British Columbia
Methadone Maintenance Treatment Program
A Qualitative Systems Review

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By Tessa Parkes, PhD

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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.

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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

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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.

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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.

Supplementary data

The project greatly benefited from data collected and shared by the VANDU Women CARE study team.[4] In this study 19 women reported on their experiences related to MMT.[5] The review also benefited from the results of a

[3] This is an underestimate because ethnicity was not recorded by focus group participants or interviewees so unless the researcher was told or knew that someone identified as Aboriginal this was not recorded as such.

[4] The VANDU Women Clinic Action Research for Empowerment study: 50 women's experiences of primary health care were documented in individual interviews between May and July 2007 in a piece of participatory action research facilitated by Dr Amy Salmon (Women's Health Research Institute), Dr Annette Browne (University of British Columbia), Ann Livingston (VANDU) and Ann Pederson (British Columbia Centre of Excellence for Women's Health). (VANDU Women CARE, 2009).

[5] Data specific to methadone was given to the investigator with full ethical permission from UBC Ethics Board, and from the Steering Group of VANDU Women CARE who co-guided the study and represented the interests of the women who were interviewed. 62% of the women interviewed for this project were Aboriginal.

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focus group held by the Positive Women's Network[6] on women's experiences of MMT in BC. The findings from both these pieces of research were used for the review data analysis and informed the review recommendations.

A large amount of supplementary materials were collected over the review year. Many participants suggested documents, reports, books, legal proceedings, press reports or other evidence. These resources were used alongside a full literature search using the main research databases on key aspects of MMT to map a range of "better practices" that were brought to bear on the BC context for possible positive systems change.

Data coding and analysis

Almost all data was fully transcribed by a small team of transcribing staff.[7] Data was coded with the aid of the qualitative analysis software package ATLAS.ti. Thematic analysis, widely used in social science and health research, was chosen as the most appropriate method for analyzing the data. According to Luborsky (1994, p. 190), thematic analysis provides "direct representation of an individual's own point of view and descriptions of experiences, beliefs, and perception." Themes were identified by searching for the central topics most often repeated in and across the interviews, focus groups and review meetings. The data were coded into 23 thematic categories by one research assistant over the period of October to January. The coding framework changed slightly over the period of coding and analysis to attend to specific nuances that emerged. The final version is included in Appendix 1. A further 5 additional searches were made of the ATLAS.ti database for themes that arose at the analysis stage that seemed particularly important to make visible. These additional searches were: children and babies, youth and teens, HIV, hospitals, and access to residential treatment for clients. The ATLAS.ti coded outputs were then transferred into discreet data category summaries by two research assistants. Representative quotes were identified for each category. This was achieved by one research assistant selecting those that seemed to be most representative and the lead investigator reviewing these choices and making a final choice for each category. The data category summaries and representative quotes were then used to write each of the report chapters.

Attending to issues of validity and reliability

To enhance the validity and reliability of the review findings and recommendations, the lead investigator collaborated with advisors from the Ministry of Healthy Living and Sport to organise a series of presentations to key stakeholder groups on draft key findings and emerging recommendations. Ten presentations were undertaken in February/March 2009 to relevant government ministry personnel, MMT prescribing physicians, an MMT client group, the BC Addictions Network and the BC Mental Health and Addictions Planning Council. A further meeting was held between researchers and ministry officials to discuss the most appropriate way to ensure effective linkages between this review and the quantitative study being done by the Centre for Health Evaluation and Outcome Sciences (Nosyk, Sun, Sizto, Marsh, & Anis, 2009). All comments were duly taken into consideration in the preparation of the final report. In addition, research advisers were sent the detailed presentation notes for comment and all responses were addressed in the final reporting of the findings and ensuing recommendations.

The final stage of this process was achieved with six research/professional advisers undertaking a detailed review of report chapters and providing feedback.[8] All comments made by advisers were duly acted upon, in keeping with the authenticity of the data. The recommendations for the review were produced by the lead investigator based on the whole data set, the participant priority suggestions for change and on the national and international best

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[6] Positive Women's Network is an organization that provides HIV education and support services to women and communities throughout British Columbia as well as providing community development and educational support across the country. See http://pwn.bc.ca for more information.

[7] 10 out of 136 data events were recorded using hard written notes, either because of the preference of the interviewee, or because of the efficiency of doing so during large group meetings.

[8] The full report was read and commented on by two advisers. The majority of the other chapters received detailed comments by at least two other advisers.

practices and research literature gathered for this purpose. These draft recommendations were then discussed with a number of the research advisers who had indicated their willingness to do so. They were "fine tuned" through this process of consultation with experts in the field of MMT in BC and internationally. This process draws on the "Delphi technique", or set of methods, increasingly used in qualitative, evaluation research or problem solving (see McKenna, 1994 for its application to nursing research). Its aim is to establish, as objectively as possible, a consensus on a complex problem using iterative feedback cycles of data, information and expert judgment. It can be used to prioritise actions and formulate solutions.

Relevant literature and context for MMT: Global, national, regional and local

Use of substances as part of human life and culture

Throughout human history, societies worldwide have used a variety of substances in order to alter or improve mental functioning, and/or gain a range of perceived benefits. Psychoactive drugs are used by many individuals for mood problems, to relieve psychological distress or as part of a dependency process. Some social groups also use substances as part of religious or traditional cultural ceremonies. Many psychoactive drugs are also prescription medications used in the treatment of illness and disease. The regulatory framework in Canada places the majority of these substances into three status categories: legal (e.g. alcohol and tobacco), prescription (e.g. morphine, benzodiazepines) or illegal (e.g. marijuana, heroin). This taxonomy does not have a base in pharmacology, economic analysis or risk-benefit analysis, but is derived from historical precedent and cultural preference (Health Officers Council of British Columbia, 2005).

Harms from substance use and harm reduction

In the USA, UK and Canada, drug use seems to have peaked in the 1970s, declined through the 1980s and has been on the rise since (Health Officers Council of British Columbia, 2005). In 2007, a new National Drug Strategy was produced, the *National Anti-Drug Strategy*, which proposed stricter enforcement of illegal drugs. Addiction services were emphasised in the strategy but harm reduction was not mentioned and federal funding for harm reduction initiatives stopped. A spectrum of policy approaches exist for drug control in Canada, with tobacco and alcohol at one end of the spectrum in a legal, for-profit commercial economy, despite the relatively high disease burden that use of these substances creates (see Figure 1).

Harms to the individual from substance use vary depending on the substance and, for example, its pharmacological effects, concentration, mode and circumstances of use. It should be noted too, that both legal and illegal drugs vary in these ways. The direct harmful effects from the drug itself can be physical, psychological or social. Physical harms to an individual drug user can include death, toxic effects, dependency, communicable diseases, injury, violence, fetal damage and neurological damage. Psychological harms can include depression, and psychosis. Social harms include, but are not limited to, stigmatization, criminalization, family breakdown, lost productivity, injuries and direct health care and social costs (Health Officers Council of British Columbia, 2005).

The harmful effects to society occur primarily due to two mechanisms: first, the loss of fully functioning individual members due to harmful drug use, and second, the unintended subsequent harms to society that arise from the fact that certain drugs are criminalized. Additional harms to society occur with illegal drugs, including: marginalization of populations, loss of social cohesion, criminal activity, local violence, adverse impact on businesses and neighbourhoods, direct enforcement costs, and the limited implementation of public health programs for drug users (Health Officers Council of British Columbia, 2005).

The approach of harm reduction in the field of problematic substance use is recognized to be one in which there is no presupposition or absolute requirement on the individual to cease drug use before accessing services and supports (Health Officers Council of British Columbia, 2005). It is a philosophical and practical approach that focuses on keeping people safe and minimizing death, disease, and injury associated with higher risk behaviour (Buxton, Mehrabadi, Preston & Tu, 2007). When applied to substance use, harm reduction focuses on the harms

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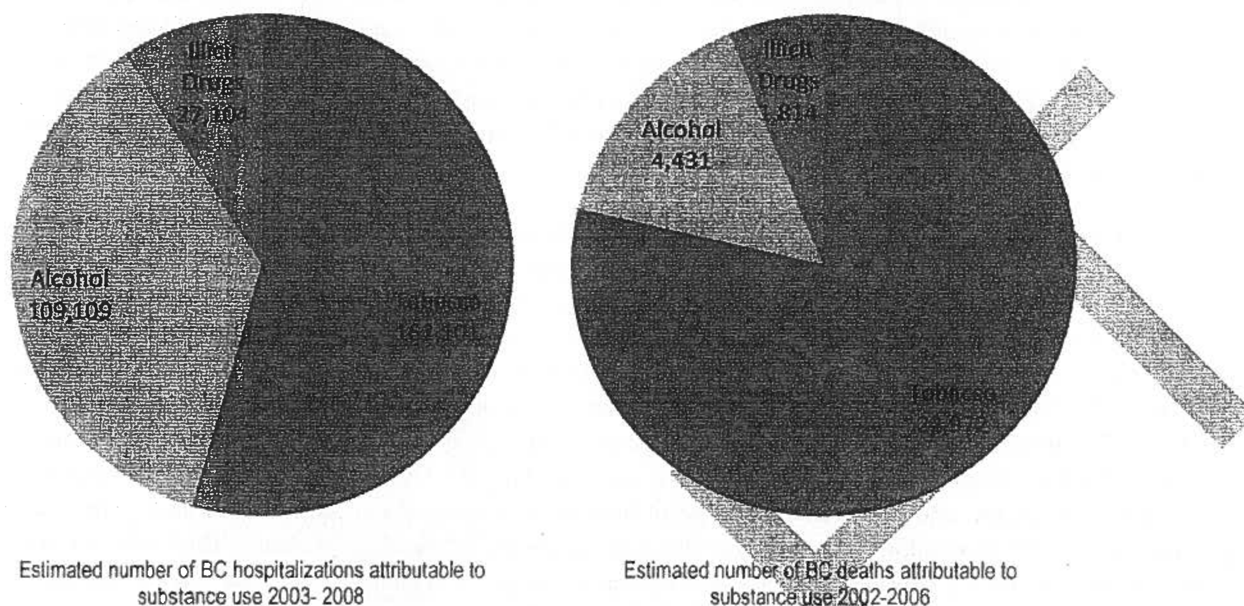
Figure 1: Morbidity and Mortality Attributable to Substance Use (CARBC, 2010)



Estimated number of BC hospitalizations attributable to substance use 2003- 2008

Estimated number of BC deaths attributable to substance use 2002-2006

from substance use rather than on the use itself and involves a range of non-judgmental strategies aimed at enhancing the knowledge, skills, resources, and supports for individuals, their families and communities to be safer and healthier. People who use drugs play an active role in harm reduction programs.

