British Columbia
Methadone Maintenance Treatment Program
A Qualitative Systems Review

By Tessa Parkes, PhD

March 2010

Acknowledgements

This review examines BC's methadone maintenance treatment program from the perspective of a wide variety of stakeholders directly or indirectly involved in the program. It identifies factors related to access, retention, quality, effectiveness and inequalities and makes recommendations for improvement. It was made possible through the generous involvement of many people.

To the 309 people across British Columbia who supported this review by discussing the strengths, weaknesses, and potential for the BC Methadone Program: this report is a compilation of the experiences, insights and vision you shared while working to create the change you want to see – this is your report.

To the many others who have contributed in a myriad of ways: research assistants (Stephanie Gloyn, Deblekha Guin, Julie Ham, Maxine Crawford, Philippa Ambrose and Lon Wright), transcribers (Angelle Brown, Stephanie Gloyn, Amy McRae, Kelty Miles, Jay Williamson and Sarah Frizelle), advisers (Dr Amy Salmon, Bill Nelles, Dr Bijan Nassirimanesh, Jackie Robinson, Dr Benedikt Fischer, Dr John Anderson, Dr Dennis Wardman, Dr Eduardo Jovel, Dr Evan Adams, Michelle Degroot, Mary Guimont and Nichola Hall), colleagues and staff at the Centre for Addictions Research of BC (Professor Tim Stockwell, Rita Fromholt and Jen Theil), the University of Stirling (Professor William Lauder), and BC government ministries (Kenneth Tupper, Warren O'Briain and Diane Osoko) and my editor from the Centre for Addictions Research of BC (Dan Reist) – thank you.

Special thanks to the VANDU Women CARE Study Team and Steering Group for permission to use the VANDU Women CARE findings related to Methadone and to the Positive Women's Network for permission to use data from their focus group on MMT.

Cover photograph by Martin Stickland, used with permission.

This report is dedicated to Marilyn

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List of Acronyms and Abbreviations

ACOD	Advisory Committee on Opioid Dependency
ARV	antiretroviral treatment for HIV
CARBC	Centre for Addictions Research of BC
CHC	community health centre
CPBC	College of Pharmacists of British Columbia
CPSBC	College of Physicians and Surgeons of British Columbia
DTES	the Downtown Eastside in Vancouver
GP	general practitioner
MHSD	Ministry of Housing and Social Development
MMP	Methadone Maintenance Program (a program administered by CPSBC)
MMT	methadone maintenance treatment
MSP	Medical Services Plan
NIHB	Non-Insured Health Benefits
PTSD	Post Traumatic Stress Disorder
VANDU	The Vancouver Area Network of Drug Users

Introduction: Background and Contextual Literature

Aim of qualitative systems review

In January 2008, the Ministry of Healthy Living and Sport commissioned the Centre for Addictions Research of BC (CARBC) to do a systems review of methadone maintenance treatment (MMT)[1] in British Columbia.

The aims of this review were threefold:

1. To examine MMT systems and identify factors related to treatment access, retention, quality, effectiveness and inequalities in BC
2. To investigate the accountabilities related to MMT
3. To summarize findings and provide recommendations for improvement to the Ministry of Health Services and the Ministry of Healthy Living and Sport

Methodology of review

Qualitative, multi-phase, stakeholder approach

The review was qualitative in nature and specifically designed to elicit rich descriptions from a wide variety of stakeholders directly and indirectly involved with MMT in BC. The system of methadone-related services in BC, as in many other jurisdictions and countries, is complex and has reach into many other health, social, welfare and criminal justice systems. There is involvement of public, private, non-profit and "hybrid" providers and funders, and varying degrees of integration with services offered by the statutory health authorities through, for example, primary care or Mental Health and Addictions Services. The geographic variations within the province also provided a challenge to adequately assessing system reach, capacity, potential and problems. In order to best address this system complexity, a multi-phase, multi method design was chosen. A team of expert advisers helped to steer the research process. The main findings and recommendations of the review were presented to a range of stakeholder groups for feedback and comment.

Data collection activities

Data were collected from February 2008 to March 2009, mostly in the form of one-to-one or small group, face-to-face or phone interviews. However, larger group meetings and focus groups were also held with both professionals and MMT clients.[2] Ethical clearance for all data collection was given by the University of Victoria Human Research Ethics Committee (Protocol Number: 08-038).

The sampling of participants was achieved using a combination of *key informant identification*, for example, representatives of all government ministries involved with MMT, and *"snowballing,"* where stakeholders recommend other key informants that have different roles and perspectives. Effective sampling ensured that the variety of MMT models and professional roles, and also the geographic diversity across the province, were well addressed. The experiences of Aboriginal and First Nations peoples, both on and off reserve, were also a priority for the sampling approach. The inclusion of people taking methadone was obviously essential for the review, and sampling ensured that clients using services across the continuum of models, and in different geographic locations, were included. Family members and advocacy organizations were also represented. Finally, sampling included

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[1] MMT is used throughout this report to refer to any and all services and supports delivered as part of a program of methadone maintenance treatment and to the system that supports such delivery. MMT is to be distinguished from MMP (the Methadone Maintenance Program) which refers to a particular program administered by the College of Physicians and Surgeons of British Columbia to assist physicians in safely and effectively prescribing methadone for opioid dependency.

[2] The term 'MMT clients' will be used alongside 'people taking methadone,' 'people prescribed methadone' and 'MMT patients' to refer to people who access and use MMT services.

those involved in MMT from within other parts of the health, social and welfare systems of BC, such as acute care, criminal justice settings, municipalities, treatment for HIV and other public health initiatives. Representatives from research and education were also included to ensure broader analysis and applicability of the findings.

A total of 309 stakeholders had direct input into this review. Ninety-seven participants were MMT clients or self advocacy representatives. Thirty-two[3] participants were either Aboriginal or working in a service specifically geared to the needs of Aboriginal people. One hundred and thirty-six data collection events took place in total. The stakeholder groups represented are summarized in Table 1.

Table 1: Stakeholder Groups

Client Populations	Service Providers	Service Settings
Aboriginal and First Nations peoples	Counsellors	Corrections settings
Men on MMT	Nurses	HIV treatment/Public Health
Women on MMT	Pharmacists (dispensing)	Non-profit agencies
Family members	Physicians (prescribing)	Northern, rural and remote
Self advocacy groups	Physicians (non-prescribing)	Outreach services
System managers	Physicians (pain specialists)	Private sector
Health authorities	Social workers	Residential treatment programs
Provincial and federal government ministries	**Other**	DTES in Vancouver
Provincial Health Officer	Educators	Youth Services
Provincial Harm Reduction Committee	International experts	
Provincial Mental Health and Addictions Planning Council	Municipality representatives	
Regulatory and professional bodies	Researchers	

While 309 is a large number of participants for a qualitative stakeholder review, all qualitative studies are limited in terms of the ability to make generalizations about the entire population from a non-random sample of respondents (Denzin & Lincoln, 1998). Stakeholders that were involved had self-selected by virtue of responding to the investigator's request for their involvement. Many people who were contacted and invited to be involved in the review did not respond. This self-selection may have created a level of bias in the research data because those who responded may have had stronger views, either positive or negative, than those that did not accept the invitation.

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Chapter 1: Who Are the Clients?

