889.5	2.7	0.56 (0.44 to 0.71)	0.47 (0.37 to 0.61)	−2.6 (−3.1 to −1.9)
>10.0	No	100	3101.8	3.2	1 [Reference]	1 [Reference]	
	Yes	70	1960.7	2.9	0.90 (0.58 to 1.39)	0.76 (0.49 to 1.16)	−0.8 (−1.6 to 0.5)
Overall	No	2357	39 150.5	6.0			
	Yes	848	29 669.3	2.9	NA	NA	NA
	Total	3205[i]	68 819.8	4.7			
NSMD							
≤2.0	No	549	9984.5	5.5	1 [Reference]	1 [Reference]	
	Yes	270	10 612.5	2.5	0.44 (0.36 to 0.53)	0.41 (0.34 to 0.50)	−3.2 (−3.6 to −2.7)
2.1 to ≤5.0	No	536	14 043.6	3.8	1 [Reference]	1 [Reference]	
	Yes	222	9206.6	2.4	0.63 (0.51 to 0.79)	0.51 (0.41 to 0.64)	−1.9 (−2.3 to −1.4)
5.1 to ≤10.0	No	369	12 020.6	3.1	1 [Reference]	1 [Reference]	
	Yes	186	7889.5	2.4	0.77 (0.59 to 1.00)	0.60 (0.47 to 0.78)	−1.2 (−1.6 to −0.7)
>10.0	No	70	3101.8	2.3	1 [Reference]	1 [Reference]	
	Yes	30	1960.7	1.5	0.67 (0.42 to 1.07)	0.51 (0.32 to 0.81)	−1.1 (−1.5 to −0.4)
Overall	No	1524	39 150.5	3.9			
	Yes	708	29 669.3	2.4	NA	NA	NA
	Total	2232[j]	68 819.8	3.2			
MED							
≤2.0	No	2730	9984.5	27.3	1 [Reference]	1 [Reference]	
	Yes	1837	10 612.5	17.3	0.59 (0.55 to 0.65)	0.57 (0.52 to 0.62)	−11.8 (−13.1 to −10.4)
2.1 to ≤5.0	No	3128	14 043.6	22.3	1 [Reference]	1 [Reference]	
	Yes	1567	9206.6	17.0	0.76 (0.70 to 0.83)	0.71 (0.65 to 0.77)	−6.5 (−7.8 to −5.1)
5.1 to ≤10.0	No	2273	12 020.6	18.9	1 [Reference]	1 [Reference]	
	Yes	1346	7889.5	17.1	0.90 (0.81 to 1.01)	0.85 (0.76 to 0.95)	−2.8 (−4.5 to −0.9)
>10.0	No	476	3101.8	15.3	1 [Reference]	1 [Reference]	
	Yes	366	1 960.7	18.7	1.22 (0.98 to 1.51)	1.15 (0.93 to 1.43)	2.3 (−1.1 to 6.6)
Overall	No	8607	39 150.5	22.0			
	Yes	5116	29 669.3	17.2	NA	NA	NA
	Total	13 273	68 819.8	19.9			

Substance use disorders

Non-substance related mental disorders

Medical disorders

Limitations

- **Generalizability** of results to other settings and jurisdictions
- Administrative data is subject to bias in response to **missing or incomplete records**
- **Involvement with psychosocial supports** (e.g., counselling supports, AA, NA, etc.) may have altered treatment adherence
- Influence of **other OST prescriptions** (buprenorphine and buprenorphine-naloxone)
- **Methadone dose**

Summary of Evidence

- **Three retrospective longitudinal studies** examining the role of methadone adherence, across an important set of health and justice outcomes (**crime, mortality and hospitalization**).

- Results of this research support the hypothesis that **harms associated with opioid dependence are significantly reduced during times when individuals are receiving methadone treatment**.

- The protective effect of methadone remained **significant even after examination in subgroup and sensitivity analyses**.