There are a range of harm reduction programs and resources available in BC. The BC Ministry of Health produced *Harm reduction: A British Columbia community guide* in 2005 to assist BC municipalities in taking a leadership and facilitating role to reduce the level of drug-related harm in their communities. The following year, the ministry released *Following the evidence: Preventing harms from substance use in BC* which identified key strategic directions for action by ministries, health authorities, local governments, and agencies involved in the development of healthy public policy in BC. A wide range of harm reduction initiatives, such as peer support programs, outreach and education, needle distribution programs, supervised consumption facilities and substitution therapies, have been developed and implemented to varying degrees across the province.

Opioid use, consequences and MMT

Illegal opioid use has existed in Western countries for almost a century. The negative consequences can include excess mortality, morbidity, and crime (Adlaf, Begin & Sawka, 2005; Fischer, et al., 2007; Healey, Knapp, Marsden, Gossop & Stewart, 2003; Substance Abuse and Mental Health Services Administration, 2006). In Europe and North America, there are an estimated two to four million illicit heroin users (European Monitoring Centre for Drugs and Drug Addiction, 2005; Office of National Drug Control Policy, 2006). One to two percent of this population prematurely die each year. They contribute to the majority of the existing hepatitis C and a substantial proportion of the HIV disease. Because of their intensive criminal involvement, dependent illegal opioid users are considered to "fuel an overall social cost burden related to illicit drug addiction estimated at billions of dollars a year," in countries like the USA, Canada, Germany, and others (Fischer, et al., 2007). Illicit injection drug use is associated with a wide array of health and social harms (Romero-Daza, Weeks & Singer, 2003; Strathdee, et al., 2001; Wood, et al., 2005).

The provision of addiction treatment is one of the most effective interventions to address these harms. During the past two decades, evidence has accumulated regarding the neurobiology of opioid dependence which is

increasingly understood as a brain-related disorder with genetic and environmental characteristics (Kleber, 2008). MMT has been increasingly implemented across the globe as a means of addressing the health, social, and fiscal harms associated with opioid addiction (Gibson, Flynn & McCarthy, 1999; National Consensus Development Panel, 1998). Methadone is a long-acting synthetic opioid agonist that is easily absorbed when taken orally with a half-life of approximately 24–36 hours, allowing for once daily administration. However, as many as ten days may be needed to reach a steady state, so new patients, either to MMT or given methadone for analgesia, are at risk for fatal overdose if care is not taken to carefully titrate doses on an individualized basis.

Several Cochrane reviews conclude that MMT is effective in treating addiction to heroin and other opioids (Amato, Davoli, Ferri, Gowing & Perucci, 2004; Faggiano,Vigna-Taglianti, Versino & Lemma, 2003; Mattick & Degenhardt, 2003). MMT has been shown to lead to reductions in, and elimination of, use of opioids (Ball & Ross, 1991; Sees, et al., 2000; Strain, Bigelow, Liebson & Stitzer, 1999), as well as reductions in criminal activity, unemployment, and mortality rates (Ball & Ross, 1991; Dole, et al., 1969; Sheerin, Green, Sellman, Adamson & Deering, 2004). Studies have shown that mortality is higher among opioid dependent people not in MMT treatment (Gronbladh, Ohlund & Gunne, 1990; Caplehorn, Dalton, Haldar, Petrenas & Nisbet, 1996). Zanis & Woody (1998) for example, report a study where patients in MMT had a 1-year mortality rate of 1% compared with 8% among patients who discontinued treatment. In relation to criminal activity, in a 1991 study, crime days per year among individuals addicted to narcotics decreased more than 70% while receiving MMT (Ball & Ross, 1991). As a result, MMT is considered to be a cost-effective strategy for reducing major risks, harms and costs associated with untreated opioid addiction among patients successfully retained (World Health Organization, 2004).

MMT is also associated with reduced HIV and viral hepatitis transmission rates (Hartel & Schoenbaum, 1998; Novick, Joseph & Croxson 1990). In a 1993 prospective study conducted in Philadelphia, Pennsylvania, HIV seroconversion rates were 4 times higher among individuals who were actively using street heroin, compared with patients receiving MMT (Metzger, et al., 1993). Risk decreased in relation to length of time continuously receiving MMT, and risk of hepatitis B and hepatitis C was also reduced, but to a lower extent (Metzger, et al., 1993). Several studies have also shown reductions in risk behaviours including needle sharing, number of sexual partners, engaging in sex without condom use, and exchange of sex for drugs or money (Iguchi, 1998; Sees, et al., 2000;).

In terms of client retention, average methadone maintenance doses of 60 to 120 mg or higher have consistently shown better results than use of lower average doses (Kleber, 2008). The negative effect of delaying entry into methadone treatment (Bell, Caplehorn & McNeil, 1994), and the benefit of a two-thirds reduction in mortality risk among dropouts re-enrolled into treatment (Estaban, et al, 2003), have been established, making accessibility to and retention in treatment, key. Indeed, structured interventions targeting treatment "dropouts" have been shown to be able to re-engage users back into MMT (Goldstein, Deren, Kang, Des Jarlais & Magura, 2002). According to Jaffe and O'Keefe (2003) two years of MMT is the minimum duration required before a person should attempt withdrawal. Even those receiving MMT for long periods, with substantial lifestyle changes, can return to illegal drug use after leaving treatment. For many patients years of MMT or lifetime maintenance may be needed, but many clients and family members oppose this (Kleber, 2008).

Despite considerable evidential support for the efficacy of MMT (Ball & Ross, 1991; Gibson, Flynn & McCarthy, 1999), the majority of evaluations have a number of limitations. In particular, studies have generally been restricted to clinic-based populations willing to initiate MMT (Shah, et al., 2000), and retained in treatment long enough for outcomes to be evaluated (Brands, Blake & Marsh, 2003). Most research has been conducted in specialized clinics, and comprehensive data from GP treatment settings have been lacking (see Fischer, Cape, Daniel & Gliksman, 2002 for a Canadian exception to this). It should also be stressed that although MMT has been lifesaving and life-enhancing for thousands of individuals, it is not a panacea. Many people taking methadone continue to use other substances or do not want to take methadone for many different reasons.

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Global differences in MMT availability and service models

There has been much debate concerning the regulation of MMT in Canada and elsewhere (Fisher, et al., 2002). Some jurisdictions, for example France and Germany, did not provide MMT until recently. Others kept it confined to highly institutional settings, imposing strict requirements on physicians, treatment procedures and patient eligibility. According to Fischer, et al., such restrictions were put into effect in the wake of considerable professional and political resistance to MMT in the early 1970s. For example, in the United States, MMT has largely been restricted to hospitals or specialized treatment clinics. These conditions have meant that in the US only a small proportion of the estimated population of opioid dependent people has had access to MMT (Fischer, et al.).

The emerging HIV and drug overdose epidemics among injecting drug users during the 1980s underlined the need for increased availability and accessibility of MMT in many jurisdictions across the world. The involvement of family physicians or GPs has been one of the ways that MMT has been made more available to populations. Australia, Switzerland, the Netherlands, Germany and the UK have a well-developed GP delivery model for MMT. As Fischer, et al., (2002) document in their study of MMT office-based prescribing physicians, an important concern with regard to the integration of GPs in opiate addiction treatment is that of workload. Significantly higher physician consultation rates are often incurred by people with opioid dependency, for a variety of reasons, compared to non-drug users. Fischer, et al., suggest that increases in workload for GPs who undertake MMT in office-based settings could be "substantial, if not unmanageable."

According to Fischer, et al., (2002), with adequate training, accreditation and credibility, family physicians or GPs may be a promising approach to creating accessible, flexible and high quality treatment. This model is also considered to be cost-effective (Fischer, et al.). Indeed, the deregulation of treatment, and a concurrent emphasis on training and professional competence by non-specialist physicians, is described as having created a "paradigm shift" within MMT (Fischer, et al.), and as having the potential to de-stigmatize MMT. Issues of appropriate qualification, education and training, and provider retention, have been considered in many jurisdictions.

