SUPPLEMENT 1: Participant narratives

Narratives have been de-identified including removal of the participant number for confidentiality. Further to this, the narratives are presented in a random order to prevent them from being matched to the participant information provided in other sections of the manuscript.

XXX holds several roles in their workplace, they spend their time equally divided between the hospital pharmacy, the intensive care unit, and an addictions unit. This position summary will focus on their role in the inpatient setting on the addiction unit.

On the addictions unit where XXX works, patients present with diverse substance use patterns and may also have concurrent mental health issues. Patients are referred by physicians in the emergency department or can receive a referral from an outpatient clinic. Patients can be admitted specifically for substance use-related concerns such as opioid overdose or alcohol withdrawal, alternatively, patients may be hospitalized for medical issues unrelated to substance use but struggle with substance use concerns, warranting referral to the addiction unit for specialized care.

The patient population on this unit typically includes individuals who are challenging to manage or monitor within the community setting, necessitating inpatient care to address their needs effectively. Unlike abstinence-based approaches, the treatment philosophy on this unit accommodates patients who continue to use substances, recognizing the complexity of addiction and the diverse needs of individuals seeking treatment.

XXX's workday typically begins with morning rounds, where they engage in discussions with the multidisciplinary team to review overnight events and patient progress. During these rounds, the team collaborates to plan and adjust treatment strategies based on individual patient needs and any developments that may have occurred. Sometimes, there may be outreach social workers who specialize in working with unhoused individuals who will sit in on rounds to provide further context for some of the issues the patients may be struggling with.

Following rounds, XXX will conduct medication reconciliation for any new patients on the unit. They then prepare for an intake assessment for new patients. During these assessments, they ask patients about their medication and substance use history. Their questions on substance use history vary based on the primary substance of use, for instance, patients with opioid or benzodiazepine use may undergo a more extensive assessment due to the potential complexities associated with these substances.

Following the intake assessment, XXX may provide recommendations to the physicians on the team. It is important to note that the physicians they collaborate with may not necessarily specialize in addiction medicine.

> *"We work with a family physician. So [we provide recommendations on] the things that they are less, I would say, they are less comfy. Like if you have a patient in delirium tremens, they are really, really, really, really happy to have a pharmacist with them because it's kind of scary to manage by themselves."*

Following the intake process for new patients, XXX engages in follow-up activities with other patients under their care. This may involve assessing treatment progress, addressing any concerns or issues that arise, and providing ongoing support as needed. Additionally, they meet

with physicians to discuss treatment plans, potential medication adjustments, or any other relevant clinical matters.
Although collaborative prescribing is not practiced on their unit, XXX has the authority to prescribe medications for minor ailments and provides comprehensive recommendations for medications they cannot prescribe themselves.

> *"For [the] addiction[s] unit, we usually do suggestions to the doctor, and we don't prescribe by ourselves except for like things that any pharmacist can prescribe."*

XXX's role does not involve the administration of injectable medications.
Regarding discharge planning, they collaborate with social workers to ensure that patients have adequate coverage for all prescribed medications upon discharge. This ensures continuity of care for their patients.

While XXX has the capability to engage in research activities, they often find that clinical service takes precedence and may not always have the time to dedicate to research or projects. However, they have contributed to the development of policies and procedures during the establishment of the ward, collaborating with doctors from across the province.

Additionally, XXX supervises pharmacy residents in their workplace, providing mentorship and guidance to aspiring pharmacists as they develop their skills and knowledge in a clinical setting.

XXX works in a community hospital, where they provide medication recommendations to physicians to support their patients who use substances. In their role, they spend 65% of their time in clinical work and 35% on administrative or professional projects. Although XXX could be expected to attend to pediatric cases, they have not encountered such instances in their practice and have only worked with adults. XXX provides support to physicians by offering recommendations on addiction management for any patient in the hospital. This includes those accessing the emergency room and those who are not admitted. Occasionally they provide guidance for patients struggling with stimulant use, but their primary area of expertise is opioid use and OAT:

> "*Either continuation [of OAT], new OAT, discharge prescription or just management of opioid withdrawal.*".

In XXX's workplace, there exists a virtual addictions medicine consultation service. This service comprises an addictions medicine physician who connects virtually (through phone or web conferencing) with people with substance use disorders. The virtual addictions medicine physician offers consultation to inpatients with opioid use disorder. Consequently, XXX bridges the service gaps by offering consultation for patients with substance use disorders admitted to the hospital or seen through the emergency room. They have the authority to refer complex cases to the virtual addictions medicine physician or provide recommendations independently.

> *"It's probably almost 50/50 about ones I refer on to [the virtual consult team] and ones that I just manage on my own…I see things like somebody's come in, they're on methadone, they've missed a dose and everybody's like, 'Can we give the next dose?' And so, I can help advise, and I don't need to bring the virtual health doc in on that."*

Physicians and pharmacists reach out to XXX via calls or texts to discuss their patients, as there is no formal referral system for their services. Upon receiving a referral for consultation, XXX sees the patient on an unscheduled, in-person basis. They then proceed to complete an intake, during which XXX typically conducts a comprehensive assessment encompassing various aspects of the patient's medical and social history. This includes obtaining a detailed medication and substance