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Providers in Vancouver and in the Downtown Eastside described most methadone clients as being on welfare. However, in some areas of BC such as Vancouver Island, Northern and Interior BC, providers reported that the majority of their methadone clients were stable and had been able to get jobs. One prescribing physician covering a small town and outlying rural communities reported that 80% of his clients were back in work. This represents a wide diversity of client experience, particularly in regard to the relationship between being on methadone, one's overall health status, and one's ability to find and keep paid work. Homelessness and poor housing was noted to be a significant problem in both rural as well as urban areas.

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The diversity of client life circumstances, and therefore the need for a broad range of services and supports to be delivered as part of MMT, was highlighted by participants and referenced in the literature (Plomp, Van Der Hek, & Ader, 1996). Targeting the appropriate resources to a particular person's needs was viewed as key if they were going to be able to reach their maximum potential and use methadone to help them achieve this potential. Many clients in the Downtown Eastside of Vancouver, for example, were viewed as needing accessible outreach, public health, addictions treatment and comprehensive primary care services.

MMT clients with mental and physical health problems

Physical injury and disability, diabetes, brain injury, neuro-cognitive disorders, and infectious diseases such as HIV and hepatitis C, were described as common for many methadone clients:

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Participants also estimated that a majority of methadone clients experienced concurrent mental health disorders such as depression, anxiety, personality disorders, post traumatic stress disorder, bipolar disorder and schizophrenia. This prevalence of co-occurring addiction and mental health problems provides challenges to health care providers. s13

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[10] Intersectional dimensions of people's lives refer to the ways that different aspects of people's identities (such as gender, race, etc.) shape their lives in complex, mutually-reinforcing ways (Hankivsky & Cormier, 2009).

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Toward recommendations

Many people in BC with opioid dependency have complex health and social needs involving physical and mental health issues, histories of violence, abuse, trauma and chronic pain, unemployment and homelessness. No single

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profile, however, fits all clients. Because of this diversity a wide range of service elements are needed within a flexible system of delivery.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations found at the end of this report.

- MMT needs to be integrated with other health and social systems of care and welfare in order to ensure a more comprehensive response to the complex needs of many clients
- A wide range of psychosocial supports are necessary to address the complex health and social needs of MMT clients (later chapters document the current lack of psychosocial supports)
- MMT services in BC need to be welcoming and accessible, and a range of "low threshold" services that successfully attract and retain marginalized people with complex health care needs is required (BC can learn from low threshold models of MMT developed in other jurisdictions around the world)
- The professionals providing MMT services to people with highly complex health and social problems need to be supported with access to specialized advice
- Responses to relapse and the use of other illegal drugs need to be therapeutic and non-punitive in order to maximize the effectiveness of the program

Chapter 2: Professional Roles and Models

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Professional roles

Role of physicians

Physicians are currently the only professional group who are able to prescribe methadone in Canada, and for this they require an exemption under the Controlled Drugs and Substances Act. The responsibility for licensing physicians and regulating prescribing practices in BC has rested with the College of Physicians and Surgeons of BC (CPSBC) since the 1990s (see Chapter 5). Physicians are responsible for initiating, stabilizing and maintaining clients on MMT, and tapering them off when the client is ready. Physicians carry out a range of tasks within this overall role, including physical examinations, bio-psycho-social assessments and medical histories, laboratory assessments, treatment planning, brief interventions and ongoing monitoring and review of client outcomes. Detailed guidelines covering the various aspects of physician involvement are set out in the *Methadone Maintenance Handbook* (CPSBC, 2009). This section is deliberately brief because many aspects of physician involvement are discussed throughout this report.

Role of pharmacies and pharmacists

The dispensing of methadone to clients in BC is most commonly done through a community pharmacist. s13

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Pharmacists were reported to play a key role in the BC Methadone Program in a number of other ways:

- Liaising with a client's physician, there is often a need for frequent contact
- Reviewing PharmaNet[16] profiles prior to dispensing or witnessing

[16] PharmaNet includes patient medication histories, drug information, drug-using interaction information and patient demographic information. When a claim is submitted on PharmaNet a complete patient medication history is accessed displaying to the pharmacist all the medications dispensed in the previous 14 months as well as any over the counter medications that have been recorded. All prescriptions in BC community pharmacies must be entered on PharmaNet.

- Reviewing and evaluating prescriptions to ensure there are no errors
- Informing physicians when prescriptions run out

The pharmacist may be the main support for clients in situations where their physician or health care provider sees them irregularly, or is unable to provide more extensive support.

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Role of Nursing

Nurses support MMT in a variety of ways. In rural areas, nurses (either registered nurses or licensed practical nurses) were deemed so essential to the delivery of MMT that "*physicians probably wouldn't do the program without them.*" In some MMT models, nurses do much of the administrative work connected with MMT, alongside Medical Office Assistants. Nurses may help physicians with physical examinations, substance use screening and counselling, chronic disease management, support and outreach. Nurse practitioners in Northern BC may support physicians and help care for "*orphan patients*" banned from family physicians. Many physicians spoke about the desire to have more nursing hours attached to their MMT programs, or to have nurse involvement where they had none. Nursing roles were also viewed as having the flexibility needed to help people with their varied needs such as income assistance, housing, counselling and parenting support.

Role of Counselling

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s13 Trained counsellors may play an important role in taking a client's social history, doing intake assessments, screening, crisis counselling, longer-term counselling, witnessing urine tests, liaison with other providers such as pharmacists, and arranging for clients to see the physician. s13

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There were widely differing views on the relevance of counselling for MMT clients. Indeed, the issue of whether counselling should be a client choice or a requirement to be on MMT was one of the most oft raised issues in discussions on counselling

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Social work, support workers and housing support

Social workers appear to be an extremely limited resource for MMT services in BC, but reported to be very much needed to help clients navigate housing problems, social assistance benefits, legal support and advice:

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Models of MMT in BC

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Family physician/general practitioner model

Family physicians or general practitioners (GPs) are a major service model for methadone provision across BC as in other parts of Canada (Fischer, Cape, Daniel & Gliksman, 2002) and the world (Matheson, Pitcairn, Bond, van Teijlingen & Ryan, 2003). Regular community primary care was seen by some participants as the ideal model for MMT because it allows for inclusion and integration of clients within mainstream services and offers MMT clients

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[17] Case Management Society UK (2008) defines case management as "A collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health, care, educational and employment needs, using communication and available resources to promote quality cost effective outcomes."

the benefits of comprehensive care. s13

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Some clients commented similarly that family physician models of care for MMT were ideal models because of the anonymity provided and the ability to be away from the "congregation" dynamic of many MMT clinics. However, methadone is not always particularly well integrated into family physician practice. In some areas, health authority managers described what they saw as a *"virtual disconnect"* between methadone services from physicians, and the wider addictions system of care.

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Integrated models of MMT

Within integrated models of MMT there are three further distinct categories of delivery: community health centres (CHCs), non-profit models and Mental Health and Addiction Services provided by the regional health authorities. These are described in turn.

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Community Health Centres

One of the main ways that methadone is provided in BC is through health authority funded CHCs. There are eight CHCs in Vancouver and these were established as part of a redesign of primary care to become multi-disciplinary and provide better access to health care services for members of the community who had many health challenges. CHCs have a comprehensive care approach and include health care provision from physicians, nurses, social workers, mental health and addictions counsellors and psychologists. Public health services such as immunizations are also available. In terms of MMT, some CHCs are able to offer case management services and some also have in-house pharmacies.

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Chapter 3: Private Methadone Clinics

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The definition of a private clinic in this review is a clinic that exclusively provides methadone treatment and which is run for profit by one or more owners, who may or may not be prescribing physicians. The major difference between this model and physicians prescribing methadone in their private office-based practices, is that the clinics provide only MMT, rather than an array of comprehensive and primary care services.[21] s13

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[21] While some physicians working in private clinics may attend to a person's other presenting complaints this was reported to be rare.