MMT in Canada and British Columbia

Canada has had a fragmented or "turbulent" history of MMT (Fischer, 2000), where policy support has waxed and waned at both federal and provincial levels. Reversion to more restrictive policies has occurred on different occasions in Canada's 50 year involvement with MMT. A restrictive regulation framework has kept the rate of treatment spaces among the lowest in the Western world (Fischer, et al., 2002). MMT practices also differ significantly between jurisdictions (Fischer, et al.). In 1992 the federal government produced a set of MMT guidelines which required physicians to undergo a two-week training internship to receive authorization. The authorization, when granted, limited the number of patients a physician could see and needed to be renewed annually. The guidelines also set a maximum dose policy, required supervised urinalysis, mandatory psycho-social counselling, and comprehensive treatment documentation (Fischer, et al.). These restrictions dissuaded physicians from becoming licensed, unless they were heavily involved in addictions work.

Vancouver was the first place in North America to use methadone for opioid dependence. In 1959 the Department of Health approved a "small controlled experiment" by a Vancouver addictions specialist, Dr. Robert Halliday, which developed into a "prolonged withdrawal" program. This program involved the "provision of methadone to clients in conjunction with other forms of psychosocial treatment." Indeed, Halliday stressed that abstinence was not the primary goal of the intervention, drawing the comparison, as Dole and Nyswander did in New York, between opioid maintenance for people with dependency and insulin treatment for diabetics (Fischer, 2000). The provincial government in BC was responsible for the methadone program in the 1960s, 1970s and

1980's. When the heroin treatment program,[9] a very brief experiment in compulsory methadone treatment of opioid dependent people, was abandoned in the late 1970's, methadone became more difficult to access in BC because the provincial government withdrew from all MMT provision.

In the mid-1990s, a number of developments occurred that fundamentally changed the way MMT was delivered in Canada. In 1996, the federal government had a change in policy and, initially only in the cases of British Columbia and Ontario, suddenly devolved the regulatory authority for MMT training, authorization and practice to the provincial level. In both BC and Ontario the provincial authorities, in joint efforts with the Colleges of Physicians and Surgeons, "substantially loosened both treatment authorization and practice guidelines, thus introducing a liberalized MT regulatory system" (Fischer, et al., 2002). These regulation reforms allowed for increases in the numbers of physicians authorized for MMT, and in the numbers of patients in treatment. In BC at the time of this policy change there were approximately 110 physicians and 1200 patients on MMT (Mullens, 1999). The number of patients/clients, at the end of 2008, was just over 10,000 (see Figure 2).

The public health crisis in Vancouver and role of MMT

During the last 15-20 years, Vancouver has been experiencing a public health crisis related to the use of injection drugs (Wood, Tyndall, Montaner & Kerr, 2006). In the mid to late 1990's, methadone became viewed as one of a number of policy and practice levers able to mitigate both the human immunodeficiency virus (HIV) and the drug overdose epidemics, taking place largely in the Downtown Eastside of Vancouver. HIV positive testing reached a peak in 1992 and has declined since (Buxton, et al., 2007). Cases in Vancouver peaked at 587 in 1992 (201 in BC), with the predominant mode of HIV transmission reported to be injection drug use between 1994 and 1999 (Buxton, et al.). Fatal drug overdoses in Vancouver increased from 19 in 1988 to 200 in 1993 with more than 1200 people dying in the City between 1990-2000 (McPherson, n.d). Vince Cain, the Chief Coroner of BC, released a report in 1994 that analyzed drug use in the province and called for policy makers to recognize the use of drugs as a health issue. A review participant spoke about the response to these public health crises from a personal perspective:

> *"It was all about going from very low capacity to high capacity in a very short period of time, in response to a public health crisis and public health emergency. The goals were very much public health goals. It was the public health community saying something significant is happening here and what can be done about it?"*

During this time there was very little methadone provision anywhere in BC. In the Downtown Eastside of Vancouver in 1991, for example, there was only one methadone prescriber. However, some proactive service provision was already in place, such as nurse outreach developed in the late 1980's with a mandate of HIV/Sexually Transmitted Infections prevention. Review participants remembered a resistance to addressing both addiction and HIV in BC during this period of time, with MMT being considered to be a very controversial treatment because of its harm reduction approach:

> *"Despite the fact that there was a lot of evidence in the research literature that supported it as being a very effective treatment modality, within the addiction medicine community it was controversial. And prior to the public health crisis there was a sentiment among the leadership in the addiction medicine community that methadone should be kept at a low level, a last resort, only something if all else fails, almost looked upon as a treatment failure."*

In light of the harms associated with injection drug use in Vancouver (Wood, et al., 2003) and elsewhere in BC, there have been concerted efforts to increase the availability of MMT in the province (Anderson & Warren, 2004; Mullens, 1999). In terms of assessing the impact of these efforts, the number of new HIV infections among

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[9] In 1978 the BC government started the Compulsory Heroin Treatment Program in conjunction with the British Columbia Alcohol and Drug Commission. Approximately a year later, the program ended when the Compulsory Heroin Treatment Act was challenged in court by a patient and a physician.

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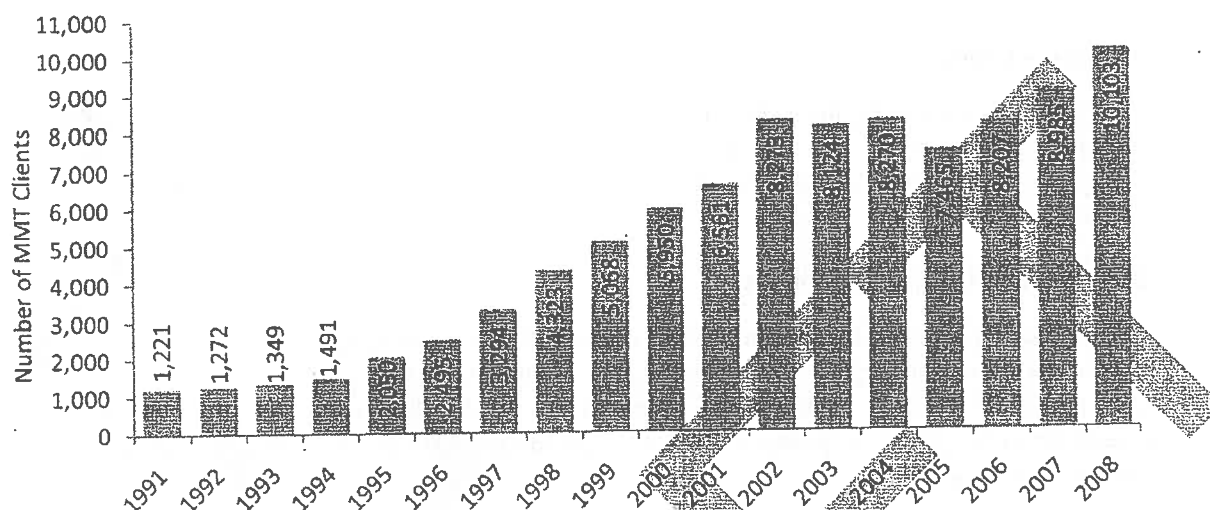
Figure 2: Number of MMT clients in BC (Ballem & Young, 2005; CPSBC, correspondence 2009)



injection drug users decreased from 387 in 1996 to 160 in 1999, a decline of almost 60% (Wong, MacDougall, Patrick, Rekart & Barnett, 1999), and the proportion of all new HIV infections related to injection drug use dropped from one-half to one-third, during the same period. Illicit drug deaths have decreased since a high of 417 in 1998 to 146 in 2005 (Buxton, et al., 2007) but drug overdose deaths in the Downtown Eastside in 2005 were still 7 times the provincial rate (Buxton, et al.).

In BC the prevalence of HIV infection among injection drug users has never exceeded 25% (Anderson, 1999), a level that is half the peak prevalence of many other jurisdictions (Des Jarlais, et al., 1989). Based on estimated rates of between 16,000-20,000 injection drug users in the province, and assuming that the prevalence rates of new HIV infections peaked at 50%, as it did elsewhere, Anderson (2000) suggests that needle exchange and MMT in BC prevented "up to 4000 new HIV infections among injection drug users." Anderson (2000) uses data that proposes that under epidemic conditions between 5 to 7 HIV infections are averted for every 100 HIV-negative patients receiving methadone maintenance for a year (Gibson, et al., 1999). Furthermore, according to Anderson (2000), for every HIV infection averted in injection drug users in BC, a total lifetime medical cost of $145,344 is avoided. "Therefore, a total of $580 million in health care costs may have been avoided as a result of the implementation of harm reduction interventions" (Hanvelt, Copley, Schneider & Meagher, 1999).

Interestingly, these intervention effects have not necessarily occurred in other jurisdictions (see discussion by Anderson, 2000). In Amsterdam, for example, the annual incidence of HIV infection, among a cohort of injection drug users receiving methadone between 1985 and 1996, remained relatively high, in spite of ready access to needle exchange and low threshold methadone services (Langendam, van Brussel, Coutinho & van Ameijden, 1999). Anderson also notes that in New York City, rates of new HIV injections also dropped

HIV and hepatitis C (HCV) in BC

- The prevalence of HIV among Intravenous Drug Users (IDUs) is reported to be 17% to 31% in different cohorts.
- In Vancouver, HIV prevalence among Aboriginal IDUs has increased from less than 5% in the early 1990s to approximately 40% in 2004.
- The rate of HCV is higher in Vancouver than BC or Canada.
- The majority of newly identified HCV cases in Vancouver in 2005 and 2006 reported intravenous drug use as a risk factor for infection. Males exceeded females in all age groups except 15-19 & 20-24 years.

(Buxton, et al., 2007)

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dramatically, in a city whose Mayor opposed methadone maintenance programs and where needle exchange was illegal.