use history, inquiring about their current substance use, the nature of their withdrawal symptoms, and any OAT options they may have explored. In instances where patients are receptive, XXX explores a broader spectrum of topics such as housing, residential treatment, and work. Subsequently, XXX formulates a treatment plan tailored to the patient's needs and communicates these recommendations to the patient's physicians. In instances where an order must be written, XXX may make verbal recommendations or write an order on a physician's behalf. *"Fortunately, because I've been here long enough, most of the physicians are very comfortable with me writing orders for them. I still have to do it under the MRP, 'cause I'm a pharmacist, not a physician. Essentially, I'm telling [the physician] what to do. I'm consulting and saying, 'This is what I want to do, do you agree?' And they say 'Yes'. And then most of the time they say, 'take care of it and continue that while they're here'. And so, you know, I have to get the initial orders under the MRP. And then the titrations most of the time I'm just doing that for [the MRP]."* XXX follows their patients during their entire admission, *"I follow the person from entrance to exit. I'm probably the only person that's with them the whole journey of their hospital [stay]. No matter what ward they're on, I'm following them through."* Because of this they will often assist with discharge planning. XXX can support referrals to the OAT clinic, making appointments for the patient, and ensuring the patient's community pharmacy has all prescriptions necessary. XXX is actively engaged in disseminating knowledge across their health region or authority through presentations, primarily focusing on Sublocade education. In addition to their educational role, XXX also serves as a supervisor for undergraduate pharmacy students. In their role, XXX has contributed to the development of policies not only within their hospital but also for outpatient clinics. They are actively involved in shaping policies, guidelines, and procedures related to substance use within their health region. Moreover, XXX has been engaged in policy development concerning fentanyl patches, and PPOs for OAT. Additionally, they have worked on the creation of a decision support tool and guidelines, which serve as resources for healthcare professionals involved in managing substance use disorders. Although not currently involved in research endeavors, XXX has previously undertaken a project examining the reasons for patients leaving against medical advice.
XXX serves as a pharmacist in a substance use stabilization unit, situated within a hospital. This unit caters to patients with complex cases, including those with mobility issues, comorbidities, and a high risk of complications during withdrawal. Patients admitted to this unit may use various substances, with alcohol and opioids being the most common. The majority of patients on this unit have a goal of abstinence or are seeking to reduce their substance use. A typical day for XXX begins with an independent review of patients and overnight events, followed by participation in multidisciplinary rounds where treatment plans are discussed and urgent issues are addressed. During rounds, patients who would benefit from a pharmacy consult are identified by the team. XXX's unit receives patient transfers from other hospital units and also admits patients directly via pre-planned intakes. During the usual intake process, XXX conducts medication reconciliation, ensuring accuracy and continuity of care. XXX will meet with patients in person when they have time throughout their day. Their discussions with patients focus on medication, though XXX is not responsible for comprehensive

substance use histories, as these are often already documented in the patient's chart. Patient education is a significant aspect of XXX's role. They engage with patients starting new therapies, providing information on expected outcomes, potential side effects, and warning signs to watch for. Additionally, XXX discusses other pharmaceutical treatments of interest to the patients, fostering informed decision-making and promoting patient-centered care. *"Whenever there's any medication, I always am involved in providing that counseling and making sure they're on board and aware of whatever we're doing."* XXX provides recommendations to physicians on dosing suggestions, schedules, and titration, however, they do not order medications unless they are non-prescription. *"I don't have prescribing authority of my own. I can put in verbal orders on our electronic health record system. Usually, if I'm going to make any adjustments, it's in discussion with my physician, and then I'll put in the order, but I don't independently make any adjustments without discussing with the team. Unless it's something like Tylenol that I'm adding on, or a laxative or something—stuff that's within my scope."* XXX does not do any dispensing or administration of medications. However, they play a large role in discharge planning: *"I'm really involved in [disposition] planning, just because as you can imagine, trying to coordinate pharmacies, and delivery, and all the different dosage forms of medications that they're getting can be quite a handful. So, I think I'm really involved in just making sure there's a smooth discharge plan."* XXX plays a pivotal role in staff education, including facilitating nursing orientation sessions. They also supervise pharmacy residents and fellows, guiding them in their professional development. Approximately 25-30% of XXX's time is devoted to research and quality improvement efforts. They contribute to various research projects and conduct chart reviews to identify areas for improvement. As part of a QI initiative, XXX has been involved in creating patient education materials. Moreover, their unit is undergoing program expansion, and XXX has been closely involved in logistical planning to support this change.
XXX fulfills multiple roles and responsibilities, serving in different capacities within their professional sphere. Their primary workplace is an outpatient clinic catering to adults struggling with substance use disorders alongside concurrent medical conditions. Additionally, they play a secondary role as a provider of recommendations within a multidisciplinary addictions medicine consultation team. In their role on the addictions medicine consult team, they provide recommendations for patients over 16 years of age who may be in the emergency department, on inpatient units, or at external RAAM clinics across their city. In the outpatient setting, XXX is often called upon by physicians to provide consultation on specific cases. Typically, by the time XXX receives the request, the patient has already left the clinic. In response, XXX initiates a follow-up by calling the patient directly or by booking a follow-up appointment. During this interaction, they may engage in gathering substance use and medication histories, educating patients on medication options, discussing treatment objectives or any side effects the patient may be experiencing. The follow-up interactions vary in duration based on the nature of XXX's involvement. If XXX is simply offering a medication recommendation to the physician, the follow-up can be brief. However, if they are providing additional information regarding treatment planning, it may necessitate ongoing monitoring.