Discussion

- **Increased engagement in methadone (or other opioid agonist) treatment**
  - Reduce barriers in custody and post release
  - Reduce interruptions to treatment
  - Improve adherence and retention
- **Interventions** are required to address the broader **health and social inequalities**
  - Addressing the ‘root causes’
  - Social determinants of health
- **Policy and practice** must consider the **complexities of OUD**
  - Integrated models of care
  - Social capital/recovery capital

Final Remarks

- *“Lewin’s insight was that if you want to **achieve change in behavior**, there is one good way to do it and one bad way to do it. The good way to do it is by **diminishing the restraining forces, not by increasing the driving forces.** That turns out to be profoundly non-intuitive*.” – Danny Kahneman

- *“British Columbia cannot "treat" its way out of this overdose crisis, or "arrest" its way out either*." Provincial Health Officer, 2019

CIHR IRSC

SFU FACULTY OF HEALTH SCIENCES

Thank you

Ministry of Justice

References and Resources

1. Russolillo, A., Moniruzzaman, A., McCandless, L., Patterson, M., & Somers, J. (2018). Associations between methadone maintenance treatment and crime: A 17-year longitudinal cohort study of Canadian provincial offenders. *Addiction (Abingdon, England), 113*(4), 656-667.
2. Russolillo, A., Moniruzzaman, A., Somers, JM. (2018). Methadone maintenance treatment and mortality in people with criminal convictions: A population-based retrospective cohort study from Canada. *PLoS Medicine, 15*(7), E1002625.
3. Russolillo, A., Moniruzzaman A., Somers JM. (2019). Association of Methadone Treatment With Substance-Related Hospital Admissions Among a Population in Canada With a History of Criminal Convictions. *JAMA NetwOpen, 2*(3): e190595.

List of full references:

Microsoft Word Document

Faculty Disclosure, Disclosure of Commercial Support, Mitigating Potential Bias

Community Transition Team (CTT) Provincial Health Services Corrections

- No disclosures
- Provincial Health Social Worker with a contracted Peer Support Worker (John Howard Society, and ASK Wellness).

Objectives

1. **<u>Not Alone</u>**: You will be able to identify and understand CTT from Corrections to Community through a "*peervantage*."

2. **<u>An OAT journey</u>**: You will understand the Opioid Agonist Treatment (OAT) journey within CTT from a "*social work-vantage*".

3. **<u>I am a part of the community:</u>** From the "*member-vantage*" you will provide opportunities for barrier reduction, engagement (meet the individual where they are at), and transition to community services.

Peer Vantage

Not Alone: You will be able to identify and understand CTT from Corrections to Community through a "*peervantage*."

Darcy and David to chat 5 minutes each to capture their experiences with:

- The substance use and correctional cycle
- The opportunity for change
- The maintenance of Recovery

Social Work Vantage

<u>An OAT Journey</u>: You will understand the Opioid Agonist Treatment (OAT) journey within CTT from a "*social work-vantage*". Heather (case example) and Virginia to chat 5 minutes each to capture Social Work interaction with clients and OAT/reintegration foundational needs in:

- Foundational needs for treatment follow-up (housing, peers, transportation, substance use, trauma, etc.) and creating connections.

Surrey Pretrial Services Centre (SPSC)

One of the biggest correctional facilities in the province

Maximum Security Facility

At this time currently houses 650 clients

Potential to house up to 735 clients

CTT at Surrey Pretrial

- Clients sometimes get released at court unexpectedly, which presents difficulties with OAT retention and follow up
- CTT attempts to frequently follow up with clients while they are in pretrial to keep up with their court dates
- CTT will try and attend clients court dates (bail hearings) as much as possible
- Proximity has presented as a challenge as some clients will have court in Chilliwack, Abbotsford, etc.
- Clients who are released on weekends have had difficulties picking up their OAT script at certain pharmacies in their area which may be closed on weekends.
- CTT works closely with the OAT nurse in keeping track of clients court and release dates

Member Vantage

I am a part of the community: From the "*member-vantage*" you will help provide opportunities for barrier reduction, engagement (meet the individual where they are at), and transition to community services:

This is your opportunity to help us build the bridge and create a welcome within the community:

- Do you have a local CTT team that you can work with to support your clients?
- Do your clients have access to transportation and safe shelter?
- How to clients gain welcome to your community within their SU challenges? What are the options for treatment?