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Private clinic settings are attractive to MMT physicians for a number of reasons. Some viewed MMT as an important service, and had an interest in this work, but feared that clients would be disruptive in their own office settings, or that other patients would be put off attending their practice if they also served methadone clients. Some had partners in their practices that do not want methadone prescribing to be a part of what is delivered, thus preventing physicians with licenses and interest from being active office-based prescribers. Many physicians were prepared to prescribe in a separate clinic setting, with the accompanying systems and staff support (e.g., managers, administrative support and medical secretaries, counsellors and/or other support staff). Having this additional support in place alleviates many of the more demanding aspects of methadone provision for these physicians.

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What do private clinics provide and how?

All private methadone clinics provide methadone prescriptions from a physician. Most provide some access to counselling or other support services. Some clinics support clients to access primary care physicians by printing off weekly lists of local GPs with space in their practices. Some clinics make active referrals for clients to other health and support services. Clinics employ support staff, administrative staff and counsellors. s13

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Positive views on private clinics

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Many of those working in the private clinic system as staff or counsellors have experience of opioid dependency and this can create a feeling of trust and connection between clients and these particular counsellors that was described as invaluable on a person's recovery journey.

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Main criticisms of private methadone clinics in BC

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Methadone provided outside of comprehensive primary care

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Lack of clear minimum standards of care

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Psychosocial supports and counselling

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Lack of regulation and accountability

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Continuity of care concerns

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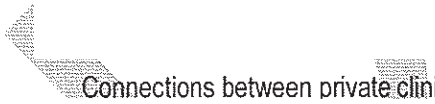

Connections between private clinics, pharmacies and support and recovery houses

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Toward recommendations

One of the main reported strengths of the private clinics is their ability to respond promptly to clients' immediate need for MMT, particularly in the context of high demand and low response from the public sector. However, the separation of MMT from other basic health care services is a problematic aspect of these clinics. Also the recurring concerns about quality and ethics within the private clinics needs particular attention. None of the review participants considered the private methadone clinics, as currently operating, an ideal model for MMT.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- Integration within, or connection to, comprehensive primary health care is essential to effective MMT
- Inclusion of sufficient high quality biopsychosocial supports are required for effective MMT
- Effective mechanisms for multi-disciplinary and organizational regulation and monitoring are needed to ensure stable delivery of an MMT program linked to multiple health and social service systems

Chapter 4: Fiscal Systems

"if policy is getting in the way of providing service for human beings, something needs to change."

The way that the Methadone Program receives funding in BC is complex.[25] The main funding streams are:

- Medical Services Plan (MSP) payments for the time physicians spend assessing, planning monitoring and reviewing client treatment and care
- MSP payments for the costs of Urine Drug Screens, for those eligible[26]
- PharmaCare payments for methadone prescriptions, for those eligible[27]
- PharmaCare contract with CPSBC to administer the BC Methadone Program
- Health authority budgets for MMT programs that provide services beyond those covered by MSP (e.g., counselling services)
- Health Canada, First Nations and Inuit Health, Non-Insured Health Benefits payments for the pharmacy prescription costs for First Nations people with Status
- Ministry of Housing and Social Development (MHSD) alcohol and drug treatment supplement can be used to subsidize user fees for Ministry clients
- User fees

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MSP payments for physician contact time

History and background

When the BC Methadone Program was up-scaled in the 1990s, elements of the existing universal health care system were used to allow for extended access to MMT as quickly and efficiently as possible. By not requiring the development of a whole new set of financial arrangements, the program was able to respond rapidly to a growing demand for access, at least in some high-density urban areas such as the Downtown Eastside of Vancouver, to

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[25] Limited financial information was available to the review. The material presented here has been gathered from the full range of participants and although reasonable steps have been taken to try to ensure accuracy it was not always possible to verify.

[26] See http://www.health.gov.bc.ca/msp/infoben/eligible.html for details on eligibility.

[27] PharmaCare is a program of the Ministry of Health Services that assists BC residents in paying for eligible prescription drugs and designated medical supplies. It seeks to ensure reasonable access to, and appropriate use of, prescription drugs and related health benefit services for eligible residents with reimbursement based on a family's net income. See https://pharmacare.moh.hnet.bc.ca/ for details on eligibility.

address the public health crises of HIV/AIDS, hepatitis C and drug overdose rates. The Ministry of Health expanded funding to cover physician costs through the existing MSP fee-for-service mechanism. This was viewed as the most efficient way to create incentives for physicians to become licensed to prescribe methadone. Using PharmaCare allowed expansion of funding for methadone to people on income assistance, and MMT development was supported by the availability of the PharmaNet system which helped to shape the program's evolution.

In retrospect, many participants felt that those early fiscal arrangements may now be distorting aspects of the program in a variety of ways. s13

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Physicians in the interior of BC have since expressed strong views about the new *"two visits per month"* rule to many different representative bodies, including the BC Medical Association's Tariff Committee, the General Practice Services Committee, MSP and CPSBC. According to these physicians the new billing requirement of bi-weekly visits is neither feasible nor reasonable for them, or their clients, for a number of reasons, including:

- The fact that many clients are stable on MMT and do not need to be seen every two weeks
- In rural areas there may only be one prescribing physician for a large geographic area so twice monthly visits are not feasible given the large caseloads some physicians are carrying
- The distance that many clients live away from their physicians and the limited travel options that people on MMT tend to have are likely to impact client access and retention
- The interference that twice monthly visits have on a person's ability to lead a full working and family life
- That the requirement is discriminatory because it treats MMT clients differently from other clients/patients with chronic or long term conditions (and their physicians)
- That the requirement does not have an evidence-base to support it and directly interferes with clinical decision making and individualized treatment planning[30]
- That this issue alone has become a barrier to increasing the numbers of physicians in the Interior Health region who are interested in becoming involved in MMT[31]

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Urine screen payment system

Urine drug screens are billed through MSP. The CPSBC guidelines suggest monthly urine screens but in practice their frequency tends to be based more on physician judgment. The samples generally go to private or hospital laboratories and the costs are billed to MSP. Urine drug screens were reported to cost between $50 and $70. There were strong views amongst some physicians that office-based point-of-care testing should be available to enable them to test urines themselves in their clinics rather than submit them to laboratories:

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Rural prescribers commented on the additional difficulty they faced in working with clients who lived a considerable distance from the prescribing office in relation to the absence of point-of-care testing. Testing a client and getting the result at the same time would mean being able to make decisions about carries while the client was in town, rather than finding out there was a problem with their urine after they have gone back home.

There was a split in views among physicians concerning the effectiveness and usefulness of urine drug screens in MMT. Some see their work as resting on the results of these screens, while others regard them as one of a number of useful tools to monitor a client's progress. A smaller but growing number of clinicians argue that they cost a lot of money but are: *"useless in terms of clinical relevance."*[32]

Views on the adequacy of physician payments

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The current fee system was described as not being viable for physicians with few patients on MMT, especially rural physicians with clients spread over a large geographic area. This is mainly because of the many associated tasks connected to MMT that need to be undertaken in addition to direct client contact time. Many participants felt that remuneration needed to compensate for the fact that many MMT clients had other complex health and social needs where fifteen minute appointments were not adequate:

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[32] Self-reported drug use has been shown to be highly correlated with positive urine screens (Dennis, et al., 2002; Fals-Stewart, et al., 2000; Hersh, et al., 1999).