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XXX spends approximately one day per week collaborating with addictions medicine consult teams, as these teams do not have a full-time pharmacist on staff. XXX's primary focus is on providing recommendations for patients on inpatient units. These recommendations are made on an as-needed basis, and XXX does not provide longitudinal follow-up for patients. *"I don't see clients where pharmacotherapy is not indicated or where it's a first-line anti-craving medication that they're starting—they don't need my input. When there's more complicating factors—whether it's drug interactions, we're switching OAT [opioid agonist therapy] or there's comorbidities that we need to address and be mindful of pharmacotherapy—then I'll be involved. I am pulled in as a consulting pharmacist when needed."* XXX's daily routine is varied, shaped by their multifaceted roles. While there isn't a rigid schedule, their typical day revolves around various activities such as follow-ups, consultations with physicians, and offering recommendations to consult teams as required. They also occasionally lend their expertise to RAAM clinics in the city, particularly for complex cases. Twice a week, XXX participates in multidisciplinary rounds with their outpatient clinic team, providing comprehensive care and insights for their patients. XXX does not administer or dispense any medication in any of their roles. XXX has two different agreements for ordering medication, for the outpatient clinic the practice is more collaborative, XXX indicates that: *"I am not allowed to prescribe. However, I can order things in the computer or write the prescription and I'll ask the doctors to print it and sign it".* But for their consulting work, there is no collaborative prescribing involved, *"For the consult service, we don't put in [the] order. I'll either write it in a note or send an email like 'These are the exact orders that we want ordered' for example.".* XXX primarily focuses on clinical responsibilities but also contributes to policy development. While they have previously assisted in developing PPOs, this is not an ongoing responsibility. Additionally, XXX occasionally participates in teaching courses or reviewing curriculum for the PharmD program at their local post-secondary institution. They also supervise undergraduate pharmacy students. Due to the non-longitudinal nature of their work when providing inpatient recommendations, XXX is not directly involved in discharge planning. However, they remain mindful of potential coverage issues when recommending medications to the addictions medicine consulting team.
XXX works in an outpatient infectious diseases clinic, primarily serving patients diagnosed with HIV, with a subset of patients also dealing with concurrent substance use disorders. While the majority of patients are adults, there are a few teenage patients living with HIV who receive care at the clinic. Patients are referred to the clinic by various providers, including general practitioners, public health agencies, immigration services, or through self-referral based on their status. Despite being an outpatient clinic, XXX occasionally checks in with their patients if they are admitted to the hospital. This allows for coordination of care and ensures continuity of treatment for patients receiving inpatient services. In this clinic, different physicians serve different clientele, with some focusing on specific patient populations. Some of the clinic physicians are OAT prescribers who manage prescriptions related to OAT and substance use for those individuals attending the clinic.

"Say for like a Tuesday a different physician will run a clinic, say she's not an OAT prescriber…She will have a very different patient population. It's generally like older men in her population. So, then my day is more like primary care-focused and talking about cardiovascular risk and all of that kind of stuff.

The clinic schedules approximately 30 appointments with patients per day. XXX's day typically begins with a team huddle, during which the multidisciplinary team discusses the patient roster and determines who needs to see each patient. This is when XXX prioritizes patients who may benefit from a pharmacy consultation. Following the team discussion, new intakes are seen by a nurse and a social worker as needed, along with XXX on an as-needed basis. Each team member completes their own assessments during this process.

During XXX's assessment, they address both HIV medication management and OAT prescriptions, as well as providing guidance on substance use management.

"I'm wearing 2 hats at that time, making sure that their HIV stuff is good, which is a lot easier than it used to be, and then also helping initiate, titrate, problem-solve and manage their opioid agonist therapy. We manage a little bit of other substance use disorders, many of our patients have poly substance use, nicotine for a lot of people, alcohol for some, we do a little bit of prescribing of medication for alcohol use disorder. Many of our patients have co-occurring stimulant use, but we're not as much in the prescribing space for that."

During the intake appointment, which can often be lengthy, some patients may not be ready to discuss OAT or their substance use. In such cases, these topics are deferred for future discussions. However, for patients interested in OAT, XXX conducts a detailed substance use history, inquiring about specific substances and previous medication history.

As part of the intake process, the pharmacist, social worker, and nurse will present their findings to the physician. A treatment plan is then formed, based on discussion among the team and with the patient. XXX provides recommendations to the prescriber regarding medication issues or potential changes to optimize the patient's care.

During follow-up appointments, particularly for patients receiving OAT, XXX may conduct urine drug tests and order necessary lab work. They also support patients with education based on the treatment plan, ensuring that patients have a thorough understanding of their medications and overall care plan.

"If we decide to plan on going on some type of opioid agonist, then it's talking about what that looks like, things to monitor, what the titration will look like, side effects."

They may also support patients with other treatment planning or goals.

"It may be coordinating appointments with harm reduction or the OAT clinic and getting patient support there. Maybe [the patient is] interested in treatment and so then it's getting the social worker in to discuss what options they have and what that might look like for them."

In terms of ordering medications, XXX *"do[es] have collaborative prescribing within the clinic, but not for any prescription review or controlled substances. Those are all outside [of their scope]".* XXX generally prepares the initial prescriptions and the physician authorizes them. In their role, they do not administer or dispense any medications.

"I do a lot of work in prepping the OAT prescriptions…we'll discuss the plan with the physician and the patient, lots of times the 2 of us together will meet with the patient, and then I'll create the prescription coordinating with the unit clerk when we're next going to see them and things like that. And then the physician reviews the prescription and signs off and faxes it to the appropriate pharmacy."

Typically, patient appointments coincide with the end date of their OAT prescription. If a patient misses their appointment, XXX flags it to ensure there is a plan in place for continuity of care. While XXX does not have ongoing planned training sessions, they have provided education in correctional centers, particularly focusing on OAT services, including Sublocade, as well as broader topics related to opioid use. This education occurs on an ad hoc basis. While they do not always supervise pharmacy students, they have done so in the past, including undergraduate PharmD students and residents. Additionally, XXX provides teaching to all students who pass through the unit, including nurses and physicians.

In terms of administrative duties, XXX sits on resident committees involved in the creation of inpatient OAT order sets and committees related to emergency room order sets. While they do not regularly participate in or lead research projects, they are willing to contribute as needed.

XXX is part of a support team dedicated to individuals with HIV, Hepatitis C (HCV) or those at risk of contracting sexually transmitted blood-borne infections (STBBIs). Risk factors may be as a result of substance use. The client demographic primarily comprises adults facing complex challenges such as houselessness, polysubstance use, or mental health issues.
In their role, XXX dedicates approximately half of their time to direct client interactions and the other half to administrative tasks. Unlike working on a specific unit, they offer support to individuals both within the hospital setting and out in the community. Their patients are either currently undergoing treatment for HCV or HIV, receiving medication for the prevention of HIV, or preparing to commence treatment.

