Experiences of Delivering and Accessing Opioid-Related Services in Oxford County

Technical Appendix

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Experiences of Delivering and Accessing Opioid-Related Services in Oxford County: Technical Appendix

Purpose and Research Questions

The purpose of this situational assessment was to inform the opioid-related strategic directions of a drug strategy for Oxford County. The situational assessment did not aim to suggest specific interventions that could be employed by organizations or committees; potential interventions will be researched and assessed at a later date as part of the development of the broader drug strategy. Drug strategies in other Ontario jurisdictions[1], as well as the Canadian Drugs and Substances Strategy[2] use a four-pillar approach: prevention, treatment, harm reduction and justice/enforcement. Accordingly, our assessment focused on services that fall under these four pillars.

This assessment answered the following questions:

1. What gaps in services and programming exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?
2. What barriers and facilitators to coordinated service and program delivery exist in Oxford County?
3. What barriers and facilitators to accessing services and programs exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?

Secondary research questions, indicators and data sources are listed in the evaluation matrix (Appendix A).

Study Design

This assessment used a mixed methods, cross-sectional design. Data collection and analysis were carried out simultaneously from February to May 2018. Quantitative and qualitative data were used to understand the service landscape and barriers and facilitators to accessibility and coordinated service delivery. The quantitative data supported and contextualized the qualitative data, providing a picture of the structural, network and individual factors affecting service delivery and accessibility for people who use and are at risk for using opioids and loved ones of people who use opioids. Data were collected at a single time point and were not compared to historical or future data.

There were three methodological components to this study:

- service inventory
- social network analysis (including network maps)
- phenomenology (including focus groups, interviews and narratives)

The service inventory was used to understand what services are offered in Oxford County, where or how they are offered and who they target. Social network analysis was used to understand how organizations that provide opioid-related services in Oxford County work with and relate to each other. Social network analysis is a quantitative study of the relationships between groups of actors – not just the characteristics of the actors themselves. It aims to understand how the group of actors function and how actors' positions within the group affect its function.[3] Phenomenology – the study of lived experience[4] – is a qualitative research methodology. We used phenomenology to understand the essential experiential elements of two phenomena: coordinated opioid-related service delivery and accessing opioid-related services.

Our methods were informed by best practices and input from our target populations: service providers and people with lived experience. Front-line service providers participated in a consultation session to provide insight into appropriate data collection methods. Twelve people with lived experience were asked to answer a brief questionnaire to identify their preferences for data collection and payment for participation; these informants were given a $5 Tim Hortons gift card as a thank you gift. The social network analysis methods were reviewed by a post-doctoral

fellow with experience using this method. Phenomenological methods are informed by the lead applicant's previous research and Master of Science thesis project.[5]

Recruitment

Social Network Analysis

We recruited decision makers and front-line staff from 15 organizations identified in previous stakeholder analyses conducted by the now former Oxford County Public Health as organizations with high levels of interest and influence related to the creation of a municipal drug strategy. Decision makers are members of the leadership or management team who have the authority within their organization to commit resources (including financial and human resources) to an initiative or partnership. Front-line staff are involved in the delivery and implementation of opioid-related services and deal directly with clients; these staff may also be engaged in collaborative work with front-line and decision making staff from other organizations.

We sent an Eventbrite[a] invitation to selected employees of the 15 core organizations, asking them to attend the mapping session and indicating that up to two people from each organization could attend. Potential participants were selected based on their previous involvement with Public Health's recent community consultation sessions regarding harm reduction services and opioids; to be eligible, participants must have been 16 years old or older and speak and understand English.

Phenomenology

This component of the assessment sought two types of participants: service providers and potential service users. We recruited service providers who participated in the network mapping

[a] Eventbrite (www.eventbrite.ca) is an online service to create and manage events, including sending invitations and selling tickets.

sessions – both decision makers and front-line staff. At the end of the mapping session, the participants were informed of the purpose, dates and times of the focus groups; participants interested in attending the focus group sessions were asked to approach the facilitator before leaving or via email after the mapping session. The project lead sent all interested parties a Microsoft Outlook invitation to the appropriate focus group, including the letter of information. Informed consent was obtained from all focus group participants prior to asking any questions.

For the potential service users, we recruited a purposive sample of people, aged 16 years old or older, who speak and understand English and have accessed or tried to access opioid-related services. This type of sampling ensured that the participants are able to describe the experience of the phenomenon of accessing opioid-related services. Participants were recruited through posters hung at churches, grocery stores, local businesses, libraries and service provider organizations; Facebook ads and online classified ads on the websites of Oxford County newspapers. Potential participants contacted the project lead by phone and/or email and were asked questions to determine their eligibility. After being provided or read the letter of information, they were asked if they would like to schedule an interview time and location, as well as the type of gift card they preferred (of five options). If an appointment was set, the participant was given an ID code.[b] Informed consent was obtained at the beginning of the appointment, prior to the start of the interview.