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MMT work is billed the same way whether a physician is the sole prescriber for a local area or not. There is no remuneration for the extra work involved in being on call 24 hours a day, 7 days a week, 365 days a year – a requirement from CPSBC for all MMT prescribers. There was a strong view from physicians, and other stakeholders, that MMT physicians should be adequately compensated for MMT, whatever their caseload and circumstances.

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On the other hand, many non-physician and physician respondents working in the community health or non-profit sectors believed that MMT practice had become a *"profit making job"* and that the fee-for-service system had made MMT too lucrative:

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Ministry of Housing and Social Development fiscal arrangements

The Ministry of Housing and Social Development (MHSD) has a supplement for alcohol and drug treatment of up to $500 per 12 month period. This can be used to subsidize user fees related to MMT if the program provides counselling or other supports, in addition to the physician services paid for through MSP. s13

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Toward recommendations

Funding arrangements and policy have a significant influence on health systems and can influence the behaviour of health care providers. Care must be taken to ensure they are constructed to ensure the best possible outcomes for clients, efficient operation of the system and appropriate accountability for public funds.

The current funding arrangements and policy may have allowed the MMP to scale up quickly, but they have also left it exposed to some strong criticisms related to fragmentation, lack of transparency and accountability, failure to support best practice and marginalization within the health care system that contributes to the stigma experienced by clients. The public accusations of abuse, particularly the view that MMT is a *"cash cow,"* are bringing the program into disrepute.[36] The possibility that fiscal arrangements are having a negative impact on access, retention, quality, effectiveness, equality, client satisfaction and outcomes needs to be examined carefully.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- A comprehensive review, involving representatives of all stakeholder groups, of funding arrangements and policy is clearly needed to address problems and restore confidence in the system
- Changes to the funding arrangements following this review should seek to normalize MMT and other substance use treatment services within health care based on models used for addressing other chronic diseases/long term conditions
- Changes to the funding arrangements should also seek to maximize best practices by ensuring access to all aspects of a comprehensive and cohesive MMT program including psychosocial services and supports
- Changes to the funding arrangements should seek to ensure access to MMT services and supports in all regions of the province including rural and remote areas

[36] See story comments from public: *Pharmacy uses kickbacks and threat of eviction to keep methadone clients* (Tomilson, 2008) Available at http://www.cbc.ca/canada/bmitish-columbia/story/2008/09/09/bc-080909-peoples-pharmacy-evictions.html

Chapter 5: Accountability and Regulation

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Health Authorities

Problematic substance use services have constantly shifted between Ministries over the last half century in BC. Now that responsibility for problematic substance use and addictions is with health authorities and the Ministry of Health Services, Health Authorities Division, MMT is viewed by many as having *"a natural place within health authorities."* In fact, all health authorities have been integrating MMT into their services in different ways. Most stakeholders agreed that MMT should be provided as part of an integrated service, either through comprehensive primary care, through mental health and addiction services or public health services (i.e. linked in with needle exchanges).

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Toward recommendations

Some of the problems with MMT have been exposed by the press and other media. This, and the perceived lack of responsiveness from those in authority, has eroded confidence in the current administrative structures and led to a lack of faith in the MMP among almost all stakeholders. Current structures do not provide a cohesive base for administering a comprehensive, multi-disciplinary methadone program that is well integrated with other systems of health care. Fragmented responsibility has not allowed for good program planning and has resulted in a lack of regulation for many key components of the system (e.g. counselling services or recovery homes). This fragmentation has also contributed to the frustration of those wishing to lodge complaints and to the inability of those concerned to resolve those complaints. The program has lacked transparency, and there is no mechanism for involving clients, families or other stakeholders in program planning and oversight.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- A clear set of provincial policies to guide a comprehensive and integrated methadone program are essential in addressing many of the issues raised
- A central planning and administrative mechanism, with the mandate and capacity to provide leadership across all aspects of the comprehensive and integrated program, is needed
- A clear advisory mechanism that involves representation of all stakeholder groups, including clients, families, advocates and community-based organizations, is essential to addressing current concerns and maintaining transparency going forward
- The involvement of appropriate professional bodies, such as CPSBC and the CPBC, will continue to be important in defining and monitoring professional practice as well as providing ongoing training and overseeing licensing/accreditation as needed

Chapter 6: Strengths

"One of the ways that I look at recovery is that the person has now become open to the idea that maybe their life is worth living. The person begins to see themselves as sacred, or having potential as a human being in the world. Maybe I am a worthy human being. I'll act as if for now."

Client views of the positive impact of methadone on their lives

Clients described the many ways that methadone had positively affected their lives. People talked specifically about their gratitude that the MMP existed.

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There were many quotes from clients that described relational care and practices where people were treated as *"like a person."* Clients described relational care as balancing the potential risks with the potential gains, such as providing MMT in a way which was compatible with a person being able to hold down a job. Having experiences with service providers who cared about them was important and these often stood out in a client's memory. Clients appreciated physicians working with them in ways that communicated their worth as human beings. Doctors who spent time with people were also valued. Kindness, compassion and respect were highlighted again and again as vital components of good MMT care, as was open-minded and non-judgmental care. s13

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Toward recommendations

The BC Methadone Program was viewed by client and professional stakeholders alike as making a substantial contribution to reducing the harms related to illegal drug use and opening a door to a more stable and better quality of life for people with opioid dependency.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- Since the benefits of the program are very much associated with the people delivering the services, careful attention is needed to ensure appropriate support and training for service providers
- Clients are a key stakeholder group and listening to what they say they value about the program, and those that provide it, is essential in order to build a more effective, accessible and responsive system of care, support and treatment
- The program has achieved many important successes that need to be celebrated, examined and built upon as the program moves forward
- There are providers in the MMP who are already local and provincial "champions" for this type of treatment/therapy, because they believe in the potential of it to transform lives. These champions could be influential in better informing the public and other professionals about MMT in BC

Chapter 7: What Clients Do Not Like

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Methadone as a "full time job"

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Many clients viewed the daily trips to the pharmacist as a major burden on their lives and felt *"married to the drug store."* Some spoke about the challenges they had encountered finding pharmacies that dispense methadone in areas that they lived or wanted to travel to, and that this had inhibited their ability to travel or move. Others spoke of their frustration of not being able to cross the US border or travel because they were unable to get carries. Clients were often unable to access new opportunities for example, for work in northern BC, or work away from home for periods of time, due to their inability to get carries for more than a few days.[43] Methadone treatment becomes a binding structure in many aspects of a person's health care experience and life. s13

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Clients reported having lost jobs because they could not get carries or easy access to pharmacies, particularly in rural areas of BC. Participants emphasized that getting a job can be a substantial move towards stabilization and recovery for many people and should be prioritized.

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[43] The guideline in the CPSBC handbook now reads, "Most stable patients are established on a twice-weekly pick-up schedule. This is a reasonable balance between safety and patient inconvenience. Patients receiving carries must be seen regularly and have random urine samples screened for methadone metabolites and illicit drugs.... Exceptions may be granted at the discretion of the prescribing physician. Exceptions should only be initiated as a trial and be reviewed to ensure that the benefits outweigh the risks" (2009, p.21). Previously it stated, "It is recommended that carries not exceed 4 days or 400mg, whichever is less ..." (2005, p. 31).