On a typical day, XXX begins by updating themselves on any patient files who may have been admitted to their hospital –

"We have a report that looks at the antiretroviral drugs so I can tell who's been ordered antiretrovirals and check with the pharmacist that's following them, make sure they're up to date on their blood work and their labs and drug interactions."

From there, XXX will meet with new patients to build rapport providing education on their treatment options. While XXX offers services to individuals undergoing treatment for HCV or HIV, their role extends beyond treatment provision and coordination. They facilitate connections with prescribers of OAT, collaborate with patients on goal setting, provide case management support, advocate for patients' needs, deliver educational interventions, and offer referrals to various resources.

"So [that] can be just letting [patients] know what treatments options they have. Check for drug interactions, help coordinate between their appointments, we do appointment reminders: we text people, we email people. We'll do outreach, outreach to their teams and pass messages through their teams or their community pharmacies."

XXX does not operate under a collaborative prescription agreement but does offer recommendations to physicians when working with individuals who may have HIV or HCV. Their medication recommendations typically target patients in inpatient settings who are considering

initiating OAT. Although XXX does not dispense medications, they will administer vaccines if the vaccine is available at their location. A significant aspect of XXX's role involves contributing to the development of order sets and exerting a substantial influence on the hospital's withdrawal prevention protocol. Additionally, they provide education to physicians on various aspects of OAT prescriptions, including methadone dose splitting, in-hospital withdrawal management, and prescription practices. Due to their diverse caseload, XXX meets with their patients on an opportunistic basis, predominantly conducting these encounters in person. To facilitate connections between patients and providers, XXX employs a variety of approaches: *“Sometimes it's [calling] a taxi or like calling [a provider] to see if they can squeeze them in right now because they're here right now and they're interested right now [in starting treatment].”* XXX provides a great deal of case management support to their clients, working alongside social workers to ensure social needs of their patients are met. Depending on their availability, they will attend rounds at different community health clinics that also serve their patients. These rounds are often about accessibility or social needs and not necessarily pharmaceutical treatment: *“Troubleshooting things about like, ‘Oh this person's banned from every pharmacy in town’ and I was like, ‘You know what? They're banned from the store that the pharmacy is in. And if you would talk to the pharmacist, I'm sure you could figure out a way to get their medication to the edge of the door.’”* XXX also takes on the role of supervising undergraduate pharmacy students on an occasional basis. This opportunity enables students to gain insights into the accessibility of prescriptions and learn about managing concurrent illnesses.
XXX works in an ambulatory care setting in an iOAT clinic, serving adults with severe opioid use disorder. The clinic operates 24 hours a day, 7 days a week, but XXX’s schedule spans from Monday through Friday during business hours. Physicians rotate through the clinic, and there’s a primary care clinic co-located within the iOAT centre. Formal referrals are required for admission to the clinic, most referrals are from the iOAT clinic physicians when they are working in hospital or community settings. The clinic primarily supports injectable OAT administration and generally avoids providing oral OAT on-site, instead encouraging patients to obtain their medications from community pharmacies. However, in instances where patients lack access to other healthcare resources and are unhoused or difficult to locate within the community, the clinic will provide oral OAT. Similarly, the clinic offers oral anti-infective agents, such as treatments for Hepatitis C and antibiotics, but prefers to refer patients to community resources whenever possible. Patients do not schedule appointments for their iOAT dosing; instead, there are three blocks of time during the day when individuals can receive their medication. Healthcare providers typically follow up with clients during these windows while they are accessing their medication. XXX indicates they are employed by a hospital but are working in an ambulatory care setting: *“I see all aspects of the system. I work with patients very directly, communicating with them and with other community pharmacies, but then also there is the hospital side where the medication [iOAT] comes from the hospital.”*

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XXX describes their role as 25% clinical care, 25% distribution, 20% projects and administration, 10% education and teaching, 10% evaluation and quality improvement, and 10% *"helping out".* XXX's duties vary quite widely within the scope of their job.

> *"When I describe [my role], it is from the very, very small: the coffee machine is right next to my office and if someone spills a coffee and the nurses are tied up, I'll clean up the coffee. But it goes all the way up to expert, high-level provincial guidance. Everything from the very small to the very large."*

XXX's clinical care duties primarily entail providing patient care recommendations, treatment planning, and documentation, as well as facilitating communication with other care providers. During intake appointments, XXX focuses on conducting medication assessments for new patients, rather than providing orientation to the clinic. Given that patients often present with recent medication or substance use histories that may require updating, XXX also assesses patients' Hepatitis C history and eligibility for treatment during these sessions. Following the assessment, XXX provides recommendations to prescribers, often directly instructing them on what medications to prescribe, and may even write the prescriptions themselves based on these recommendations.

> *"Sometimes we have prescribers [at the clinic] who are not overly familiar with iOAT and not overly familiar with the patients in particular. For those prescribers, I will do a lot of 'Hey, please accept my recommendation because this is what's best for the patient' and they're generally very well willing."*

XXX can also receive and document verbal orders for iOAT.

> *"I would say the prescribers never actually physically write orders for iOAT. Generally, they're going to be provided to myself or a nurse through verbal orders."*

XXX possesses the authority and training necessary to be involved in medication dispensing and administration. However, they generally refrain from these tasks due to concerns regarding role overlap within the clinic setting.