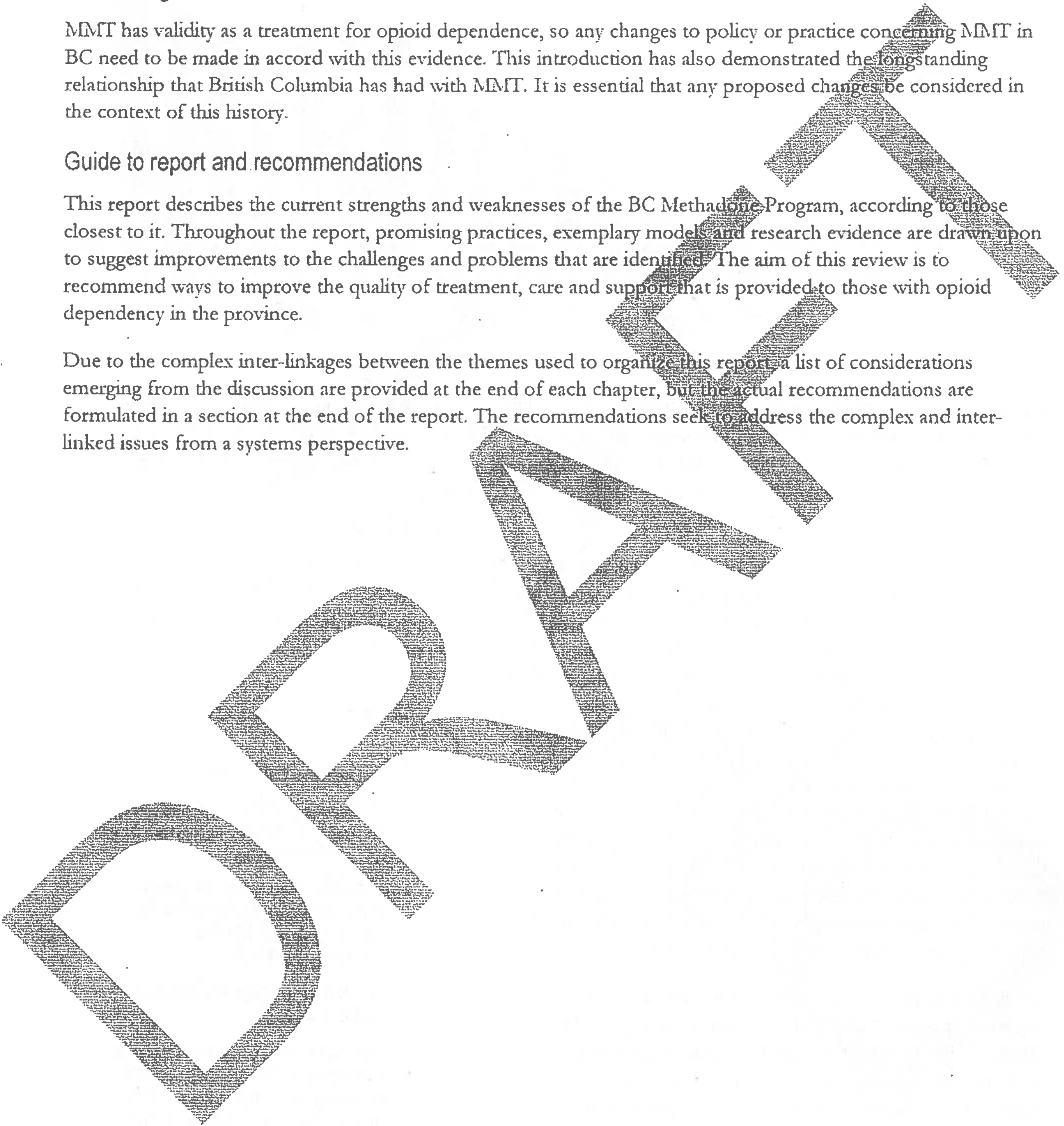
Concluding comments

MMT has validity as a treatment for opioid dependence, so any changes to policy or practice concerning MMT in BC need to be made in accord with this evidence. This introduction has also demonstrated the longstanding relationship that British Columbia has had with MMT. It is essential that any proposed changes be considered in the context of this history.

Guide to report and recommendations

This report describes the current strengths and weaknesses of the BC Methadone Program, according to those closest to it. Throughout the report, promising practices, exemplary models and research evidence are drawn upon to suggest improvements to the challenges and problems that are identified. The aim of this review is to recommend ways to improve the quality of treatment, care and support that is provided to those with opioid dependency in the province.

Due to the complex inter-linkages between the themes used to organize this report, a list of considerations emerging from the discussion are provided at the end of each chapter, but the actual recommendations are formulated in a section at the end of the report. The recommendations seek to address the complex and inter-linked issues from a systems perspective.



Chapter 1: Who Are the Clients?

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This chapter aims to provide a context for the systems review by referring to the intersectional[10] dimensions of methadone clients' often complex and challenging lives. Taking an intersectional approach can help to better understand many of the prevalent and hard to manage dynamics of working with this group of clients, such as client's continued street drug use, or the prevalence of chronic pain (Orgel & Colvin, 2008).

Complexity and diversity of client population

Clients using the BC Methadone Program were described by professional stakeholder observers as the *"most exploited and disadvantaged"* and the *"most addicted, most socially volatile, susceptible people"* in the province. They were viewed as situated *"outside of the system"* and as *"lost people."* The majority were viewed as *"challenging, complex patients," "tough to deal with," "chaotic and unstable."*

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:

> *"We have a lot of homeless methadone patients now. We didn't have very many before and now we've got lots. They come in smelling of campfire smoke: 'Where are you living?' 'In a tent down by the river.'"*

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:

> *"I have a lot of concern for this population of people who are generally also very ill, living with so much illness in their lives. HIV, Hep, diabetes and you don't have a home? You don't eat regularly but you have diabetes."*

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. s.22

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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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People with HIV and hepatitis C on MMT

"To see someone who is HIV positive, deteriorating in health and on methadone, standing in a line-up at seven a.m. outside a clinic in the rain … it's like, you know, what are we doing here? It's seven am, you're lined up in the rain, waiting for a pharmacy to open. They are really, really sick people ... Some are dying you know. And here they are, standing outside a pharmacy at 6:30 or 7:00am."

The original goals of the MMT Program's expansion were public health goals, most specifically, to mitigate the HIV epidemic located in the Downtown Eastside of Vancouver that occurred in the 1990's. While MMT has likely contributed to the decline of HIV rates in BC, many former or current injection drug users in the province, and particularly in the Downtown Eastside, are currently living with HIV and hepatitis C.

There is now a much more developed understanding of the costs of care and treatment of people with HIV and AIDS and of the importance of prevention. Likewise, there have been some favourable virologic and clinical results from interventions that formally integrate MMT with directly administered antiretroviral therapy (Altice, et al., 2004; Conway, et al., 2004; Lucas, et al., 2004). However, as Palepu, et al., (2006) note, few such integrated programs exist and achieving this integration in practice was reported to be very difficult in BC, for a number of reasons. Few clients who still use illegal drugs and are street-involved prioritize their HIV care, for example. A community pharmacist talked about the challenge clients with both substance dependence and HIV faced in adhering to their treatment:

HIV Prevalence in British Columbia

Estimated HIV+ population in BC, 2005: 12,300 (upper limit of range) Median: 10,420

Estimated HIV+ but unaware population in BC, 2005: 3321 or 27% of total HIV+ population

Estimated HIV+ population by Health Authority, 2005:

- Vancouver Coastal Health - 7380
- Fraser Health Authority - 2583
- Vancouver Island Health Authority - 1353
- Interior Health Authority - 246
- Northern Health Authority - 738

(BC Centre for Excellence for HIV/AIDS)

"They don't have this eagerness for life. They hate their life. They don't care if they are going to die from HIV. And HIV pills, it's like chemotherapy for cancer. Some people choose not to go and have a second course of chemotherapy because it's very hard. You throw up, you have pains, you are covered with rashes, your legs go numb. You are HIV positive for so long, you don't feel anything until your CD4+ counts[11] drop to a certain level where the opportunistic infections come, then you feel pain and you feel ill. Until this point, "These pills make me feel even more horrible. I'd rather not have pills in my life, because I feel more ill and sick. When I am off the HIV pills I feel better."

[11] A CD4+ count is a blood test to determine how well the immune system is working in people who have been diagnosed with HIV. The CD4+ pattern over time shows the effect of the virus on the immune system. In people infected with HIV who are not getting treated, CD4+ counts generally decrease as HIV progresses. A low CD4+ count usually indicates a weakened immune system and a higher chance of getting opportunistic infections. (Web MD, 2007).

There are also systemic problems with ensuring consistent linkage between MMT and HIV treatment. While participants described some good pharmacy support to link anti-retroviral treatment (ARV) for HIV with methadone, there are many pharmacy-related challenges to the integration of these treatments. Good pharmacist systems or practices were described as key in the process of linking methadone and ARV medications, as this participant described:

> *"Our pharmacist provides a lot of support in terms of making sure the anti-retroviral treatment is being well tolerated and being appropriately taken, along with the methadone and their other health concerns."*

The BC Centre for Excellence in HIV/AIDS oversees ARV medication in the province and will only allow these to be dispensed from a relatively small number of designated and approved pharmacies.[12] This means that clients are often accessing methadone at one pharmacy and getting their ARV medications at another. ARV treatment and MMT tend to operate in the province as separate systems and this contributes to pharmacy-related problems for MMT clients.