To gather experiential data from a larger sample of people, we solicited narratives from service providers and people with lived experience about the experiences of coordinated opioid-related service delivery and accessing opioid-related services. We made efforts to solicit narratives in all eight municipalities within Oxford County for one month through a page on the Oxford County Public Health website, online classified ads and submission boxes with narrative templates located at select public libraries and service provider organizations.

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[b] People who were currently using opioids received codes that began with CUI (currently using illicit opioids) or CUL (currently using licit opioids); people who used to use opioids were given codes that began with FUI or FUL. Loved ones' ID codes began with L and the ID codes for people who were at risk of using opioids began with R. For example, CUI-1 was provided to the first enrolled participant who identified as currently using illicit opioids. Because most participants identified with multiple categories of experience, their ID codes were based on the category that fit best with how they initially presented their experience to the project lead and the order in which they enrolled in the study.

Data Collection

Service Inventory

A service inventory was created to understand the service landscape. We combined service data from a previous environmental scan of mental health services in Oxford County conducted in early 2017[6] with a list of services provided by front-line service providers to create an initial inventory of 99 services. Service details were verified using the organization's website or the SouthWesthealthline.ca database.[c] To be included in the final inventory, services had to meet the following criteria:

- physically located in Oxford County or provide a phone or online service to Oxford County residents
- target one of the assessment's populations of interest (i.e., provide a service to them *because* of their status as a population of interest)
- address opioid use, its consequences or risk factors[d] for opioid use
- not restricted to rostered patients of a family physician, family health team, nurse practitioner-led clinic or community health centre
- not offered by a committee or coalition
- not limited to dispensing opioid prescriptions

We reviewed the data previously collected for accuracy and sought missing or new information from organization websites and the SouthWesthealthline.ca database. To fill in remaining information gaps that could not be found on the organizations' websites or SouthWesthealthline.ca, we contacted the organization providing the service via phone or email and ask for additional information and clarification.

The inventory was collated in a Microsoft Excel file with the following column headings: service name, organization name, municipality/format, age(s) served, gender(s) served, target

[c] A previous situational assessment[6] determined that SouthWesthealthline.ca was a comprehensive database of local health-related services.
[d] Risk factors include: a history of trauma or abuse, experiencing chronic pain, homelessness, living in poverty, being a teenager or older adult and a personal or family history of addiction.[7]

population(s) and drug strategy pillar (see Appendix A for options under each heading). Every combination of population, target municipality/format, age, gender and pillar was listed on its own row; therefore, a single service could have multiple rows of data.

Social Network Analysis

Social network analysis research involves three primary phases: defining the network, describing the relationships between actors within the network and analyzing the network's structure (see Data Analysis section).[8] We took the perspective of a socio-centric network where the relationships between actors of a pre-defined or "bounded" community are examined.[3] In this assessment, the 15 organizations form the bounded community we studied.

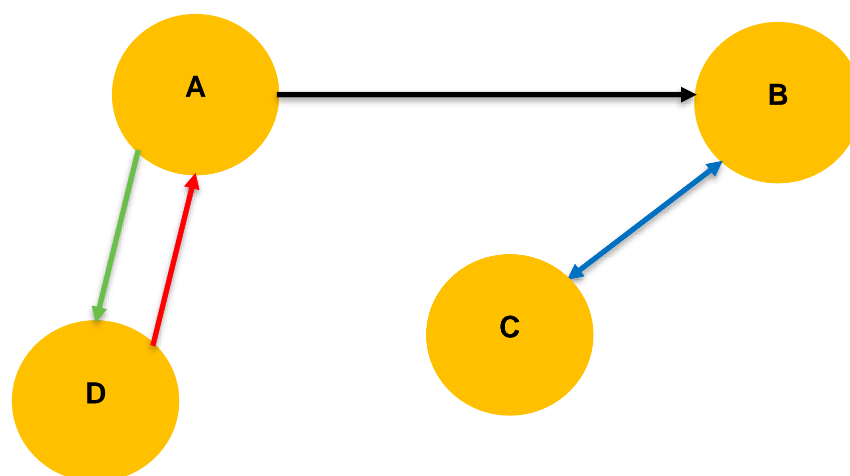
Two participatory mapping sessions – one with decision makers and one with front-line staff – were held to understand the organizational relationships among community members. Each mapping sessions lasted two hours. Five organizations were represented during the session with decision makers and six organizations were represented in the session with front-line staff. The procedure and collection tools for the sessions are provided in Appendix C. During the sessions, individual participants were asked to describe their knowledge of their organization's current relationship (including examples) with the other 14 organizations across four partnership strategies:

- **networking:** exchanging information for mutual benefit
- **coordinating:** exchanging information for mutual benefit and altering activities towards a common purpose
- **cooperating:** exchanging information, altering activities and sharing resources for mutual benefit and towards a common purpose
- **collaborating:** exchanging information, altering activities, sharing resources and enhancing the capacity of another organization for mutual benefit and towards a common purpose[9]

Once brainstorming was complete, participants were asked to create a paper map to illustrate these relationships by drawing coloured arrows from a dot representing their organization to the other 14 organizations' dots. Organizations may engage in more than one strategy with another organization. In this case, participants were asked to choose which strategy is most frequently

used. These relationships do not need to be mutual; for example, Organization A may describe its relationship with Organization B as networking, but Organization B may characterize this relationship as cooperating. Additionally, organizations may not identify a relationship at all. These differences were noted with the use of different coloured arrows as depicted in Figure 1. The black line with an arrowhead at B connecting A and B indicates that A described a networking relationship with B, but B did not describe a relationship with A. The blue line with arrows at both ends between B and C indicates that both B and C described a coordinating relationship with each other. Neither A nor C described a relationship with each other, therefore there are no connectors. The red line with an arrowhead pointing from D to A denotes that D described a cooperating relationship with A; the green line with an arrowhead at D indicates that A described a collaborating relationship with D. After each session, the maps were entered into a networking software, Social Network Visualizer (SocNetV).

Figure 1. Examples of relationship depictions in a network map



Phenomenology

We used interviews with people with lived experience and focus groups with service providers to elicit rich descriptions of the two phenomena under study: accessing and delivering opioid-related services in Oxford County. We also solicited written or audio narratives from both people with lived experience and service providers.

During the interviews, participants were asked broad, open-ended questions that elicited rich descriptions of their experiences and the meaning of those experiences. Each interview lasted

60-90 minutes and was conducted at a time and place convenient for the participant. An essential component of qualitative interviewing is flexibility and responsiveness to what the participants identify as important aspects of the experience.[10] A semi-structured interview guide (Appendix C) was used to guide the interviews; the interview questions were based on the three components of accessibility: availability, affordability and acceptability.[11] Although key topics and questions are outlined in the interview guide, the participant was allowed to direct the conversation and determine what is salient about the experience of accessing opioid-related services. The interviewer asked probing questions to elicit more detail and rich descriptions of the experience. Interviews were audio recorded and transcribed verbatim (with identifying information removed) by a transcriptionist and field notes were taken by the interviewer. Interview participants were provided with a $20 gift card at the conclusion of the interview.

Focus groups were conducted by two members of the project team (one acting as a moderator and the other taking notes about the discussion) and lasted approximately 90 minutes each. Two focus groups were conducted: one with decision makers and one with front-line staff. A semi-structured focus group guide (Appendix C) adapted from Krueger's[12] structure was developed for these sessions, but as with the interviews, the participants were allowed to direct the conversation. Audio from the focus group sessions were recorded and transcribed verbatim (with identifying information removed) by a transcriptionist to facilitate analysis.

Narratives could be submitted via email or in hard copy at public libraries and select opioid-related service organizations. They could be hand-written, typed or an audio file, but must have been submitted in English (Appendix C). One narrative was submitted, but it was excluded because it did not address the phenomenon being studied; therefore, no narratives were included in the final analysis.

Project team members involved in data collection wrote reflexive and analytical memos throughout the assessment to promote incorporation of the participants' voices in the analysis and engagement of the researchers with the data.[4,13] These memos consisted of observations, theories and questions. Peer debriefing and member-checking were used to share the researchers' interpretations with the rest of the project team and select participants, respectively, and ensure the interpretations reflect the experience of the phenomena.[14] Member-checking occurred throughout the data collection sessions and four participants were invited to review and comment on the complete analysis of their experiences prior to the publication of the final report.