> *"On a general level, I try to not touch the medications as much as possible and try and keep it more clinical. So generally, I will not be doing any of the direct witnessing, unless I need to help out the nurses…I won't be monitoring the injection room or anything like that. I don't do any of the actual medication actions like I don't do any of the dispensing or the administration or the monitoring. For the most part, that would be a nursing responsibility. But in the event that they need my help and we're struggling, I am allowed to do that."*

XXX is responsible for ordering iOAT medication for the clinic, as well as managing any shortages or other issues that may arise. It's worth noting that the iOAT clinic does not have a pharmacy on-site, so XXX's role involves coordinating with the hospital and the clinic's community pharmacy partner for medication procurement and management.

> *"There is no centrally responsible distribution person [in the iOAT clinic] and so a lot of that just lands on me. The drugs just sort of come in and so there needs to be a pharmacist here to help manage that."*

While they primarily work in the clinic, they occasionally provide support to the hospital dispensary. This support may involve verifying orders and assisting the hospital pharmacy when they are backed up. They also provide acute care clinical consultation upon request.

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XXX engages with pharmacy residents, providing them with opportunities for learning and growth within the clinic setting. However, they do not supervise pharmacy undergraduate students. XXX will also 'help out', which looks different depending on the day: *"Clients will come in, they may or may not be in distress. I help them, I can get them socks, a blanket, clothes, food. Our clients coming in can be very unregulated and they may make a mess and we may have a skeleton crew, so my role is kind of everywhere all over."* XXX's spends the majority of their time dedicated to projects and administration working on order set creation and sitting on committees. These committees vary from providing guidance at the provincial level to those related to clinic operations and policies. Additionally, XXX coordinates the clinic's waitlist and manages referrals to ensure efficient clinic access for patients. They also evaluate clinic performance by tracking metrics such as average dosing and daily visit numbers.
XXX holds two separate roles, working in two ambulatory care clinics. Their primary workplace is a chronic pain clinic that caters to adults with chronic pain concurrent with substance use or mental health concerns. This outpatient clinic operates on an appointment basis, and patients require a referral from a physician or nurse to access services. Most patients in this clinic struggle with opioid use, but may also have issues with alcohol, stimulants, cannabis, or Kratom. Additionally, XXX provides consultation and recommendations to a Rapid Access Addictions Medicine ambulatory care clinic. They dedicate one day a week to this clinic, which serves a larger population of individuals struggling with substance use. While opioids are a common concern, patients may present with various substance use issues. This clinic does not require a formal referral and accepts walk-in patients. In the RAAM clinic, XXX is called upon by the full-time team for a variety of reasons, *"Like, cost of medication, potential medication related side effects, trying to figure out what they've taken in the past if they can't remember the name of it, then we get pulled in."* These consults are infrequent, and XXX does not follow these patients on a long-term basis. As there are *"thousands"* of active patients with the RAAM clinic, it is not feasible or necessary for XXX to consult on each individual's case. XXX plays a much larger role with patients at the chronic pain clinic, XXX follows almost all patients, with exceptions for those on straightforward medication plans or not using opioids or benzodiazepines. Their role extends beyond pharmaceutical recommendations to encompass wrap-around patient care. *"So rather than kind of strictly like drug information questions, dosing, like it was very like consult based, which we still do a lot of, but now I kind of have a patient roster that I regularly follow up with and it's more like longitudinal rather than a consult kind of model."* Several times a week, the chronic pain clinic team conducts comprehensive in-person intake sessions with the full interdisciplinary team, including prescribers and other healthcare professionals. During these sessions, the pharmacist, along with other allied health professionals, see the patient, conduct assessments, and participate in debriefing discussions afterward. In XXX's intake assessment with patients, they typically review the patient's medication history and substance use history in detail. This involves conducting a comprehensive review of any

illicit substances used by the patient, ensuring a thorough understanding of their substance use patterns and potential interactions with prescribed medications. *"If they're on opioids it's granular, like 'What time do you take your first dose? How does that work? How many hours until this happens?'"* This in-depth assessment provides enough information to those who have diagnosing privileges to be able to establish whether the patient has a diagnosable substance use disorder. After the patient has met with other members of the team, they then see a prescriber for further evaluation and treatment planning. At the end of the day, the full team convenes for a debriefing session where they make recommendations and creates a treatment plan for the patient. XXX plays a role in designing treatment protocols and forwarding them to prescribers. Recommendations made during the debriefing sessions typically result in follow-up appointments scheduled for the next week. XXX will conduct these follow-up appointments over the phone and may involve providing patient education regarding medication changes or other aspects of their treatment plan. Additionally, the clinic offers an opioid rotation program, which allows patients to stabilize through microinduction on opioid replacement therapy. This program aims to support patients in achieving stability and managing their opioid use disorder effectively. *"We have this sort of day unit here, so it's still an ambulatory clinic, they don't stay overnight. But we can kind of more aggressively titrate their Suboxone, for example, or Kadian, monitor them while they're here and stabilize them a bit faster."* XXX is responsible for a large portion of the patient care and planning when it comes to these opioid rotations: *"So, pharmacists do the bulk of the work for any opioid rotations and new medication starts, things like that where we're doing a lot of follow-up and monitoring for that as well…In addition to making the initial recommendations as well…and then we kind of relay [that] to the prescriber. Like 'this is what we think the dose adjustment should be. This is how it's going.'."* XXX, despite playing a significant role in recommendations and treatment planning, does not engage in prescribing medications, with the exception of potentially prescribing NSAIDs, which is not a frequent occurrence. Additionally, they do not participate in any administration or dispensing tasks, as the clinic has an in-house pharmacy to handle prescription needs. XXX's focus remains on their expertise in assessment, consultation, and providing recommendations to support patient care within the clinic setting. Approximately 10% of XXX's role in the chronic pain clinic involves administrative duties, including providing guidance on the chronic pain program and offering education to interested staff members. They also deliver presentations to community providers and prescribers, often focusing on topics such as transitioning from hydromorphone to Suboxone. XXX has previous experience supervising undergraduate pharmacy students and conducting didactic teaching sessions for community prescribers. These activities contribute to their role in knowledge dissemination and professional development within the healthcare community.
XXX holds two roles – they work half time in a hospital in general medicine and half time in an adult residential addiction treatment facility. This description of their role only includes their position in the addiction treatment facility.