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This tendency toward control and punishment was thought to be due to a lack of compassion and empathy for people who use drugs. Many felt that compassion and empathy, along with patience and affirming people, wherever they were in their commitment to change, were essential in a methadone prescribing physician. A punitive or restrictive approach to treatment has the potential to compound people's substance use and addiction when they are prevented from visiting supportive environments, family, and friends, or taking part in activities such as traveling and work to improve their quality of life and facilitate recovery.

Poor pain management

Poor pain management for people on methadone was another common complaint, despite many people having co-occurring addiction and chronic pain problems. Clients were convinced that physicians viewed them only as drug-seeking so would not properly assess, investigate or treat their pain. s13

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Stigma and discrimination

In describing things about the program that clients do not like, the experience of stigma and discrimination within the system was a common theme.

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"We have to go in and other people are walking around the pharmacy and you've got to drink this stuff. Other people can go down and get 100 morphine pills or other things and don't have to sit there and show everybody this is what we're doing."

"… they have a disdain, that these people are so low that they don't deserve thoughtful care."

"There are methadone clients that go into pharmacies and the pharmacist says to them, 'OK, I get that you are coming here for your methadone, but please don't shop for anything else in the store. I don't want people to see you as being a client here.'"

"That's the thing that I just don't like, is the controlling. Here I'm an adult. I should be able, it doesn't matter if they dispense it every day to me but it's the controlling that I don't like. You don't go to this pharmacy or else you'll be cut off. You don't do what I say you'll be cut off or we'll hold it. It's not right and it's killing people. It's hurting people and also raises the crime rate too because people go out there and do things to get it. That's what I don't understand."

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Stigma and discrimination was a theme returned to again and again by review participants and for this reason has a chapter devoted to it towards the end of the report.

Physical effects of methadone

The physical health impact of methadone was also a common theme in this review. s13

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One of the most passionate criticisms advanced by MMT clients was how difficult it was to come off methadone.

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Toward Recommendations

The benefits of optimized methadone treatment include increases in quality, safety and stability in people's lives. However, the negative experiences associated with being on methadone prevent many people from achieving these potential improvements. The voices of clients, and of their supporters, suggest that MMT in BC is sometimes

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experienced as dehumanizing and less than optimal. Systems, rules and practices need to be carefully designed to maximize the intended benefit while avoiding unintended consequences or structural violence.[47]

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- Clients have strong views about what does not work for them with regard to MMT and these views can and should helpfully inform the treatment system and services to enhance client satisfaction. This will likely positively impact willingness to access MMT, retention and treatment effectiveness
- Clients need to be fully informed and involved in the specifics of individualised treatment planning and review
- Client representatives need to be involved in treatment system planning and monitoring mechanisms

[47] Structural violence denotes a form of violence which corresponds with the systematic ways in which a given social structure or social institution kills people slowly by preventing them from meeting their basic needs. Institutionalized ethnocentrism, classism, racism, sexism, nationalism, heterosexism and ageism are just some examples of structural violence (Farmer, et al., 2006).

Chapter 8: Problematic Practices

> *"It's not that our program is horrible, it's just that there are some very obvious things that could be corrected. It just boggles my mind that we don't correct them."*

Many informants reported issues that they described as *"unethical," "abusive,"* or problematic in some way. This review cannot determine the validity of individual claims but the number of times such problems were cited suggests a real concern. Most, but not all, of the reports cited here relate to practices in the Downtown Eastside of Vancouver.

Pharmacies and problematic practices

Pharmacy practices were one of the most common areas of concern.

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Physicians and problematic practices

Participants reported that some methadone prescribing physicians have ownership of, or shares in, particular pharmacies, or have ownership of, or shares in, recovery houses where clients are being sent by these same physicians.

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Toward recommendations

Systemic problems related to the practice of some pharmacists and physicians has resulted in many clients and providers across the Lower Mainland reporting a loss of faith in the MMP. Clients felt a keen sense of unfairness, of being taken advantage of. The people on methadone in the Downtown Eastside that attended the focus groups and interviews believed that the services they received as *"addicts"* or people with substance use problems, were being held to a *"lesser standard of care"* than health services targeted at other groups of patients or clients.

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- Clear practice guidelines need to be defined for all professionals involved in MMT, and these need to be widely available to clients and the public as well as providers
- Clear conflict of interest guidelines need to be defined with appropriate mechanisms for disclosure
- An effective, efficient and transparent complaint resolution mechanism needs to be put in place

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Chapter 9: Access

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In general, participants felt that a rapid expansion to MMT throughout the province had occurred in response to the public health crisis and had been very positive. Credit was given to CPSBC most specifically, but also to the CPBC, for taking on the challenge and expanding the program in very challenging and sometimes actively hostile circumstances. Many participants stated that they believed that access was now *"good"* in some parts of BC, with others stating that *"availability is improving, there are more options."* In fact, there are some areas of BC where prescribing physician access is *"very good."* Compared to mental health and addiction services more generally, methadone was described as having relatively good access.

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Other systemic barriers

Some providers said that while the process required to initiate a new client was improving, the paperwork still created a barrier:

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Toward recommendations

Significant improvements in access to MMT were reported, particularly since 1996 when CPSBC was given administrative responsibility for the MMP, and the number of clients in the program has correspondingly increased. However, many ongoing challenges were also identified. The most significant among these revolve around attracting and retaining prescribing physicians. There is clearly a need for creative and innovative solutions to address the access challenges. One other theme that emerged repeatedly related to regional diversity. What works in one region may have detrimental impact in another.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- Attention to physician recruitment and retention is critical for increasing access to, and improving effectiveness of MMT
- Related to physician recruitment is the need to develop mechanisms to normalize MMT as part of regular medical practice in BC while recognizing and enhancing the multi-disciplinary nature of the program
- There is a need for training and other wider proactive interventions for physicians in BC to address the stigma and discrimination that pervades views about substance use and MMT and affects willingness to become involved in this area of medicine
- Reported barriers to physician involvement such as financial compensation, caseload and workload demands, training and regulations all need to be reviewed and carefully adjusted to balance the need for improved access with the need for quality service
- The MMT system needs to enhance its regional responsiveness and should explore mechanisms for getting local stakeholders more involved in planning and implementation

Chapter 10: Retention

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Retention

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As well as undermining the therapeutic relationship, inadequate dosages also directly impact on the ability of people on MMT to become stabilized and reduce their illegal drug use. With inadequate doses of methadone people will take other drugs in order to deal with their cravings or withdrawal.

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Another key issue for retention in MMT is the fact that many clients are dissatisfied with the quality of care they receive. The cited a lack of time with their doctor, long wait times, lack of other support services as factors that undermine commitment to the program. They often experience the program as punitive, for example, in the way urine drug screens are administered, how carry privileges or dose adjustments are used as control mechanisms and the threats of being cut off for other drug use (see Chapter 7). s13

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One of the most significant factors impacting client retention is the fees that many clients have to pay to get MMT in BC. Both clinic fees and the cost of prescriptions are not only a barrier to access but also can have a direct impact on client retention.

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Toward recommendations

The issue of client retention on MMT in BC is complex and interconnected to many other issues described throughout this report. Retention is an area where many of the problems combine to destabilize the potential for optimized MMT. A significant body of literature is now available on ways to improve treatment retention for people taking methadone and this could be utilized to good effect in the MMT system through enhanced leadership, multi-disciplinary working and interest in working with clients, their families and client-representative organizations. Review stakeholders emphasized that client retention on MMT must be understood to be intimately connected to almost every other dimension of the methadone program: systemic, relational, financial and societal. The triangle of access, retention and quality of care is an important conceptual or analytical device to understand these interrelationships.