Data Analysis

Service Inventory

The data from the service inventory were analyzed in Microsoft Excel to obtain the number of services targeting each subgroup under the following categories: target population, gender, age, municipality and drug strategy pillar (see evaluation matrix, Appendix A). Once the inventory was complete, a second Excel spreadsheet was created to summarize the characteristics of each service. Using this summary spreadsheet, we created three pivot tables to cross-tabulate the frequencies of services in the following categories:

- target population and municipality/format
- target population and age
- target population and pillar
- age and municipality/format
- age and pillar
- municipality/format and pillar

To ensure consistency when categorizing and analyzing the services, we defined the various categories as described in Appendix B. To reduce the risk of overestimating the number of services, we made distinctions in the categorization that oversimplify the “real world” situation. For example, we classified all services that would respond to overdoses as targeting people who use illicit opioids even though it is possible for someone to overdose while using opioids licitly. Similarly, we defined people in recovery from opioid use as former users of opioids who are currently abstaining from all opioids – licit or illicit; consequently, people using methadone or suboxone would be classified as currently using licit opioids. We only noted which populations were specifically targeted by a service – that is, they were sought out because of their opioid use, risk status or connection to someone who uses opioids. It is possible, however, that organizations may provide services to a population that isn’t specifically targeted (e.g., someone in recovery could access a service that targets people who use illicit opioids).

Social Network Analysis

Network maps

Network maps were first created on paper in the participatory mapping sessions and then entered into and analyzed in a social network analysis software called Social Network Visualizer (SocNetV). To protect the participants' identities, we assigned each organization an ID number (between 1 and 15) prior to entering data into SocNetV. Each organization is represented by a node in the network map. Relationships between two nodes are denoted with an edge.[15] Edges were weighted to distinguish between the four strategies, with networking given a weight of one, coordinating given a weight of two, cooperating given a weight of three and collaborating given a weight of four. These weights reflect the amount of time, trust and risk required of the organizations involved to engage in each strategy and were incorporated into the analyses. SocNetV's[16] built-in analysis tools were used to analyze the network properties. In addition to descriptive statistics about the number of nodes, proportion of each relationship type and density of the network (i.e., number of edges divided by the total number of possible edges), two categories of network properties were calculated for each map: centrality and clusters/cliques. The properties of each map were compared and contrasted to understand how the experience of collaboration differs between decision makers and front-line staff.

Centrality

Local centrality metrics (i.e., measures at the level of individual nodes) help identify the key actors within a network: that is, organizations that are connected to many other organizations in the network.[3] For this assessment, we calculated local degree, closeness and betweenness centrality; for degree centrality we inversed the weight of the relationships in the calculation. Local degree centrality measures how many direct relationships an organization has with others by the number of edges going out of a node. Local closeness centrality measures how close each organization is to all the other organizations it could reach in the network; it is "the standardized inverse average distance between a node and every other node reachable from it."[16] Betweenness centrality measures how many times an organization lies in the pathway of connecting two otherwise unconnected organizations – that is, how many times an organization

could act as "middle man" for other organizations.[16] Higher scores on each of these measures signify greater influence within the network. Peripheral actors are those with relatively few connections to other actors in the network and isolates have no interactions reported.[3]

Because only two-thirds of the organizations were represented at each session (and only three organizations were represented at both the decision maker and front-line sessions), our prominence measures risked underestimating[e] the prominence of the organizations who did not attend the sessions when the maps were analyzed separately. To mitigate this risk we combined the mapping and qualitative information data by the two groups to produce a single map. If the decision makers and front-line staff differed in characterizing a relationship (e.g., one said it was a coordinating relationship and another said it was a collaborating relationship), we included the highest strength relationship. The qualitative examples provided during the discussion were used to identify networking relationships between organizations that were not represented at either mapping session. For example, if participants identified that Organizations 10 and 15 were members of the Situation Table, but neither of these organizations were present at the mapping sessions, we assigned a networking relationship (i.e., the lowest strength) between 10 and 15.

Clusters/cliques

A clique exists when two or more nodes are directly connected to each other, but no other node is connected to all clique members. Cliques increase diffusion and adoption of interventions and information among the members, but new information and interventions are introduced to the clique through network members who are weakly connected to one or more clique members.[3] SocNetV identified all cliques within a network using the Bron-Kerbosch algorithm and produced a clique census that identified which organizations comprise each clique.[16] These cliques can become pilot testing sites for new interventions and to use as case studies for ways to strengthen relationships between other members of the network.

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[e] Because participants in the mapping sessions did not draw arcs out of nodes for organizations that were not represented at the session, the degree centrality would be 0 for those organizations. The undirected degree centrality would be similarly underestimated because the organizations that did attend would have the opportunity to have up to two edges per node for attending organizations, but the non-attending organizations would only have one.

Phenomenology

We used thematic analysis to understand the essential and incidental experiential components of accessing opioid-related services and coordinated opioid-related service delivery. The analysis included three phases: line-by-line coding, determining essential themes and describing the essence of the experience.