The treatment centre offers a 28-day residential treatment program. Patients pre-plan their admission, there is no planned withdrawal management on site, but there is one bed available. Patients are referred to the program by a physician or Nurse Practitioner (NP). Patients are admitted on Mondays and Tuesdays, they have 5-8 new admissions per week. Once admitted to the program, patients can self-refer to consult with a pharmacist, or a member of the care team can refer them for a pharmacy consult.

XXX's typical day at the addiction treatment facility begins by collaborating with the unit NP to conduct an intake assessment with the patient being admitted. This joint process ensures that participants are not required to answer the same questions multiple times.
During the intake assessment, the NP will ask for a medication history, XXX will flag any issues with medication adherence for follow-up. The NP then delves into the patient's substance use history. XXX actively listens during this process and asks any relevant questions that arise. As the intake assessment is brief, XXX may need to follow up with the patient at a later date to gather additional information or address any concerns identified during the initial assessment.

> *"If need be, I will follow up with that client afterwards, you know, and introduce, more detailed concepts of pharmacotherapy and do they know why they're taking this and things like that."*

Following the intake assessment, XXX consults with the NP regarding pharmacological treatment planning, particularly if the patient is requiring any tapering or dose adjustments. They collaborate to determine the appropriate treatment approach based on the patient's needs and circumstances.

Furthermore, XXX follows up with patients individually to discuss treatment options based on their diagnoses and the substances they struggle with. For example, for patients struggling with alcohol use disorder, they may provide education on anti-craving medications. The patient makes the final decision, after which XXX collaborates with the NP to write the prescription. This process may also involve adjusting dosages or changing the format of medications to better suit the patient's needs.

In terms of prescribing practices, XXX can provide extensions and prescribe for minor ailments, but does not engage in any medication dispensing or administration:

> *"I do a lot of extensions, let's say if someone is on a [benzodiazepine] and [the NP is] unavailable, then it come to me or anything really, but including a Benzo…If people have anything, you know, muscle problems, aches and pains, I can kind of assess those and prescribe. So, the minor elements are where I can prescribe. But I can also, you know, extend the prescription or give an interim supply, things like that."*

As XXX works with an NP and not a physician, there are limits on what they can prescribe as a team. XXX will often follow up with community prescribers to ensure continuity of care for patients admitted who are on OAT. XXX also provides consultations and follow-ups to patients, particularly for those who do not have prescription coverage. They assist these patients in applying for coverage and ensure they have access to the medications they need.
XXX allocates 2 hours per week to conduct group education sessions for patients at the addictions treatment facility. These sessions cover a range of topics, including but not limited to Hepatitis C, benzodiazepines, depression, anxiety, and the science of cannabis. Additionally, XXX provides education to new admissions, specifically discussing "Addiction and the Brain." This educational component aims to increase understanding among patients regarding the

neurobiological aspects of addiction and how it affects brain function and behavior. These educational initiatives play a crucial role in empowering patients with knowledge and fostering greater insight into their addiction and recovery journey.

> *"I have designed my groups to integrate concepts of our programming that are also being taught by my colleagues, so the clients can better understand and buy into all programming."*

XXX previously played a significant role in staff training; however, as the staff has gained experience over time, this training has transitioned to an as-needed basis. XXX continues to supervise post-graduate PharmD students, providing them with valuable learning opportunities within the addiction treatment facility.
Moreover, any changes to medication policies are routinely referred to XXX for their input. Their expertise in pharmacology and addiction treatment ensures that medication policies are informed by best practices and align with the facility's treatment goals and protocols.

XXX divides their time between two main areas within the hospital: the dispensary and an inpatient adult infectious diseases ward. The focus of the interview with XXX was on their role within the inpatient ward. This unit serves patients who are dealing with health issues linked to their substance use:

> *"Either for complications of HIV or for various, usually substance-related infections, like bloodstream infections, osteomyelitis, skin and soft tissue infections."*

A typical day for XXX commences with a review of the admissions to the unit, identifying patients who may benefit from a pharmacy consultation. They will then participate in multidisciplinary rounds with their team, discussing treatment plans and priorities for the day. Throughout the day, XXX engages in various activities including reviewing lab and test results, conducting patient follow-ups, providing education to patients, completing pharmaceutical workups, and offering recommendations as necessary. Additionally, they play a role in facilitating patient discharges. It's important to note that XXX typically does not directly prescribe medications.

> *"I'll sometimes independently initiate smoking cessation therapies like a nicotine patch. But for anything that has to do with prescription medications like things for alcohol use disorder or opiates, it would be more of a collaborative decision-making thing—making a recommendation to the physician and having them take ownership over it."*

XXX's expertise extends to providing recommendations across a wide range of infectious disease medication areas along with a notable focus on multimodal pain management strategies.

> "*Because often, for acute pain, the physicians will order the opioids, but they might not think to schedule anything else for pain or to explore the pain a little bit more deeply. So, I think that's a piece that I think about a little bit more than them."*

Within XXX's workplace, an addictions medicine consulting service is available to offer support to patients who use substances, provided they consent to their involvement. Given the primary focus of XXX's workplace on infectious diseases, they frequently turn to this consulting service for assistance with initiating opioid agonist treatment (OAT) and managing alcohol use disorder among their patients.

XXX's involvement in medication administration is limited, as they do not administer any medications to patients on the unit. Their dispensing responsibilities are confined to their other role. However, they do engage with patients in person when there is a need for education on overdose prevention or general medication counseling.