The following considerations emerge from the discussion summarized in this chapter and have informed the recommendations at the end of this report.

- Most of the issues reported in this systems review are complex and interconnected and need to be appreciated as such. A "systems approach" is therefore needed so that there is an awareness that changing one part of the program will impact other areas
- The interests and concerns of clients needs to be a focus within the MMT system, and mechanisms to ensure client input in policy development and review are essential
- Policies and regulations should be regularly evaluated in light of their actual and potential impact on retention
- A strategic plan is needed for making optimized MMT, as defined within the NAOMI trial, standard in BC

Chapter 11: Gender and Age

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Gender Differences in MMT

Participants noted that gender differences in opioid use in Canadian society were reflected in the fewer numbers of women accessing MMT in BC (see Table 3). These figures show that men access MMT almost twice as frequently as woman, across the program as a whole. However, in the 10-19 age group more young women are involved in MMT compared to young men. One reason for the higher numbers of young women on MMT could be the proactive use of MMT for pregnant opioid dependent women:

> *"Pregnant women, one place where we do a good job of ensuring good access."*

Women were felt to be under-represented in MMT in BC, but how much of this can be accounted for by the higher numbers of men using opioid drugs is unclear s13

Table 3: Age and Gender of MMP Clients (CPSBC, correspondence February 2009)

Age of Patients	Total Patients	Female Patients	Male Patients
10-19 years	137	73	64
20-29 years	2,293	999	1,294
30-39 years	2,999	1,026	1,973
40-49 years	2,914	953	1,961
50-59 years	1,576	434	1,142
60-69 years	162	44	118
70-79 years	15	4	11
80-89 years	2	0	2
Total	10,098	3,533	6,565

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Some participants reported differences between men and women in terms of their needs for adjunct services connected to their participation in MMT. The main differences were that men preferred support in getting themselves back into work, over access to counselling, particularly in rural parts of BC:

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For women, comments were made concerning their increased need for counselling:

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Many stressed the importance of a comprehensive bio-psycho-social assessment that asked people clearly what they wanted in terms of services and supports for therapeutic interventions:

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Methadone and pregnancy

The stigma associated with problematic substance use was viewed by client and professional commentators as *"much worse"* for mothers and pregnant women with substance use problems: a *"double discrimination."* That said, pregnancy can also be a gateway to MMT and to associated stabilization. As discussed above, pregnant women are prioritized for treatment in BC in rural and remote as well as urban areas. However, access in rural and remote areas was sometimes described as very challenging. Despite these problems, many participants described the improvements that had been made to substance using pregnant women's care and treatment:

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MMT, women and children

For many women methadone was viewed as being a way to get their children back into their care. However, participants also reported women's fear that the Ministry of Children and Family Development would take children away from them if it was discovered that they were on methadone.

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There was some client concern that too many young people were being placed on methadone prematurely. One of the issues that participants agreed upon was that if youth were going to have access to MMT, it is even more essential that the case management, outreach and psychosocial supports are available to ensure they are provided with the best opportunity to become stable. The need for regular review with opportunities to come off methadone, if and when they choose, was also emphasized.

According to Table 3, there are only 179 MMT clients (1.8% of current clients) over 60 years old. However, the very large group of MMT clients, especially men, in the 40-59 age group (a combined total of 4490 or 45.4% of current clients) will change this percentage dramatically in the years and decades to follow. Anticipating this demographic shift with careful planning would seem a sensible thing for both government and health authorities, especially given the rates of intersecting health problems, chronic illness and disability that these clients are likely to have.

Toward recommendations

Both gender and age have significant relationships with MMT, despite few participants addressing these two aspects of identity in their comments about the program. The importance of a gendered-approach to the needs of men and women was felt to be an important component of a quality MMT services. Age was also very much an under-explored dimension of methadone provision in BC and further research should be undertaken to ensure both older and younger people's needs are being met.

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- MMT services, like all services and supports, need to be planned and implemented in ways that ensure they are responsive to diverse needs related to gender, age and other factors

Chapter 12: Aboriginal and First Nations Peoples

"Sometimes our people get tossed out of the system."

Providing a context: substance use and colonization

"we know from living and working in our communities that what really is going on is folks are self-medicating."

Aboriginal and First Nations peoples in BC are overrepresented in mortality and morbidity rates connected to problematic substance use, particularly alcohol use but also increasingly illegal drug use (BC Provincial Health Officer, 2002), and many participants linked this to experiences of colonization (cf. Aboriginal Justice Implementation Committee, 1999).

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Substance use and primary care services

Mental health and problematic substance use services are not meeting the needs of Aboriginal and First Nations peoples, according to review participants. This was partly because these resources are so thinly spread, in both rural and urban areas, but also because services are not viewed as culturally appropriate or equipped to address the major issues of concern that Aboriginal people have. For example, services most commonly do not make connections between health problems and past or ongoing trauma. One Aboriginal health lead emphasizes this here:

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Across the province, addiction services were noted to be severely under-funded, as the *"poor relation"* of healthcare, with long waitlists to access specialized treatments. A lack of services for Aboriginal women was particularly concerning to participants who pointed to the increased rates of violence and associated trauma that many Aboriginal women have had, and currently experience (Aboriginal Justice Implementation Committee, 1999; Benoit, et al., 2003).

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The lack of comprehensive harm reduction services available to those dwelling in rural and reserve communities means that those seeking services may be forced to travel long distances to larger urban areas to obtain methadone (BC Provincial Health Officer, 2002; Wardman & Quantz, 2006), something participants highlighted:

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Another major issue raised by participants was that of Aboriginal people moving frequently between their reserve community and urban areas of BC – an issue that presents challenges for MMT continuity as well as initiation. Due to a lack of services for MMT continuation on or near reserve communities, it is also hard for people who have been started on methadone in urban areas or, for that matter in corrections settings or hospitals, to return to their communities, should they wish to.

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There are access issues for First Nations peoples with status because there is a different fee structure for Health Canada's Non-Insured Health Benefits (NIHB) program in BC, which was described as limiting access to MMT.

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Returning to the MMT review data, in practical terms, creating culturally appropriate, safe, and accessible environments was seen as best done through mainstream providers partnering with Aboriginal providers, such as Native Health in Vancouver and Prince George, or Aboriginal Friendship Centres.[60]] s13

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One of the most popular ideas for practical change to make MMT more accessible to rural and on-reserve populations was that of using telehealth (videoconferencing) technologies:[63]

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- The unique cultural and historical factors that influence Aboriginal people need to be understood and appreciated in developing and delivering MMT services and supports to Aboriginal individuals and communities
- There is a need for a greater consistency between service delivery systems relative to funding mechanisms and other policy issues
- New methods of delivery of MMT in rural, remote, northern and Aboriginal on reserve communities should be trialed or piloted to learn more about "what works" in these particular environments
- Values and approaches used within Aboriginal cultures may provide models for the delivery of MMT in non-Aboriginal communities as well

Chapter 13: Corrections

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Participants involved in this review noted improvements over the last few years regarding the provision of methadone services in correctional facilities. Both federal and provincial corrections now have active methadone programs for both continuing and initiating MMT during a person's term of incarceration. Correctional institutions have access to PharmaNet including information on prescribing physician, dose and last pick up. All corrections physicians are now licensed, at a minimum, to be able to continue a person's methadone treatment. Even initiating MMT in prison is fairly prompt: *"usually a week or at most two weeks passes."* The correctional system was described as a *"huge repository for people that we are not involving within our regular communities."* The potential to engage people on MMT while in corrections settings seems, therefore, to offer important public health possibilities.