In line-by-line coding, the researchers examined each sentence in the transcripts, narratives, field notes and memos to understand what it told us about the experience of the phenomenon. The sentence was labelled with words or phrases (i.e., codes) that represent its meaning to the experience. Codes could be repeated across data sources and new codes can be used at any time. As more data were analyzed, the descriptions of the codes were refined and some codes were combined as it became clear that they were speaking to the same underlying meaning. Once all data sources were coded, these codes became the basic themes of the text.[4]

Essential themes are those that, if removed from the experience, would change its meaning.[4] To determine which themes are essential, the analysts considered the place of each theme in the experience as a whole. The analysts returned to the data to reflect on how the basic theme contributed to the whole experience. To complete this phase of the analysis, each essential theme was described so that it was clear how the theme provides meaning to the whole experience and how it is manifested in different ways and among different groups of people (e.g., among front-line staff vs. decision makers).

Describing the essence of the experience requires a similar process as identifying essential themes. In this phase of the analysis, the analysts reviewed and reflected on the descriptions of each essential theme to determine what concept underlies everything else. The essence of the experience provides greater understanding of the essential themes and vice versa.[5]

Limitations

As with all research, this assessment has a few limitations. The service inventory data is limited to the information that could be found online and provided by service providers who returned our

requests for clarity. Similar to a previous situational assessment of mental health services in Oxford County, opioid-related service information was difficult to extract due to vague or limited online descriptions. The information given to us by service providers was limited to their knowledge of the service's objectives and eligibility criteria. To mitigate the risk of reporting inaccurate results, the authors created a set of standard rules and definitions for each category and the authors had to achieve consensus about the categories assigned to each service.

Nine of the 15 network organizations were represented by participants in the mapping sessions. Only three organizations were represented by participants at both the decision maker and front-line staff sessions. As a result, the number and strength of relationships present in the opioid network may be underrepresented – especially among the non-participating organizations. To combat this problem, we combined the data for both sessions and assumed networking relationships among non-participating organizations that were identified by participants as members of committees, coalitions and planning tables (e.g., Oxford Addiction Treatment Strategy). The potential for bias exists if, for example, the non-participating organizations place less value on collaboration or opioid-related services than those who were represented in the sample or may have been unable to participate due to workload, illness or vacation schedules. However, we are unable to determine if this bias does exist in our findings.

Finally, the lived experiences of delivering and accessing opioid-related services may not be representative of all people who have experienced these phenomena. The methodology we used (phenomenology) does not aim to generalize findings to an entire population; instead, it aims for transferability of the findings to other people and contexts.[14] To achieve transferability, we engaged the participants in open-ended discussion and elicited detailed descriptions of their experiences and purposively sampled our populations of interest. Our sample of service providers included decision makers and front-line staff from organizations who provide services under each of the four drug strategy pillars.

Our sample of people with lived experience included participants who identified with all four of our populations of interest – half of which identified with multiple populations. Although we attempted to recruit participants with lived experience from across Oxford County, no participants resided in rural municipalities. Similarly, our attempt to elicit written narratives from people who may be uncomfortable sharing their experiences in person or unable to participate in an interview was unsuccessful. As a result, the lived experiences of rural residents may include unique nuances that were not captured in this assessment.

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Appendix A – Evaluation Matrix

Question	Indicators	Data Sources
1. What gaps in services and programming exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?		
1a. What services exist in Oxford County?	List of services and organizations	Environmental scan
1b. What are the characteristics of each service offered in Oxford County?	# targeting or serving each of the following subgroups: **Target population** - People who currently use illicit opioids - People who currently use licit opioids - People who are at risk of using opioids - People who are in recovery from opioid use - Friends and family of people who use opioids **Gender** - Males only - Females only - Any gender **Age** - Children (0-12 years) - Youth (13-25 years) - Adults (26-64 years) - Older adults (65+ years) # providing service in each of the following municipalities/ formats:	Websites, SouthWesthealthline.ca, email and phone follow-up

Question	Indicators	Data Sources
	- Blandford-Blenheim - East Zorra-Tavistock - Ingersoll - Norwich - South-West Oxford - Tillsonburg - Woodstock - Zorra - Online - By phone # providing services under each of the following drug strategy pillars - Prevention - Treatment - Justice - Harm Reduction	
1c. What gaps in service availability exist?	Cross-tabulated frequencies of services in each of the categories: - Target population and municipality/format - Target population and age - Target population and pillar - Age and municipality/format - Age and pillar - Municipality/format and pillar Service gaps identified by: - service providers - people with lived experience	Websites, SouthWesthealthline.ca, email and phone follow-up Focus groups, narratives Interviews, narratives