Sometimes related, is the issue of incentives offered by pharmacies. In Vancouver's Downtown Eastside, some pharmacies allegedly use a range of incentives to encourage clients to switch from their existing pharmacy (for a fuller discussion, see Chapter 8). To the degree that these incentives draw clients away from pharmacies where they can access both methadone and ARV medications, they tend to inhibit integrated care, and, according to physicians, they often interrupt established relationships of care.

In terms of potential integration, Vancouver's supervised injection site, operated as a partnership between Vancouver Coastal Health and the Portland Hotel Society was described as the "perfect place to have methadone and ARV's dispensed" (Vancouver Coastal Health, n.d.). Publicly funded pharmacies attached to community-based clinics that could dispense both ARV medications and methadone were also suggested.

Client experiences of past and current violence and trauma

According to some professionals, all or the majority of people with opioid dependency that they have worked with, have had a very long and early history of violence and/or complex trauma. While the literature substantiates the connections between violence, abuse, trauma and substance dependence generally, this is reported most specifically for women (Bensley, van Eenwyk & Simmons, 2000; Jantzen, Ball, Leventhal & Schottenfeld, 1998; Martin, Kilgallen, Dee, Dawson & Campbell, 1998) and for men and women with opioid dependency problems (Mate, 2008). A counsellor described the interconnections between heroin use, mental health problems and abuse in the following way:

> *"There is a sub population that, because of histories of trauma and abuse . . . isn't sure that living is a good thing. And I find a lot of people who have that experience tend to get caught up in heroin."*

A physician s.22 talked about using a new screening tool to try to identify abuse in the lives of clients and comments here on the connections he made personally between childhood abuse, Post Traumatic Stress Disorder (PTSD)and substance use:

> *"We've just started doing screening on our intake using a screening questionnaire and the amount of PTSD that is turning up that I couldn't recognize before is amazing. What is PTSD all about? It's about physical and sexual abuse in childhood. And then we get on to, 'Do you remember the first time you ever used?' and 'What did it feel like?,' and anecdotally my experience is self-medication, 'The first time I used, it was like a missing piece of the jigsaw puzzle. Click. And now I'm a*

[12] As an interesting comparison to methadone fees, the dispensing fee for HIV medication was described as *"ridiculously low,"* leading to many pharmacies not being interested in dispensing ARVs because of the lack of financial incentive.

complete person. I can feel like a normal person because I'm using.' Of course it doesn't stay that way but that [is] *the way it starts."*

Some talked about heroin specifically as a drug that allows women to self-medicate trauma, as this physician emphasizes:

"When you work with the women, you realize what it is. It's not dual diagnosis, it's not co-occurring, it's post traumatic and they're burying it and they're getting through the day with heroin. And the women in the west side who have a lot of money and who have been sexually abused as kids and are living in their expensive homes, they're doing heroin three or four times a day with clean needles and a safe supply and they're eating well and they've got a nanny looking after the kids. Heroin works for them. Not the stuff that their doctor prescribed fifteen years ago or five months ago. If you understand why people are using, then you understand that heroin works. It's the only drug that allows women to self-medicate their trauma. You can talk about all the other prescribed stuff, the Seroquel and the antidepressants, but if you talk to women, heroin is the thing that allows them to sleep and get through the day."

A number of substance use professionals described men with substance use problems as dealing with similar issues around violence and abuse as women, but with *"different levels of emotions connected to it,"* believing it to be just as important to ask men about these experiences, as women.

Connections between addictions, chronic pain and methadone

Many informants connected complex childhood and adult trauma to client experiences of chronic pain. Indeed, some health professionals suggested that chronic pain should be considered a *"co-morbid condition"* for people with substance use problems, similar to the co-occurrence of mental or physical health problems.[13] One participant commented on the importance of making these links when working with Aboriginal women, in particular:

"We know from the literature that a high number of these clients, and in the case of my work, all clients, every single one, has had a very long and early history of complex trauma. This is very important because we know that complex trauma is also related very much to chronic pain, and it's very real."

Due to a growing concern that opioid medications are being over-prescribed, over used and diverted into a black market, many health care providers are becoming more cautious about prescribing them. Prescription opioid medications were especially noted to be a growing problem in smaller towns, away from the coast and in rural parts of BC, where heroin was less available:

"These days I'm seeing a different population. I'm seeing a younger population, they may be other opioid dependent, say Oxycodone or prescription drug dependent."

For some physicians, this has led to greater caution in the prescribing of opioid medications. According to some observers, this caution was felt most acutely in the Downtown Eastside of Vancouver, with participants reporting implications for the pain management of people who use health care services in that neighbourhood. People on

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[13] Estimates suggest that 15-28% of substance misuse disorders have co-morbid chronic pain (Orgel and Colvin, 2008).

Health service providers with expertise in chronic pain management described the co-management of chronic pain and addictions as *"one of the ultimate challenges"* of medicine and health care, but described the dominant view amongst many health professionals as, *"we do not need to treat people on methadone for pain."* Some observers viewed inappropriate or inadequate pain management as a human rights violation.[14]

Promising examples

Stakeholders stressed that BC needs to dramatically "ramp up" the capacity for services to respond more effectively to the range of health and social care problems described in this chapter. In particular, integrated services critical to addressing complex needs were reported to be rare.

There are, however, a number of excellent examples of services that are currently working to achieve better integration between health and social care systems, to "join up" care, and to improve treatment outcomes and quality of life for their clients. [15]

AIDS Vancouver Island

AIDS Vancouver Island is a community-based AIDS service organization that provides comprehensive prevention programs (including education, support and advocacy) and integrated services for individuals with HIV/AIDS, hepatitis C, tuberculosis and other communicable diseases. In Victoria, Street Outreach Services provide services for people who use drugs by injection. AIDS Vancouver Island has managed the country's oldest needle exchange program since 1988. Primarily through volunteers and community partnerships they target and educate difficult-to-reach populations (AIDS Vancouver Island, 2007).

Programs in the Downtown Eastside of Vancouver

Sheway provides comprehensive health and social services to pregnant women and women parenting children less than 18 months old, who are experiencing current or previous issues with substance use. The program uses a client and woman-centered philosophy of care.

Vancouver Positive Outlook Program, provides nursing care, ARV medications, counselling for substance use, support for housing, advocacy, outreach visits, hospital visits and case management for people who have HIV or AIDS.

The Maka Project is a community-based research partnership between the BC Centre for Excellence in HIV/AIDS and WISH Drop-In Centre Society focused on increasing access to HIV prevention, treatment and care among women in survival sex work. The project aims to explore health-related harms and the impact of current harm reduction and HIV prevention strategies among women in survival sex work in an effort to inform evidence-based policy and practice tailored to women. A primary component of Maka is community capacity-building by engaging and supporting a team of experiential women (women with a lived experience of sex work and addiction) who have been hired to play an active role in all aspects of the project.

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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[14] The management of chronic pain as a human rights issue is emerging in the global literature on chronic pain management, but the ability of people living with both chronic pain and addictions in poor neighbourhoods such as the Downtown Eastside of Vancouver to draw on such discourses is likely to be limited. See Bell and Salmon (2009) for a full discussion of this issue.

[15] In addition to the examples discussed below, the following were cited as exceptions to the norm: Victoria Sexual Assault Centre, Aboriginal residential treatment centres and Maxxine Wright Community Health Centre.

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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

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Chapter 2: Professional Roles and Models

This chapter describes the professional roles involved in MMT and the dominant service models that have emerged across the province. The issues pertaining to private methadone clinics are so complex that this model is described separately in the following chapter. The different models in BC impact the themes of access, retention, quality, effectiveness and inequalities in a variety of ways.

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. Many MMT clients saw picking up their prescription, or doing their daily witnessed ingestion at community pharmacies as important in enabling them to integrate methadone in their daily lives:

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To access MMT, clients need to be able to access a pharmacy that dispenses methadone, as well as a physician that can give them prescriptions. The pharmacist's role includes client engagement and ongoing communication with the client as set out in the *Pharmacy Methadone Maintenance Guide*:

> A unique opportunity to have an on-going dialogue occurs with daily methadone dispensing. Daily patient interaction requires innovative counselling. General product and procedural information are usually discussed while dispensing the first prescription. Pharmacists are required to have a brief conversation with the patient after they drink their methadone dose to ensure they swallowed the dose. This provides an opportunity to emphasize the benefits of methadone treatment and provide support for the patient. At the same time a discussion about the patient's treatment goals, compliance, adverse effects, and lifestyle choices can occur. By initiating dialogue with your patient you can have a positive impact on their treatment (CPBC, 2007, p. 8).

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.

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- 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. Professional and clinical judgment was reported to be important for pharmacists because of the complexity of their role. A number of pharmacists stated that they enjoyed being involved in the MMT program – that it was a complex but nonetheless rewarding part of their very varied role. One rural pharmacist describes the complexity and challenge and his enjoyment of the role here:

> *"I do enjoy it … with addiction it's not an easy fix. I've been doing it for years, at one time we were the only methadone dispensing pharmacy in town. You get some pretty creative stories. At the same time you have to realize that it's part of the addiction so you have to sort through it and try and give them a leg up each time. If you took every story that came in you'd get pretty cynical but at the same time if you realize it's part of the process, that one day they might turn around and make the decision to change … I enjoy it. It's a challenge for sure. One of the major things that other pharmacists have told me, stereotypically, 'Wow, you don't want those type of people in the store. They're bad. When they're under the influence or if they're not well kept, they could scare away other customers.' And there's been situations where maybe some people had felt uncomfortable but at the same time it doesn't matter. Those situations arise with any illness … I realize that there's those type of challenges. You're setting yourself up for more of them with the program, but that's part of the enjoyment of it too. One day someone might change. When somebody goes off it or starts going down on a dose and they're doing well … I guess you take it a little bit personally. You really like to see them succeed. It's just part of the roller coaster. The number of people that have come off it the years I've been doing it. The number of people that maintain jobs or not been exposed to hep C or AIDS or other risk factors and they're still very functioning members of the community too. That's a success as well".*

Some pharmacists spoke about not enjoying the *"policing role"* they had, or *"being treated like a dealer."* Their role is not an easy one, in many respects, because they often feel that they are uncomfortably located: *"in the middle,"* between a client and their prescribing physician.