A significant aspect of XXX's role revolves around patient monitoring, particularly for specific or rare side effects from medications. They play an important role in discharge planning, ensuring adequate medication coverage for prescriptions issued during the inpatient stay. In some instances, XXX consults with the addictions medicine team to ensure comprehensive coverage for medications.

While XXX primarily focuses on clinical service delivery, they also undertake the responsibility of supervising undergraduate pharmacy students intermittently.

XXX serves as a clinical pharmacy specialist within an addictions medicine consulting team at an adult hospital. This team receives automatic referrals for patients who disclose struggles with substance use or are currently receiving OAT. These patients may be admitted to any unit within the hospital and may not necessarily present with primary concerns related to substance use.

> *"Any service outside of [the consulting team] would not prescribe methadone, or Suboxone, or Kadian without [the consulting team] being involved, so we're always involved in those cases. And then, if the patient is in withdrawal—like alcohol or other substances—we will also be involved. I would say any substance use history or situation that requires reassessment, [the consulting team] will usually be consulted to come and assess the patient."*

In XXX's hospital, regardless of the unit physician's comfort in prescribing OAT or medications for withdrawal management, referrals to the consulting team are standard procedure. XXX will not see every patient referred to the consulting team, and depend on verbal indications from colleagues, including team members and pharmacists from other units, to identify patients who would benefit from a pharmacy consult. Additionally, they use a screening tool to determine when a patient should receive a pharmacist consult, particularly if the patient is on Sublocade, a fentanyl patch, or receiving iOAT.

XXX typically sees their patients in person on an unscheduled basis. The reasons for seeing a patient vary:

> *"I will also often see patients to help out with medication titrations—if they're going through a methadone titration or Suboxone microinduction, there's a bit of a gap in care in our hospital. Patients who are experiencing pain—acute or chronic pain. And so, [the consulting team], we often help out with pain management if they also have a concurrent opioid use disorder, and sometimes that takes a lot more time to dig into, so I'm often asked to help out with that."*

A typical day for XXX commences with an independent chart review to identify any patients who have been discharged overnight, ensuring follow-up on any prescriptions that need to be faxed to community pharmacies. Subsequently, XXX engages in multidisciplinary rounds with their team, where treatment planning and urgent cases or concerns are discussed. Following rounds, they meet with their patients, providing patient education or medication counseling. While full intakes are typically conducted by unit staff or consulting addictions medicine physicians, XXX may perform a more comprehensive assessment in cases where patients have chronic pain concurrent with opioid use.

XXX does not dispense or administer any medication. Regarding recommendations or medication ordering, they do not have independent prescribing authority or official collaborative prescribing:

"I often get asked for my input on dosing or what medications patients could be switched onto—and all things. But in terms of how the order actually goes in, sometimes after I see a patient, I would make my recommendation— I would speak to the physician verbally—I generally have a pretty good working relationship with all my physicians, and so often, I can put in the orders myself, but as a verbal order from the physicians on our system. Other times, the physicians would want to put it in themselves, and they are welcome to do that."

XXX will often support discharge planning by ensuring medication coverage and that patients' prescriptions are sent to accessible pharmacies.

"If the patient's being discharged and needing to figure out where they want their medications, or if they need a follow-up, I often try to help out with [that]. A lot of our patients don't have regular follow-ups, so myself and the liaison nurse, we often split the role—doing referrals, and helping patients get connected, and chatting with them about that."

XXX characterizes their work as primarily clinical, comprising approximately 70% of their responsibilities, with the remaining 30% dedicated to administrative tasks. However, they acknowledge that there are occasions when their workload leans heavily towards clinical duties, prioritizing patient care.

In addition to their clinical duties, XXX takes on supervisory roles for residents and fellows. They provide monthly teaching sessions to physician learners within their addictions medicine team, with a notable emphasis on Sublocade. Furthermore, XXX actively participates in program development and writing PPOs. They also contribute to quality improvement initiatives, including conducting surveys with patients to gather feedback and enhance the delivery of care.

XXX works as a pharmacist in a hospital on a short-term adult psychiatric inpatient unit. Their role is focused primarily on clinical service delivery over administrative tasks. Although the primary reason for admission for their patients is mental health concerns, XXX states that

"Roughly 50% of [the patients on the unit] also have concurrent substance use disorders."

As their unit is for short-term admissions only, there is quite a bit of patient turnover. To begin their day, XXX reviews new intakes from the night prior. Following an independent review of the bed list, they have rounds with their multidisciplinary team, discussing treatment planning and identifying any urgent issues for different members of the team to address. XXX decides which patients they believe could benefit from a pharmacist consult in addition to team members requesting their recommendations on specific patients. They meet with their patients in person on an as-needed basis.

XXX conducts intakes by reviewing the patient's electronic medical record and consulting the patient for any additional information required to develop a treatment plan. XXX will sometimes complete a detailed medication and substance use history using discharge summaries. At times, patients will already have substance use histories from other admissions, and XXX uses those as a reference but will ask the patient as needed and incorporate results from urine drug screens. Psychiatrists working alongside XXX will seek their guidance on anti-craving options and opioid agonist treatment (OAT) recommendations.

"Perhaps a patient who's not already on OAT, I would be involved with providing advice to the psychiatrist on what might be appropriate to start for them, what might be safe and appropriate given their other medications and disease states."

Supplement to: Wiebe A, Pecson R, Coupland M, Halpape K. Role of pharmacists in addiction medicine in Canada's publicly funded health care systems: a qualitative study. *Can J Hosp Pharm.* 2025;78(2):e3680. doi: 10.4212/cjhp.3680

XXX educates their patients on treatment possibilities, discussing the corresponding side effects and benefits of the different options.

XXX does not administer any medications to their patients, but ordering tests and certain medications are within the purview of XXX's role. However, they indicated that although they can independently order some medications, they always consult with their multidisciplinary team.