Question	Indicators	Data Sources
2. What barriers and facilitators to coordinated service and program delivery exist in Oxford County?		
2a. How do key organizations interact with each other?	Social network maps identifying relationships between organizations: - networking - coordinating - cooperating - collaborating	Participatory mapping
2b. What are essential themes of service providers' experiences of coordinated service and program delivery?	Essence of the experience and essential themes of the experience from service providers' data	Focus groups, narratives
2c. How might the service network structure influence these facilitators and barriers to coordinated service and program delivery?	Aspects of the network structure: - central actors - peripheral actors - isolates - clusters/cliques	Network maps
3. What barriers and facilitators to accessing services and programs exist in Oxford County for people who use and are at risk of using opioids and loved ones of people who use opioids?		
3a. What are essential themes of peoples' lived experiences accessing services and programs in Oxford County?	Essence of the experience and essential themes of people with lived experience's data	Interviews, narratives
3b. How might the service network structure influence these facilitators and barriers to accessing programs and services?	Aspects of the network structure: - central actors - peripheral actors - isolates - clusters/cliques	Network maps

Appendix B – Service Inventory Definitions

Category	Definition
At risk of using opioids	At risk of using illicit or licit opioids in the future due to: a history of trauma or abuse, experiencing chronic pain or homelessness, living in poverty, being a teenager or older adult or having a personal or family history of addiction
Currently using illicit opioids	Currently using illegal opioids (e.g., heroin) or using legal opioids illicitly (e.g., without a prescription or in a greater dose or frequency than their prescription)
Currently using licit opioids	In need of, or currently using legal opioids, for a therapeutic reason (e.g., for chemotherapy or opioid substitution therapy) and presumably using the opioids as prescribed
In recovery from opioid use	Former users of any kind of opioid (licit or illicit) and they are presumably currently abstaining from all opioid use
Friends and family of people who use opioids	Anyone who has an interpersonal relationship with someone who uses licit or illicit opioids
Prevention	Services trying to stop problematic opioid use before it happens (e.g., education programs); can be delivered to people at risk, people in recovery, and friends and family, but not people currently using illicit or licit opioids
Treatment	Services trying to stop or reduce current opioid use or providing opioids as a treatment for a medical condition; can be delivered to people currently using opioids, but not people at risk, people in recovery or friends and family
Justice	Services supporting people who are dealing with law enforcement, courts or tribunals as a result of their opioid use or their risk factors for opioid use (e.g., living in poverty)
Harm reduction	Services trying to mitigate the negative physical, emotional, social and legal consequences of opioid use

Appendix C – Data Collection Tools

Participatory Mapping Session Procedure

1. **Verbal Consent:** the researchers provide attendees with the letter of information and reads it aloud to the group; attendees are offered the opportunity to ask questions and are asked to describe what they believe participation entails; the researchers then ask each attendee if they agree to participate in the mapping session.
2. **Introductions:** everyone introduces themselves with their name, organization and role.
3. **Overview:** the moderator describes the session objectives and the four collaboration strategies (i.e., networking, coordinating, cooperating and collaborating).
4. **Describing:** on the template below, participants individually describe how they communicate and work with each of the remaining organizations and share back with the group.
5. **Brainstorming:** the group thinks of examples of organizations working together on opioid-related programs and services.
6. **Labelling:** each example is labelled with one of the four collaboration strategies.
7. **Mapping:** using the examples and descriptions, the participants draw the relationships between organizations on a large paper map.
8. **Reflecting:** the group discusses the map and what they think it means for opioid-related service delivery in Oxford County.
9. **Debriefing:** the moderator reviews what was accomplished during the session and the next steps for the map data.

Relationship Template

My organization: ____

In the table below, describe how you communicate and work with each of the organizations with respect to **programs and services that serve people who use opioids, people who are at risk of using opioids and loved ones of people who use opioids.** Your responses should reflect your personal opinions and experiences, not the official position of your organization.

Organization	Description of Working Relationship
Organization #1	
Organization #2	
Organization #3	
Organization #4	
Organization #5	
Organization #6	
Organization #7	
Organization #8	
Organization #9	
Organization #10	
Organization #11	
Organization #12	
Organization #13	
Organization #14	
Organization #15	

Interview Guide

Thanks for meeting with me today. Before we get started, I want to review the letter of information and consent form with you. [*Interviewer reads letter of information and completes consent form, if appropriate.*] Are you ready to get started with the interview? [*Start recording.*]