References and Resources

Site	Contact Name	Title	Cell Number	Office	FAX	Email Address
Kamloops	Heather Cooke	Social Worker	(250) 320-6642	(250) 571-2242	(250) 571-2203	heather.cooke1@phsa.ca
	Darcy Long	Peer Support Worker	(250) 318-0559			d.long@askwellness.ca
	Taira Blacklock	Access/Transition Nurse		(250) 571-2230	(250) 571-2203	taira.blacklock@phsa.ca
Nanaimo	Della Kane	Social Worker	(250) 741-7844	250-729-7760	(250) 756-3322	della.kane@phsa.ca
	Joel Rustin	Peer Support Worker	250-816-2790	250 729 7760		joel@johnhowardnanaimo.org
	Mary Esson	Addictions Counsellor	(250) 729-7711	250 756 3310	(250) 756-3322	maryann.esson@phsa.ca
Victoria (Resource not CTT)	Umbrella Society: Blake Andison	Substance Use Outreach (VIRCC)		250-380-0595		Blake@umbrellasociety.ca
Fraser Regional	Varinder Kamboj	Social Worker	604 329-2461	(604) 462-5168	(604) 462-5150	varinder.kamboj@phsa.ca
	Brandon See	Peer Support Worker	778 689 4225			brlewis1123@gmail.com
	Andrea Routley	Access/Transition Nurse		(604) 462-5168	(604) 462-5150	ARoutley@phsa.ca
Prince George	VACANT	Social Worker	(250) 640-2861	(250) 960-3101	(250) 960-3034	
	Nicole Fleury	Peer Support Worker		250 562-6262 x224		nfleury@unbc.ca
	Richard Berger	Access/Transition Nurse		(250) 960-3101	(250) 960-3034	richard.berger@phsa.ca
Surrey Pretrial	Virginia Reynolds	Social Worker	604-690-0589	(604) 599-7531	(604) 572-2161	virginia.reynolds@phsa.ca
	Russell Clark	Peer Support Worker	(604) 889-4853			rcelclark@yahoo.ca
	David Towers	Peer Support Worker	(604) 217-4640			dklincolntowers@gmail.com
	Shannon Eley	Access/Transition Nurse		(604) 599-7511	(604) 572-2161	shannon.eley@phsa.ca

Community Transition Team

About Community Transition Teams

Each day, hundreds of people are released from a correctional centre and don't know where or how to find health care. The Correctional Health Services Community Transition Team helps people who use opioids (like fentanyl or heroin) get linked to the health care they need after leaving a correctional centre, for up to **30 days** post-release.

Why Choose Us Our mission and vision

We know that going from a correctional centre back to community living is hard. Our mission is to help make the transition easier for you and your loved ones. We understand the struggles of opioid addiction and know that each person is on a different recovery path. We are here to offer a helping hand, moving at your own pace and on your own terms.

A service that's all about you

It's important to us that your transition be as smooth as possible. The Community Transition Team is all about connecting you to health care supports and resources in your community. We'll match you to the best supports to fit your needs and goals.
You are our #1 priority.

Ongoing support

Once you've been released, we'll stay in close contact with you - face-to-face and through phone calls, video chats, or email - for the first month to make sure you're settling in. You will be well supported during the entire time!

A dedicated team

You will work one-on-one with a **Social Worker** who will talk with you about what your needs are, give you counseling, information and support. A **Peer Support Worker** will also be there with you through every step of your journey, giving you guidance and advice. Working with someone who's lived through similar experiences can give people hope that it does get better.
Tailored to your needs and delivered by people who understand you, can help you start building the life you want.

Contact us

*I*f you have any questions about the program while in custody, please fill out a Health Service Request to speak to the **Access and Transition Nurse** at your centre.

CTT *Outcome Objectives*

- Proportion of appointments attended within the first 10, 20, and 30 days post-discharge
- Relapse rate within 30 days of release (target to actual)
- Number of deaths due to overdose
- % of clients retained on OAT at 30 days
- Number of clients who achieved at least X (number) of their risk-reduction and/or treatment goals
- Total number/type of contacts with the client over the course of 30 days (e.g., phone calls, meetings)
- % of external service usage (e.g., primary care visits, ER visits, inpatient admission)
- Number/type of linkages to health and social services
- Number of early discharges/program exits and reasons why (e.g., no contact, not interested, re-incarcerated, no longer meets program mandate, linked to community service, safety risk)
- Number/type of prescriptions written at 30 days
- Proportion of prescriptions filled/refilled at 30 days
- Symptom reduction – self-reported client feedback
- Reduction in number of crises – client feedback
- Reduction in unmet needs – client feedback
- Increased knowledge about available community resources – client feedback
- % of clients who are employed at program exit*
- % of clients with stable housing at program exit*

CTT at Surrey Pretrial

- Clients sometimes get released at court unexpectedly, which presents difficulties with OAT retention and follow up
- CTT attempts to frequently follow up with clients while they are in pretrial to keep up with their court dates
- CTT will try and attend clients court dates (bail hearings) as much as possible
- Proximity has presented as a challenge as some clients will have court in Chilliwack, Abbotsford, etc.
- Clients who are released on weekends have had difficulties picking up their OAT script at certain pharmacies in their area which may be closed on weekends.
- CTT works closely with the OAT nurse in keeping track of clients court and release dates