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

CPSBC includes counselling as a key component of MMT in their guidelines. Addictions counsellors are involved in many different ways across the different models and settings where MMT is provided (see next section for descriptions of these models). 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. Some respondents felt that counsellors were, in fact, better placed to do social history and addictions speciality work. Counsellors often worked closely with physicians, as this counsellor describes:

> *"I am a go between for clients, for potential clients. I am a voice for the local clients with the methadone doctors. We work out of different offices, he works out of a family practice and I am employed by a counselling agency. We communicate over the*

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phone. We have meetings, usually once a year. And we communicate by faxing back monthly reports on clients and client progress, and client challenges."

There was a wide range of counselling experience, expertise and qualification status (particularly in private clinics). This ranged from peer counsellors and those with no formal qualifications to counsellors with a Masters in Counselling Psychology. Some counsellors described being excluded from decision-making in work with clients, despite feeling qualified to provide valuable inputs, as this counsellor describes:

"I'm a qualified drug counsellor but that's all I am and that doesn't go very far up the totem pole here, particularly in terms of clinical stuff and doctors go immediately 'whoa, that guy shouldn't be anywhere near clinical decision-making. He should just be counselling patients.'"

While most private methadone clinics employ counselling staff, they are often *"thin on the ground."* Group counselling sessions are sometimes provided, but these are rare and often short-lived, reportedly due to poor attendance. In office-based physician prescribing, physicians sometimes provide and fund part-time counsellors. Where they were available, counsellors were viewed as being able to offer time for clients when doctor's appointments were very time limited. This was one of many positive elements of counselling being offered as part of MMT. Many clients spoke about the positive impact their counsellor or counselling had had on their health, wellbeing or recovery journey. A client from Interior BC spoke about the way that counselling had positively impacted his experience of MMT:

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Methadone Maintenance Handbook:

Methadone programs should be more than a simple dispensing of methadone prescriptions: they should incorporate a comprehensive biopsychosocial and spiritual approach to help patients cope with their problems.

When counselling is integrated into methadone maintenance programs, there are significant reductions in drug use. It is important for methadone prescribers not to adopt the perception that counselling is a task to be taken on exclusively by other staff or caregivers...

Depending on each patient's circumstances, physicians may opt to work in collaboration with counsellors, or may refer patients to independent counselling agencies or self-help groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). Many other specialized resources may be available to aid methadone patients.

(CPSBC, 2009, pp. 22-23.)

Client case load varied between settings, but was generally viewed to be far too high (e.g. calculated as over 250 clients per counsellor in one setting described). It was noted that there is still a stigma attached to receiving counselling, which may affect clients' willingness to attend.

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. Some physicians were adamant that counselling needed to be an integral part of MMT for all their clients:

"I have to be fairly assertive about the fact that you have to go through counselling because we need you to understand a lot more than you do understand about your illness and if you don't do this, then I can't; this is part of the program."

Other physicians were less convinced that counselling should be compulsory and felt it should be an individual choice, or was better suited for some clients than others.

> *"It's an evolving balance. I think that it works for some people and it's not appropriate for other people. So I don't think it should be a rigid rule where you say, 'Look, I'm not going to see you unless you see a counsellor,' for example. But I think that some people, you know, if you don't ask anything of them, they won't do anything."*

While most physicians did encourage counselling of some form, many felt that intensive therapy may not necessarily be the most important intervention for a person who is trying to go drug free and that *"support and encouragement that they're on the right track,"* may be more welcomed and useful for preventing relapse or facilitating stabilization. Also employment, education and training support, or parenting support, was reported to be very important, sometimes more relevant to people depending on their stage in their recovery journey. Overall, despite this variety of opinion, most participants reported the view that there was not enough counselling offered to MMT clients.

In terms of counselling models used, abstinence based counselling was reported to be the dominant model in BC, certainly outside of MMT services. Some MMT specific counselling was also described as abstinence based. The impact of this on clients, when provided either outside or inside of methadone services, was sometimes a *"paradigm-clash"* between models of abstinence and harm reduction. One counsellor, for example, spoke about experiencing frustration in his work with methadone clients because:

s.22

One methadone client described the difference in approach between himself and his counsellor:

s.22

In terms of counselling models that were viewed as more helpful to clients, approaches that considered the person in their specific life context, came from a harm reduction rather than abstinence base, and were non-judgmental, supportive and compassionate, were noted.

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:

> *"It would be nice to have a social worker on the team, now all of us are doing social work."*

A lack of low-income housing was reported to be creating health problems for many people, including those with mental health and addiction problems. Housing was reported to be a major problem for people with problematic substance use. In particular, the short supply of quality recovery houses that provide longer term support was noted. Unregulated recovery houses were reported by many participants to be a substantial problem. Semi-independent living program workers were in place in some Health Authorities to help client's access housing and income assistance. These workers gain client trust, meet clients wherever they feel safe, and use strategies to bridge the gap between a person's culture and health services. New investment for housing and housing support was viewed as a priority.

Many respondents suggested that ideally support to access adequate and safe housing would be built into the MMT programme through social work or other workers with a broader social remit. Because of the extent of the housing shortage or inadequate/unsafe housing reported to be negatively impacting the lives of MMT clients, a Housing First approach was suggested by some respondents. In this model, housing and addictions/mental health support are provided concurrently. This was not a suggestion that access to housing be tied to MMT but that housing is an essential aspect to health, wellbeing and recovery from addictions.

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Case management and outreach

Case management is used in some MMT services, but the term refers to different roles and activities in different places. It was commonly used as a catch-all term to describe *"trying to meet all the needs of clients,"* for example, their housing, outreach and advocacy needs, rather than a more defined role that would be understood by reading literature on case management interventions.[17] *"Loose"* case management was viewed as an important intervention with this population of clients, but providers spoke about doing case management *"by default,"* given it was not necessarily an area of their expertise. Ideally, participants wanted to see clients engaged at the front end of their MMT, be assessed regularly, and have individualized care plans developed by a case manager. Case managers were seen to be most important for clients that frequently moved between corrections settings, or between hospital and community settings, or potentially also for Aboriginal people moving between reserve and off-reserve communities, where gaps in continuity of care could be most problematic.

Doing advocacy and outreach to connect people to treatment was viewed as a vital component of effective MMT services, but these were infrequently provided. There were, however, a few examples of creative and innovative practice where health care professionals were providing outreach services as part of their roles, with considerable benefit to people taking methadone. In the Kootenay area of BC, for example, a mental health outreach worker was enabling MMT access for clients in the mental health service by facilitating transportation to a physician in a neighbouring town some distance away.

Administrative support and security

Medical Office Assistants play an important role for a well-operating MMT service, as they have a large impact on clients' access to and experience of care. They are used extensively by physicians and clinics to help with phone calls, paperwork, scheduling of appointments, talking to pharmacies and urine screen laboratories, and the coordination of client files. Some are also involved in urine drug screening. The need for training on MMT for administrative staff was viewed as essential. Participants reported that non-clinical staff often provide the main source of support for clients because they had built a rapport:

> *"People need a lot of chatting but doctors are not the ones to do that."*

Security guards are on staff in some methadone clinics and community health centres, and their role is to deal with crowds, and sometimes *"watch people pee."* On the other hand, one service reported that they had

> *"fired security guards because they improved their systems so security guards were no longer necessary."*

Models of MMT in BC

There are three main models of MMT in BC: the general practitioner/family physician models, integrated models and private sector models. The rest of this chapter will profile the first two of these, and the next chapter will describe the private sector models.

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."

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the benefits of comprehensive care. The GP model may be particularly good for certain patients, for example those who were more stable, or for people in Northern, rural or remote areas of BC:

> *"I like the GP model, I think it works well, it allows for much better integration of care especially with these multi-problemed patients with AIDS and hepatitis and everything else. Methadone should just be part of that. It shouldn't just be some little island off in left field."*

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.

Leaving methadone provision to the discretion of individual family physicians[18] means that some communities do not have any access to methadone services at all. Where it is available prescribing physicians often report being taxed and overburdened. Overall client load is often not shared equally, with some GPs taking an active interest and attracting hundreds of clients, and the majority of physicians in BC being unlicensed. Vancouver Island, for example, has challenges where prescribing physicians outside of Victoria are few and far between. For those few family physicians providing MMT most tend to also meet their clients' primary care needs, and sometimes also their public health needs, at the same time:

> *"It's not integrated in a meaningful way into family medicine, except where you have family doctors who know the evidence. Dr. J is a doctor who strives to make sure that his methadone patients feel like they're there for all their health care needs, that it's not just about the methadone treatment, it's about all the other physical problems that they may have."*

Given that GPs in smaller communities may not be able to refer clients to health authority funded counselling and support services due to a lack of local and appropriate services (e.g., where abstinence-based counselling is the only counselling available), they may have to choose between either providing these services themselves by hiring a counsellor (as per Qualicum Beach Surgery, Vancouver Island), or having clients unsupported in this way. Few GPs appear to have the time, expertise or inclination to provide counselling services to people prescribed methadone, especially given they cannot straightforwardly bill extra for this service (see Chapter 4 on reimbursement for physicians).