- Tell me about your experience using or trying to use opioid-related services in Oxford County.
    - What are some positive experiences you've had with services here? Negative ones?
    - What makes it easier to use services here? What makes it harder to use services here?
- Tell me about how you find out what opioid-related services are available to you.
    - How do you know that the information is correct?
    - What do you do if you can't find the information you're looking for?
- What do you think about the availability of opioid-related services here in Oxford County?
    - Tell me about when services are offered. How convenient are the times and days you can use the services?
    - How long does it take to get into a service or program?
    - Where are the services located? How easy is it to get to the locations?
- Tell me about what it takes for you to be able to use an opioid-related service. What does it cost?
    - What about costs that aren't about money? What about your time?
    - What would be some acceptable costs for getting to and using services?
- Sometimes there are lots of opioid-related services that we can use, but we don't want to use them. What would make you not want to use a service?
    - Tell me about a time when you haven't wanted to use a service or didn't want to go back to one. What was it that made you not want to go?
    - Tell me about a time you really liked a service – one you liked to go to. What was it about that service that you really liked?
- What do you think is the most important thing we should know about opioid-related services in Oxford County?

- If you could change one thing about services here to make them better, what would that one thing be? Why?
- What is one thing about services here you would like to keep? Why?

Focus Group Guide

Hello everyone and thank you all for coming today. My name is [insert moderator's name] and with me is [insert note taker's name]. Together, we will be moderating this focus group. We will guide you through the process of a focus group by asking questions. You will also find us taking notes about what was said during the discussion. We will try to keep you on topic and we will monitor the time. We expect today will take about 90 minutes.

Focus groups are meant to generate discussion and debate and it is important to understand that there are no wrong answers to any of the questions that might arise. Please speak your mind, even if your opinion or experience differs from others in the group. Diversity of opinions and experiences is very useful in focus groups. We ask that you be respectful of others and that only one person speak at a time because we are audiotaping today's session. If more than one person speaks at the same time, it may be difficult for us to transcribe the recording later. Although we will refer to each other by name today, we will remove all identifying information – such as names – when we transcribe the recording.

Please help yourself to the snacks and drinks we have laid out and feel free to get up and move around the room. Before we begin, I will review the letter of information and consent form with you. [*Moderator reviews the letter of information and consent form and answers questions. Note taker retrieves the signed consent forms.*]

Let's get started.

As you know, we are trying to understand the barriers and facilitators to coordinated opioid-related service delivery in Oxford County. We want to hear about your experiences – both positive and negative – planning and delivering programs and services that target people who use opioids, people at risk of using opioids and loved ones of people who use opioids. I'm going to call these "opioid-related services" because you may be providing services that do not deal directly with opioid use, but support those people I just listed in other ways – like finding housing. I'll walk you through some broad questions and may ask more specific questions to get more details about your experiences, opinions and feelings.

Opening Question

- Briefly tell us about your role at your organization in planning or delivering opioid-related services in Oxford County.

Introductory Question

- What are some important characteristics of good collaboration?
    - Why did you choose that characteristic?
    - Is that characteristic found in all examples of good collaborations?

Transition Question

- Think back to a time when you were trying to work with another organization to provide coordinated or collaborative service. What was that like?
    - What were some positive experiences or outcomes?
    - What were some negative experiences or outcomes?

Key Questions

- Opioid-related services are delivered across several sectors. Tell us about the challenges and successes you've faced working with people and organizations from a sector different than yours to deliver opioid-related services.
    - What made that experience a challenge/success? Think about something that would make that experience completely different if you changed it.
    - How did you overcome challenges or obstacles when working together?
- What individual-level factors – like skills, knowledge and attitudes – have contributed to the successes or challenges you experienced when trying to provide coordinated opioid-related services?
    - How do those factors differ between the people delivering the service, the people planning the service and the people receiving the service?

    - How do those factors change to be more positive influences?
    - What needs to be in place for individuals to successfully deliver coordinated opioid-related services?
- What organizational-level factors – like funding, internal policies and leadership – have contributed to the successes or challenges you experienced when trying to provide coordinated opioid-related services?
    - How do those factors change to be more positive influences?
    - What needs to be in place for organizations to successfully deliver coordinated opioid-related services?
- What system-level factors have contributed to the successes or challenges you experienced when trying to provide coordinated opioid-related services?
    - How do those factors change to be more positive influences?
    - What needs to be in place for systems to successfully deliver coordinated opioid-related services?
- Looking at the network maps that we created in the mapping sessions, what differences do you see between the one created by you and the other group?
    - Why do you think those differences exist?
    - What do those differences tell us?
    - What are the pros and cons to each network structure?

Ending Question

Of all the things we talked about today, what do you think is the most important part of the experience of delivering coordinated opioid-related services?