> *"In terms of ordering medications, we have certain scope in the hospital. If it falls under the medication reconciliation piece, we can order it independently and I think a few other things. But to be honest, I usually don't take advantage of ordering those medications without at least letting the primary most responsible physician that day know I'm doing it. Just to close the loop always."*

In XXX's workplace, there is an addictions medicine consult service that their team can choose to contact for any medication recommendations. Certain physicians will refer to this consultation service for medication recommendations, and other physicians feel comfortable using only XXX's guidance.

> *"I find our psychiatrists are good with continuing [Suboxone], good with dose titration, feel pretty comfortable with Kadian, feel pretty comfortable with methadone, but they get very nervous around initiation of Sublocade or Suboxone, and also transitions to Sublocade, so I feel like they quite frequently refer to the consult service for that."*

XXX feels comfortable providing recommendations for nearly all patients but notes that the addictions medicine consult service provides continuity of care as there are several psychiatrists rotating through their unit and caring for patients.

Working alongside a discharge coordinator allows for XXX to focus on their clinical duties, when a patient is discharged, they will often write a short note but do not coordinate any community care.

XXX operates within a specialized healthcare setting that combines primary care services with addiction management, with a focus on individuals with substance use disorders, particularly opioid misuse. The clinic is closely affiliated with an overdose prevention site, co-located within the same facility. Patients served by XXX are typically adults over the age of 18 who are experiencing challenges related to substance use. Eligibility criteria for services are a lack of a fixed address or residency within the clinic's neighborhood.

XXX's day typically commences with a team activity alongside their multidisciplinary colleagues before the clinic opens to patients. The nature of this activity varies and may involve case management, disengagement reviews, educational sessions, presentations, or research projects. Following their multidisciplinary meeting, the clinic doors open, and patients begin to filter in to see their providers. Often, patients will have appointments with specific physicians, but can also access the clinic as a walk-in client. Utilizing an electronic patient management system, the team can track patient check-ins and physician appointments in real-time. As patients begin their clinic visits, XXX and the interdisciplinary team convene to review each patient's case. Discussions center around determining which team member should attend to the patient during their visit, identifying necessary tests, reviewing current medications, and addressing any other pertinent issues.

> *"It will be a triage scenario where the team is assessing the situation in tandem and collaborating in the client's care."*

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doi: 10.4212/cjhp.3680

XXX is responsible for offering medication recommendations to both nurses and physicians as they attend to patients checked into the clinic. XXX may provide guidance on complicated cases or adjustments to medication dosages as needed.

> *"The dose of methadone maintenance therapy that the client is on might be insufficient to manage their withdrawals given a change in use…Or, based on my recommendation directly to the physician after seeing them in the community, we may look, 'Okay, let's increase them a bit to encourage them to feel better and then to see us', and just keep building relationships and continued engagement."*

Aside from recommendations, XXX will at times write orders and have physicians sign off on them. Often this occurs with opioid substitution therapies.

> *"Yeah, so if the [physician] would say, 'I've never prescribed diacetylmorphine before', and I'd go, 'This is the dosing, sign here', and they would go, 'Okay' The same thing with fentanyl patches too a lot of times."*

At XXX's clinic, medication dispensing is not currently offered. However, XXX is actively working towards integrating this service to enhance the delivery of care for patients. Previously, XXX applied fentanyl patches, but due to workload constraints, this practice was discontinued. Currently, there are no medications administered by XXX; instead, nurses handle injection procedures:

> *"Given the abundance of our nurses, in conversation it felt that it was more appropriate instead of me administering, to be more involved in the monitoring, dosing, and adjustment side of things."*

XXX occasionally engages in hospital follow-up activities to ensure continuity of care for patients who have recently been discharged. Given the clinic's clientele, many of whom lack access to cell phones or stable housing, XXX may conduct outreach efforts alongside a peer support worker to locate these individuals. This outreach typically occurs in situations where there are issues related to prescriptions, such as patients failing to pick up their medications, challenges with discharge planning from the hospital without subsequent follow-up care arranged, or cases where patients require additional support but are not actively seeking care at the clinic. During these outreach sessions, XXX can coordinate changes to prescriptions by contacting prescribers by phone.

> *"I may call [a prescriber] while I'm [doing outreach]—I just say like, 'I'm here with [patient], and they're on 50 of methadone, we all know based on the drug supply right now, that's probably not doing anything for their physical experience too much.'…But having me there, relaying information, and being able to have the doctor ask them one or two questions like, 'Yeah, no, we'll increase it'…We might need to escort the client, have a little chat, and walk down to one of the pharmacies depending which pharmacy they're using."*

XXX frequently collaborates with community pharmacies to facilitate medication coverage for patients. They play a significant role in assisting patients in navigating the accessibility of neighborhood pharmacies. This support may involve coordinating with pharmacies to ensure patients have access to their prescribed medications, addressing any coverage or insurance-related issues, and advocating for patients to receive the necessary support and resources to manage their health effectively.

XXX spends one day per week off-site to work on quality improvement and research projects. During this time, they engage in various initiatives aimed at enhancing the delivery of care within the clinic. XXX is actively involved in several working groups, where they contribute expertise and guidance to initiatives at their organization such as the fentanyl patch program. Their role involves providing logistical information to facilitate the implementation of services, particularly in ensuring the smooth provision of fentanyl patches to clients.

Additionally, XXX is involved in monitoring and follow-up activities related to iOAT clinics. In this capacity, they offer insights and recommendations regarding logistical considerations and opportunities for improvement within these programs, focusing on enhancing operational efficiency and service delivery.

Furthermore, XXX supervises an undergraduate pharmacy student who is exclusively engaged in research and quality improvement projects. This student's responsibilities do not involve direct patient care but instead focus on contributing to the advancement of research and quality improvement initiatives under XXX's guidance.