Many family physicians recounted that they provide methadone prescriptions alone without the wider package of supports that many felt were needed. There was a sense that there was still "much to do" in supporting physicians to provide counselling and psychosocial supports. Sometimes individual physicians or practices were well connected, through referral patterns, to local Mental Health and Addictions teams. However, many doctors may not necessarily know how to link people up with supports effectively. A lack of integration was noted to be a large problem for the methadone program in general, with many participants reporting their belief that there is no methadone "program" as such, because of its fragmented and disorganized nature.

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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[18] Physicians are able to "opt into" MMT because of the need for a special exemption under the *Controlled Drugs and Substances Act.*

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.

The one-stop-shop nature of CHCs, with their multiple services, was viewed by many participants as an ideal model for MMT. Some participants expressed the view that Vancouver Coastal Health had done a good job at implementing integrated MMT through primary care provision in CHCs. Vancouver Coastal Health managers described using an approach where physicians were not responsible for the entire methadone service, but where a multi-disciplinary team was the foundation for care. Other participants were more critical and reported being less convinced that the CHC model had the capacity to deal with the volume of need in their local communities:

> *"Those clinics were part of a massive redesign of primary care in the Downtown Eastside that was supposed to be barrier-free. Let's be multi-disciplinary, let's bring services to people where they're at. However,* [we've ended] *up with these very dehumanizing cattle calls where people are lining up outdoors with a number that they can't leave from."*

Some people reported that the CHCs were over-stretched and there was no guarantee of the quality of health care they were able to provide. The VANDU Women CARE study (2009) reported that women living in the Downtown Eastside experienced some CHCs as providing a poor level of care for their needs, for example in experiencing long wait times and *"dehumanizing"* waiting processes.

Not-for-profit

Some not-for-profit organizations run comprehensive health clinics where physician services are integrated with other supports, such as nursing, case management and counselling. Vancouver Native Health and the Portland Hotel Society both provide comprehensive primary care services to people living in the Downtown Eastside of Vancouver. Many participants felt that the not-for-profit model was a very successful model for MMT:

> *"If I had to signal out places where the patients get the best care, it is not-for-profit clinics. These clinics provide a structure where patients receive excellent medical care."*

A number of people felt that this model should be rolled out more widely across the province. Sheway, in the Downtown Eastside, was one example of comprehensive health provision for pregnant and parenting women where a "wraparound" service was evident:

> *"Doctors prescribing methadone at Sheway are doing so in a context of a wraparound, interdisciplinary working where people sit down collectively and make decisions."*

AIDS Vancouver Island offers people with HIV/AIDS health care and support with an onsite physician, counsellor, nurse, HIV specialist, and welfare and disability support person. A key issue identified as critical for MMT in the not-for-profit sector was sessional funding for physicians:

> *"These community outreach clinics are based on a sessional remuneration model and therefore are only about offering an interface between patients and physicians who have no other incentive but to just practice good medicine, offer the best treatment for these patients."*

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Mental Health and Addiction Services
All Health Authorities have developed some level of integration of MMT in their work, but this varies considerably across the province. Some Health Authorities integrate MMT into primary and comprehensive care; others are planning more integration between MMT and public health, addictions and harm reduction services. One model that has been developed, in both Interior and Northern BC, is the teaming up of local prescribing physicians with mental health and addiction services.

In these hybrid or integrated models, case management and administrative support is provided by the mental health and addiction outpatient office. Access to a range of individual and group counselling and support services is facilitated for people taking methadone who are well integrated to avoid them being *"ghettoized."* The physicians involved with this model report finding it very attractive, as it gives them the support they feel they require, uses their expertise in an efficient way, and keeps a separation between their methadone work and other physician activities.[19] While this model has not had the desired effect of getting physicians to take clients back to their private practices, it has offered a new model of MMT that seems capable of joining up some of the gaps in service that other models suffer from. More will be said about the involvement of health authorities, including the potential for increased health authority involvement in MMT, in Chapter 5.

MMT in Fort St John, s.22

"We treat the person as a person. Active encouragement and support for clients and collaboration with other agencies are the foundation of our service. Within the first week of clients being involved with us we try to make sure they have a place to stay, that their medication cost is covered and that they have food. If they need medical follow up we make sure they have booked doctor's appointments and ensure immunizations are up to date. We have addictions counsellors available and Supported Independent Living Workers to take clients to appointments if needed. We have done collaborative outreach education work with Fort St. John emergency and Fort St. John medical/surgical ward to try to help them feel more comfortable dealing with people on MMT. We have also noticed, perhaps because of this support, there have been an increasing number of referrals from family physicians."

The "Kelowna Model"

One innovation designed to increase physician support and retention has occurred in Kelowna where Health Authority managers work with prescribing physicians to address MMT issues in their local area and provide support for physicians. MMT is provided through a local Mental Health and Addictions Outreach Clinic. Interior Health covers the cost of participating in the licensing training as well as other relevant training events including travel costs, in the recognition that getting a MMT license, and keeping up to date with current research and best practice, is a shared goal between the Health Authority and physicians. Quarterly dinner meetings provide opportunities to discuss emerging practice, quality, retention, and recruitment and access issues, in order to further expand and develop local MMT work. The physicians currently working within this arrangement report feeling better supported and valued and the Okanagan is moving ahead well with physician recruitment.

Toward recommendations

While there are many different professionals involved in MMT in BC, inter-disciplinary or multi-disciplinary working is less frequent than might be imagined. The majority of MMT work is done by prescribing physicians and dispensing pharmacists. While nurses, counsellors and social workers are important to MMT provision, their

[19] A number of physicians emphasized that while they were keen to run a methadone service from their clinic, their partner physicians did not allow them to. Individual prescribing physicians often do not have the power to make these decisions alone and a wider stigma against methadone and methadone clients can put practice partners off including this service.

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roles differ widely between MMT models and across the province. Many of the emerging models provide considerable potential for greater multi-disciplinary working in MMT in BC.

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

- Greater involvement of multi-disciplinary teams may improve the efficiency and effectiveness of MMT services while ensuring that professionals are appropriately supported
- While no single model is likely to be universally applicable, effort must be given to ensure the model used does not perpetuate stigma and marginalization
- New integrated models appear to have the greatest potential to meet the needs of clients and communities

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Chapter 3: Private Methadone Clinics

"We'd better be careful because the private clinics are basically right now the only thing that's keeping the methadone program from sinking. If you close those down today, you'd have a huge deficiency in methadone care."

Private methadone clinics deserve a separate chapter for three main reasons. First, the private clinic system is reported to provide the majority of treatment spots in the Lower Mainland.[20] Second, many participants had strong views about this model of MMT. Third, the private clinic model is very complex. The details are important to comprehend in order to effectively understand the MMT system in BC.

Definition, background, clients and access

"The very fact that there are so many successful privately run for-profit clinics tells us that there is a huge demand, unmet demand."

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] Some of the other reported differences are not so robust because there are variations and anomalies. For example, the private clinics tend to charge fees whose payments are commonly shared between methadone clients and, if eligible, the Ministry of Housing and Social Development (MHSD). However, some private clinics now waive user fees and require physicians to contribute more of their Medical Services Plan (MSP) earnings to cover clinic overheads. Also, GPs working from their office-based practices sometimes charge user fees and claim MHSD funding to pay for the counselling or case management part of a client's treatment (non-insured health benefits that are deemed best practice in methadone delivery but are currently not covered by MSP).

Private methadone clinics began in the 1970s, when government retreated from methadone provision after the human rights challenge to compulsory heroin treatment using methadone. According to interviewees who had watched the development of the BC Methadone Program for a number of decades, some of the clinics were started by people who came out of the government run clinics and *"knew the ropes."* Some respondents held the view that the main motive for starting the private clinics was a financial incentive. However, other reasons, such as a desire to ensure that the needs of people were being met when the public system pulled out, were also viewed as factors:

"they saw a need in the community, I may be wrong, I have only been with one clinic, but there was a need and it has continued to grow ... It is a service that is obviously needed."

Private clinics can be large enterprises. One company has over 1500 clients served by their clinics. Clinics are commonly strategically placed in population-dense areas. While almost all private clinics are located in the Vancouver Coastal or Fraser regions, there are two in Victoria. There is a history of private clinic involvement in the Interior, but there are now no private clinics in the Interior or Northern Health regions. A physician prescribing within VCH and the private sector described the private clinic model and how its development may be contrary to the initial vision for methadone provision in BC:

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[20] This is impossible to validate because no records are currently kept that indicate how many clients use the different models of service provision for MMT.

[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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"Initially the vision was for a limit on the number of methadone clients that each particular physician would be able to monitor and prescribe for. It was hoped that most family physicians and general practitioners would be treating methadone clients within their practices as part of their overall care. Well that largely hasn't happened. What we have now are physicians who dedicate a particular portion of their week's work to prescribing nothing but methadone. We have a lot of private clinics now in operation. Some are run very well, some are run not so well. Especially where the concentration of methadone clients are, we have very few family docs who are part of that initial vision of what methadone was about."