Problems that still exist

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The majority of client comments on corrections concerned poor access to methadone when they were already stable on a regular dose, or where methadone was being withheld causing the person to go into withdrawal. Transferring of patients from facility to facility during initial intake was reported as a particularly vulnerable time for this, as this person describes:

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Use of methadone as an incentive and punishment

There were also reports that prison staff attempted to control or change a person's stabilized dose. Access to methadone or adjustments to dose were reportedly sometimes used as an incentive for certain behaviour or as a punishment:

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Problems with continuity of care

Participants raised several concerns about a lack of continuity of care between corrections systems and the wider community. A lack of prescribing physicians seems to be most problematic in this regard, s13

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As described in Chapter 9, there are still large expanses of rural and remote communities, including First Nations reserve communities, that are poorly served by health services generally, let alone physicians with licenses to prescribe methadone and a willingness to take people released from corrections with substance use histories. As the above participant made clear, the lack of MMT provision in rural and remote communities can be instrumental in forcing newly released ex-prisoners back to the settings where they are most vulnerable.

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Toward recommendations

The recent improvements in corrections settings, reported by clients, advocates and providers alike, show what can be achieved. Ensuring continuity of care for optimized MMT across complex systems, with a range of different service providers, is a complex task. Based on the progress represented by review participants in this particular area of MMT provision, it is clearly worth continuing to strive towards these goals.

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- Mechanisms for case management in MMT that ensure continuity between community, acute care and correctional setting should be considered a priority
- Continued attention to developing awareness about MMT designed specifically to change attitudes of providers in corrections settings is needed

Chapter 14: The Need for Pharmacological Alternatives

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Need for alternatives

Almost every stakeholder involved in the review wanted to see alternatives to methadone. A significant majority believed that providing alternatives would address many of the problems that currently exist related to MMT. s13

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Buprenorphine

Buprenorphine has become a front line treatment option in many countries, particularly where there has been limited or no access to MMT (Carrieri, et al., 2006; National Institute for Health and Clinical Excellence, 2007). Recent studies support the use of buprenorphine and buprenorphine/naloxone (Suboxone[64]) as a safe, cost-effective, and long-term alternative to methadone in retaining patients in treatment and in improving quality of life and health status (Giacomuzzi, et al., 2005). A recent Cochrane Collaboration review (Mattick, et al., 2008) compared flexible-dose sublingual buprenorphine and oral methadone using 8 studies and statistical pooling where possible. Across these 8 studies, 18% more methadone than buprenorphine patients remained in treatment for time periods varying from six weeks to a year. Among the studies that included this data, numbers of positive urine tests, indicative of continued illicit opioid use, only slightly and non-significantly favoured buprenorphine, similarly to patients' self-reports of heroin use. There were also no significant differences in use of cocaine or benzodiazepines or in crime. The review concluded that given adequate doses, methadone was the more effective treatment. However, as analysts have pointed out, this was not by an overwhelming margin and limitations in the analysis of the review and in the source studies arguably "introduce considerable uncertainty" (Drug and Alcohol Findings, 2008).

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Physicians and clients alike agreed that there was a need for Suboxone/buprenorphine to be available as an alternative in order to allow for more flexible, individualized and client-centred care. Many believed that there would be cost savings in the long run, despite Suboxone's comparatively high upfront costs, because of the increased effectiveness of the system in meeting the needs of various sub-populations, and client satisfaction which is critical to client retention and treatment effectiveness.

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Heroin Assisted Treatment

Heroin assisted treatment has been tried with success in the Netherlands, in Switzerland and in the UK (Fischer, Oviedo-Joekes, Blanken, Haasen, Rehm, Schechter, et al., 2007). Generally, improved client retention is one of the most pressing arguments for making heroin assisted treatment available.

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Client retention in treatment has been studied in the Vancouver/Montreal NAOMI trial (North American Opiate Medication Initiative, 2008). To be eligible for the study, participants needed to have had chronic opioid addiction (at least 5 years) and must have tried opioid addiction treatment at least twice in the past without success. Thus, the study was aimed towards the most severely affected individuals who had not benefited from conventional treatment options. The results published in October 2008 show a retention rate of 88% for heroin assisted treatment over a 12 month period compared to 54% for optimized MMT.

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Morphine

There were a smaller number of comments on morphine as a potential opioid substitution treatment. Some participants believed that morphine

- was easier to get off than methadone,
- was potentially less controlling than methadone because there was no need to go to a pharmacy as frequently
- could be used to help people transition off methadone and other opioids.

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Toward recommendations

Review participants wanted alternatives to methadone to be a priority development. Alternatives now exist in many other jurisdictions. Professionals want to be able to individualize opioid substitution treatment, and clients and family members want medications that do not have the negative health impacts of methadone, including the difficulty of coming off the medication.

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- There is a need for clear and transparent policy on alternatives to methadone that is based on the best available evidence and provides the best fit to the BC context with particular attention to those populations not well served by the current MMP

Chapter 15: Stigma and Discrimination

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Stigma and discrimination were cited with reference to almost every topic discussed in this review.

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Societal, public and community views of methadone

Similarly, a huge stigma and judgment of methadone and people who take methadone was described. *"There is nothing positive about that word for people."* There is a view that people take methadone when other options run out, or that methadone makes a person high. The dominant view of methadone is that it is a "drug" rather than a "medication" to enable people to come off other drugs, as this person describes:

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Media representations of methadone contribute to this stigma by focusing only on the system failures s13

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Stigma was viewed as directly contributing to poor health care and poor treatment outcomes. Providers and clients alike had experienced health care professionals *"shaming people,"* or treating people badly, once it became known that they were taking methadone. Two clients reported being treated *"worse than shark shit,"* or having had health care professionals *"turn their back."* As described in Chapter 10, clients stated that they did not want to go to the Emergency Department for fear of *"being labelled an addict."* Challenging the stigma or the poor practice connected to it was regarded as a dangerous thing for clients to do, and participants talked about the consequences of speaking out:

Provider bias toward abstinence

There is still a stigma from health professionals towards people taking methadone because of personal beliefs in the importance of abstinence:

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Within the group of treatment centres who do accept people on methadone, the majority have certain specific criteria (e.g., 'down to a 40 mg dose') before considering admitting the person. Some health authorities have taken a lead in trying to address this issue. In Fraser Health, funding for treatment centres and recovery houses is contingent on allowing access to people taking methadone and this is reinforced through clear policy and contracts with services.

MMT systems that reinforce stigma

MMT historically and currently operates as separate from the rest of the health care system in BC. People taking methadone are therefore seen as being *"outside of the system."* s13

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Without information and education, the first reaction from the public towards addiction is often anger, particularly if women or children are involved. Documenting and disseminating information about interventions that work, such as MMT, could help the public understand substance use much better. Challenging the myths and stereotypes is a key step in this work. MMT does work and there is an important public relations campaign needed, according to review stakeholders, to take this information out into local communities:

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Toward recommendations

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- Current policy needs to be reviewed and amended to ensure practices do not contribute to stigma and discrimination (this includes addressing the marginalization of the system)
- Improved education and training for all health professionals is needed
- Public education to reduce stigma related to substance use problems and MMT should be a priority

Chapter 16: Looking to the Future

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Nurse Practitioners are increasingly called on to provide high-quality health care in BC, particularly for people who face significant barriers to accessing services.