Narrative Template – Accessing Services

Tell Us Your Story About Accessing Opioid-Related Services in Oxford County

Oxford County Public Health is doing research about what makes it easy and what makes it hard for people who use or take opioids, friends and family of people who use or take opioids and people who may use opioids in the future to find and use services. Opioids can be legal or illegal drugs like fentanyl, heroin, methadone, codeine and hydromorph. If you have a story you want to share, please tell us in the boxes below or send us a recording of your voice.

You can choose to participate or not. Your choice won't affect the services you receive from Oxford County Public Health. We aren't asking for your name or any other information about you and we won't know who sent in stories.

Sharing your story might make you feel uncomfortable. You don't have to share any information you don't want to. If you need help or want to talk to someone about how you feel, you can call **Reach Out at 519-433-2023 or 1-866-933-2023**.

We will use the stories to help us understand what it's like to find and use services in Oxford County. We may use parts of your story, including direct quotations, in our report about the results, but we will remove any information that could identify people. By sending us your story, you agree that we can use it for our study. Once you have submitted your story we can't return it because we don't know who sent in the stories. We will post the report on our website.

You can send us your story by email to **healthevidence@oxfordcounty.ca**, bring a paper copy to Public Health (410 Buller St., Woodstock) or put your paper copy in the submission boxes at public libraries and select services. To make sure your stories are private, please do not include people's names, including your own.

If you have any questions about the study, please contact Laura Gibbs, Public Health Planner – Foundational Standards at 519-539-9800 x3516 or lgibbs@oxfordcounty.ca. If you have questions about ethical issues related to the study, please contact Tim Westberg, Research Ethics Coordinator, ethics@oahpp.ca.

Instructions:

Please tell us about a specific time you **used or tried to use a service that helps people who use or may use opioids or their loved ones**. If you're not sure what to write about, here are some ideas:

- What did you like about that experience? What didn't you like about it?
- How did you feel? Were they good feelings or bad feelings?
- How long did it take to use the service? Did you have to wait to get in or travel to it?
- Who could you talk to about your experience? How did other people support you or make it hard for you to use the service?
- Where did you have to go for the service? How did you feel in that place?
- If you could change your experience, how would you change it?

Use the next few pages to write your story or record your voice reading the story. You can write as much or as little as you want.

When you're ready, here are the ways you can send us your story:

- Put it in the submission box next to where you got the template
- Email healthevidence@oxfordcounty.ca
- Bring it to Oxford County Public Health at 410 Buller St., Woodstock
- Send a recording of your voice reading the story to healthevidence@oxfordcounty.ca

Write your story here:

Narrative Template – Delivering Services

Tell Us Your Story About Delivering Opioid-Related Services in Oxford County

Oxford County Public Health wants to learn about what makes it easy and what makes it hard to provide coordinated services for people who use or take opioids, friends and family of people who use or take opioids and people who may use opioids in the future to find and use services. Opioids can be legal or illegal drugs like fentanyl, heroin, methadone, codeine and hydromorph. If you have a story you want to share, please tell us in the boxes below or send us a recording of your voice.

You can choose to participate or not. Your choice won't affect the services you receive from Oxford County Public Health. We aren't asking for your name or any other information about you and we won't know who sent in stories.

Sharing your story might make you feel uncomfortable. You don't have to share any information you don't want to. If you need help or want to talk to someone about how you feel, you can call **Reach Out at 519-433-2023 or 1-866-933-2023**.

We will use the stories to help us understand what it's like to find and use services in Oxford County. We may use parts of your story, including direct quotations, in our report about the results, but we will remove any information that could identify people. By sending us your story, you agree that we can use it for our study. Once you have submitted your story we can't return it because we don't know who sent in the stories. We will post the report on our website.

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Instructions:

Please tell us about a time when you were part of **delivering a service that helps people who use or may use opioids or their loved ones**. We are particularly interested in learning about how organizations work together to deliver these services. If you're not sure what to write about, here are some ideas:

- What did you like about that experience? What didn't you like about it?
- How effective was the service delivery? What went well and not so well?
- How quickly did the client receive the service? How long did the service relationship last?
- Who did you work with to deliver the service? What were those relationships like?
- Where was the service delivered? What were the qualities of the space?
- If you could change your experience, how would you change it?

Use the next few pages to write your story or record your voice reading the story. You can write as much or as little as you want.

When you're ready, here are the ways you can send us your story:

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Send a recording of your voice reading the story to healthevidence@oxfordcounty.ca

Write your story here:

Southwestern Public Health
www.swpublichealth.ca

St. Thomas Site
1230 Talbot Street
St. Thomas, ON N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON N4S 4N2