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A stepped care model was identified in Health Canada's *Best Practices - Methadone Maintenance Treatment* (2002). In this model, more stable clients receive their care with GPs, and more complex or unstable clients receive their care through clinics where there is a range of other specialist addictions support. With a multi-level approach, people can move through different settings of care as they stabilize, receiving care that best suits their needs. The ultimate goal of stepped care approaches is to move people into the most optimized level of care through a process of long-term recovery into a decent quality of life, whether they continue to take methadone or not. Stepped care was noted to be a key area for development in the 2008 *National Treatment Strategy* which should give a good foundation of support for the expansion of stepped care approaches within MMT in BC.

One size does not fit all

The majority of stakeholders wanted a multi-model approach to the development of MMT in BC. Most believed that *"one size does not fit all,"* as this family physician emphasizes in her final interview comments:

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The province needs to develop a full range of options for the variety of geographic areas and sub-populations needing MMT services, for example, rural, remote, urban, Downtown Eastside, people with HIV, people who are stable and working, women and Aboriginal reserve communities. Policy and practice also needs to attend to the differences between individual clients at different times of their lives and different stages of recovery. Northern BC needs a carefully designed model that can cope with providing MMT across the considerable geographical distances and the isolation of communities, as well as addressing the needs of on- and off-reserve Aboriginal communities. Certainly, for a number of parts of rural BC, MMT would be best delivered in the context of regular primary care services where substance use expertise could be provided as and when needed. The telehealth model is an important potential resource to develop such a shared care model, as described in Chapter 12. Without priority being given to developing services outside of urban areas, clients will continue to be drawn back to them for care, especially to the Downtown Eastside of Vancouver, described as *"the box,"* somewhere many people are trying unsuccessfully to move away from. While it is necessary to provide good health care and substance use prevention and treatment services in this neighbourhood, the dangers of increased ghettoization must also be addressed by devolving good services throughout BC.

Recovery and non-judgmental, individualized and client-centred care

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Currently there are new concepts and models that seem to have resonance with many, generally organized around the concept of "recovery" (Simpson, 2004; White, 2008), such as recovery management (White, 2008; 2009), recovery capital (Cloud & Granfield, 2001; Klingemann, et al., 2001), and recovery careers (White, 2008). According to Wardle (2008), recovery in substance use treatment settings is about putting the service user at the centre of care, support and treatment, shifting the balance of power towards individuals (rather than professional systems), and involving service users in their care and treatment. The importance of an individualized approach to MMT was a theme participants returned to again and again through the review:

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Participants suggested that when clients start organizing and working actively with health providers, the standard of services can only rise, despite partnership working being a challenging process for providers, client, supporters and family members alike. The involvement of clients in services also seems to increase their satisfaction with the care and support they receive (Fischer, Jenkins, Bloor, Neale & Berney, 2007). s13

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Leadership, champions and multi-agency dialogue to create a program fit for the future

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Many participants spoke about the need for renewed leadership for MMT to develop a system that was better able to meet the needs of its clients. Many were also clear about the need for multi-agency dialogue to move forward

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Summary of Review

MMT is making a significant contribution towards the care and treatment of people with opioid dependency in BC. This review has highlighted significant developments and innovations in the province that are truly inspiring to witness and discuss. Each geographic area had a different set of innovations and challenges which made painting a provincial picture a challenge. This report documents a wide range of examples of promising practice already in existence, and being developed, which have the capacity to move practice forward in the province.

The problems that often prevent the system from delivering optimized treatment to those that use its services are also many and diverse. Most importantly, the fragmentation and lack of integration of MMT with other mainstream health and social care supports, is severely limiting the ability of the program to meet the needs of its clients. The lack of a treatment "system", as such, leading to a lack of coherent and comprehensive care/treatment policies and practices across the province, is preventing MMT from achieving its potential for many individuals. Lack of "buy in" to this treatment/therapy still pervades, at all levels of responsibility. Concerns about the quality of MMT services provided, and the lack of "humanized" and optimised care, support and treatment, have been dominant. Problems with monitoring and evaluating outcomes, as well as what is being provided, feeds this problem. There are some points in the current arrangements that are under considerable strain, such as physicians covering large areas of rural and remote communities, those working in the context of the Downtown Eastside.

While there are examples of promising practice across the province, much more should be done to support a holistic and person-centred approach to avoid isolating responses to addiction. Addressing the issues behind problematic substance use, such as unresolved trauma, experiences of violence, neglect, gendered or cultural oppressions, racism, poverty and grief and loss, is essential. Attention to social inequities, poverty, unemployment and the needs of parenting women and men should also be a priority. Good quality housing is an essential factor in supporting a person's recovery from opioid dependency, as are employment opportunities that are motivating and encouraging. Finally, the overarching stigma and discrimination that pervades MMT must be faced head on.

The people that supported this review, telling of their experiences, hopes and dreams for MMT and for people taking methadone, are a group of highly committed and visionary people. They described the importance of supportive counselling and of having access to programs that help to nurture a person's self-confidence, self-belief and self-efficacy. They enthused about the importance of using cultural models of recovery and intervention. They demonstrated the importance of effectively targeting sub-populations to promote equitable, respectful, compassionate and dignified care. While more resources are clearly needed to develop and support existing programs, the greatest resource is the people that work in MMT services and they need to be valued and supported. It is therefore with great respect that the following recommendations are offered to the province of BC, with the intention of helping to build on this capacity for excellence, while at the same time creating clear policy and practice solutions to address the significant challenges. Improving MMT in BC requires the active involvement and contribution of its stakeholders, including those that take methadone, their families and supporters, working together with courageous leadership to create a program of which everyone can be proud.

Recommendation 1: *Health authorities should be given the lead responsibility and resourced to develop MMT and effectively integrate it within their mental health and addiction services and primary care. Leadership within the health authorities should be supported by the Ministry of Health Services and other government ministries and informed by a provincial, multi-stakeholder Methadone Maintenance Committee.*

Recommendation 2: *The Methadone Maintenance Committee should provide a forum for partnerships to develop a range of improvements in the MMT system in BC. It should use key quality indicators to monitor system performance and outcomes and use this information to make recommendations to government and other lead agencies regarding necessary steps for system reform and improvements in care.*

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Recommendation 3: *MMT services should be universally available and accessible across the province, whether in high or low-density areas, and in other systems such as corrections.*

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Recommendation 4: *MMT should be integrated into existing health and social care services, including mental health and addictions services and primary care, and be provided through inter-disciplinary, "whole systems" and stepped care models. MMT should include different care model options, including low threshold care, and optional psychosocial care.*

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Recommendation 5: *MMT should be free of user fees and fiscal arrangements should incentivize best practice in terms of access, client retention, quality of care, effectiveness and equity.*

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Recommendation 6: *The present federal licensing arrangement for prescribing opioid substitution treatment should be reviewed with respect to the impact this has on access, retention, quality, effectiveness and equity in MMT. Consideration should be given to eliminate the need for special licenses for physicians. Alternative models of prescribing used in other jurisdictions (e.g., such as non-medical and nurse-prescribing) should be actively considered.*

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Recommendation 7: *Peer-led, advocacy and mutual aid groups must be resourced effectively to build capacity for clients and peers to become partners in care.*

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Recommendation 8: *The benefits of MMT should be celebrated more widely to proactively address the stigma and discrimination still faced by people taking methadone.*

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Recommendation 9: *Evidence based alternatives to MMT should be made available in cases where MMT is not effective as a first line treatment.*

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Recommendation 10: *Inter-disciplinary training must be provided on MMT for all health care staff and should have an anti-stigma and anti-discriminatory focus. Continuous professional development for all those involved in MMT should be expected and facilitated.*

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