This comment suggests the initial desire was for methadone to be part of a comprehensive primary care model. The needs of people with substance dependence would be met through a predominantly GP office-based model. This report touches on a number of factors that appear to have disrupted this initial vision for MMT in BC (see particularly Chapter 9).

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. There was suggestion that some physicians may want to supplement their income by seeing methadone clients through the private clinic system, as income gained by prescribing to large numbers of clients in private methadone clinics was described as *"lucrative."* Having said this, a few participants also described the difficulties clinics have had experienced in attracting MMT physicians: *"getting physicians to come to our clinic is not easy. There's not many out there that want to."*

Due to different health authority policies and practices in providing services to treat substance dependence, there are inequities. Some MMT clients are required to pay for their treatment and others are not, depending on the presence or absence of CHCs. For example, in Fraser Health, where treatment spots for methadone within CHCs and GP offices are small in number for the population served, clients at all stages of need and stability have little choice. Private clinics were therefore viewed by many participants as *"mopping up"* client demand when clients were not able to access local not-for-profit, GP or CHC services.

In fact, there appears to be a substantial crossover between the private and public sector services where both are available. Public clinics were reported to be directing clients to private clinics when they had no treatment spots for methadone, and private clinics were described as referring more *"challenging"* patients to public clinics where these were available. The fact that there are so many privately-run clinics seems to indicate a huge unmet demand for methadone services within the public service system.

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. In some clinics, management is described as being available 24 hours, 7 days a week, 360 days of the year to cover for emergencies. The larger clinics tend to be open most week days but the newer and smaller clinics may only be open one or two days a week or part days. Some clinics offer late opening hours to provide access for clients who are working. Client intake is usually done by support staff, counsellors or nurses prior to physician appointments that involve a physical examination and the development of a treatment plan.

Positive views on private clinics

While there were many criticisms of private clinics a number of participants stressed that there were large differences between the private clinics and yet *"all the private clinics seem to be painted with the same brush now."* A number of clients talked about the support given at some clinics very positively:

> *"I felt the caring when I first started and to me it's still there: caring of the client and trying to help the clients make changes."*

s.22

> *"This is a good clinic."*

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. One counsellor stated:

> *"the client-centred to me comes from being that client, from that understanding of somebody on the other side. The methadone program is sort of my life in a way because it has really given me my life ... Just having that person that has changed their life involved in the program is a big benefit to clients. Anybody that has changed their life is going to be a guide to the next person, is going to give the next person hope ... they look at it and know they can do it ... When you are talking to a person and they find out, it's as though there's a light that comes on in their eyes. It's like they listen more. That's the biggest gift of my profession, when something changes, when they understand that something can change, there's something in their eyes, it's like something clicks. Those are the moment ... that's what we should work towards."*

Main criticisms of private methadone clinics in BC

Six main criticisms were raised concerning the private clinics by study participants.

Methadone provided outside of comprehensive primary care

> *"The biggest travesty I see is that I'm getting patients going to private clinics and they are there for dispensing methadone, they're not there to look after anything else. You have people with the biggest IV lacerations in the world, they're just an absolute mess and if the physician looks after their medical needs, it's only out of his [22] compassion, but he's not getting paid for that. He's just there for the methadone. How can you divorce it? It's madness."*

Many commentators conveyed their unhappiness with the fact that methadone is often provided separately from comprehensive primary and public health interventions. This was seen to be a *"missed opportunity,"* because of the associated health needs many MMT clients have. Clients coming to services in private methadone clinics to get care for their opioid dependency were, in the majority of occasions, unable to receive any other care:

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[22] Female methadone physicians are rare enough in the BC Methadone program as a whole, but especially rare in the private sector.

"She's got medical issues that would keep me as her personal physician for the rest of my life."

"I know a lot of the clients would have liked that extra piece to it where the doctor would have not only been his or her methadone doctor but also his or her family doctor."

Some private methadone clinic operators suggest that a number of them are working much more proactively than these comments suggest. For example, a nurse in a private clinic talked about her frustrations with the missed opportunities she was witnessing:

"You've got the clients coming to this clinic. Right off the bat, you've got them in the door, you can start addressing some of their health needs the potential to actually make some changes on a grand scale if there. We are just getting them in the door but there isn't the funding to do it. In terms of the lifestyle, most of them are hep C positive and those kinds of things aren't addressed within our clinic on a big scale … We try our best because I believe you have to, we have to try to address other issues when we can and we look at gathering as many community resources as we can and trying to direct people."

As with most of the issues in the review, the views were polarized and reflect the views of divergent providers and commentators in the MMT system in BC. That said, one physician working in the private clinic system stated that more multi-disciplinary provision within such clinics would be a good thing:

"The idea of having primary care, methadone and ancillary services all under one roof is definitely the best way to be treating this population … this idea that they just show up in this one place and everything's available to them where they are ready to accept it. It may be expensive but it's got to be the ideal because they're such marginalized people. There's a few that I have that do have family doctors and have jobs and that's great, it's nice progress, but it's not the majority by any means … I've come to realize that there are much better models to do a lot of things that we do."

Some physicians prescribing methadone in private clinics spoke about clients frequently bringing up another health problem in their methadone appointments. Clinic managers, and some physicians, reported that practice in this regard varied between physicians with some being more comfortable than others in attending to wider health issues.

Restrictions on physician billing from MSP was seen to add to this fragmentation of care (see Chapter 4). Some observers stated that whatever the major drivers, some private clinic physicians were liable to become

"very focused on putting limits on how much they're going to engage with their patients."

In geographical areas of BC where methadone is really only available through the private clinic model (e.g., Fraser Health region and some areas of Vancouver), this means that clients are highly likely to be receiving methadone in isolation from other health services.

Lack of clear minimum standards of care

The variability in quality of care was a major area of concern for many participants, and the private clinics were perceived by many to be most vulnerable to such problems. Reports from participants both inside and outside of the private sector indicated that a range of different practices takes place at clinics. So while the private sector clinics are often perceived as a whole, this is not an accurate way to understand or present these services.

Some participants felt that many of the clinics do a *"decent job"* with the resources they have or even cited *"very reputable private clinics"* for MMT in BC. On the other hand, a comment at a focus group involving people taking methadone in the Downtown Eastside of Vancouver provides a counterpoint:

"Privatization is going into the hands of a lot of the wrong people. These clinics are filthy. We're treated like second-class … No doctor's office that I've ever been in has looked like that. The way they treat us … we're not deserving of a clean clinic.

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There's no toilet paper. These places are disgusting and so are the pharmacies where you take your juice. I don't think that any of us deserve to be treated that way."

While such comments were most often made relative to private clinics, similar comments reflecting a concern about quality and standards of care were common when discussing any of the service models or components, particularly in contexts like the Downtown Eastside. This connects with stigma and discrimination which is a theme left to the end of this report but which percolated through the whole of the review in a myriad of ways.[23]

In particular, participants expressed the view that private methadone clinics should be required to provide more information (e.g., what physicians work in the clinic, how many clients these physicians have, how many different clinics physicians work across, physician caseloads, counsellor caseloads). That said, it must be stressed that no model currently providing MMT in BC is required to provide this level of information to the public. In fact, this lack of information on quality or standards of care makes it impossible to accurately compare the private clinics to other treatment models.

Psychosocial supports and counselling

Another of the main criticisms of private methadone clinics was the lack of standards regarding the presence or absence of qualified counsellors to offer psychosocial support to clients, in addition to the prescriptions they receive from the physicians. Indeed, there are no clear guidelines on what qualifies as counselling in the MMT program, no way to ensure that there is a qualified counsellor, or that patients who are paying fees or having MHSD contribute to their fees are even receiving any counselling.
point:

s.22

A physician lead is more pointed about the lack of counselling provided:

"What I learned in the private clinics is there really is no counselling. In the other programs it's very limited, more or less some kind of case management, it's not really systematic psychosocial intervention."

There are no guidelines or regulations on client-to-counsellor ratios, the frequency that patients should be seen for psychosocial interventions, or the qualifications needed to work as a counsellor. There was concern expressed by some counsellors concerning the number of people in the private sector who were in the role of counsellor but who were, to their eyes, *"unqualified."* "Unqualified" in this sense meant not having a certificate, diploma or Masters Degree in counselling. Counsellors themselves wanted better counsellor-to-client ratios, better pay and clearer job descriptions to inform their work. A physician prescribing in one of the private clinics describes a difficult situation concerning a conflict of interest for a member of clinic staff:

"We are in a difficult situation right now, our social worker/ counsellor is also having to be the manager which doesn't work very well because now she is in a dual role of trying to help these people with counselling at the same time having to chase them for their fees."

These issues regarding counselling standards are not unique to private clinics. Similar concerns were raised with respect to GP office-based services. They were raised most repeatedly with reference to private clinics, in part,

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[23] This theme of being treated as second class citizens and suffering long waiting times and poor environments of care was also a central finding of the VANDU Women CARE study (2009) where women in the Downtown Eastside were commenting on the full range of health care services they accessed in that neighbourhood.

because the clinics most often claim to provide counselling and charge for those services. The lack of counselling standards within the MMT program is exacerbated by the fact that counselling is not a regulated profession in BC.

Lack of regulation and accountability

Participants were concerned that there were *"no checks and balances"* or standards, regulations or quality control in place for the private clinics. The arms-length relationship between physicians and the clinics was raised as a particular weakness by some respondents:

> *"There is no accountability by the methadone clinics out there. It seems that anybody can open a clinic. You go to the physicians and they say, 'I'm just renting the space in here. I just have my patients.'"*

There was a sense from participants that practices in private clinics were: *"invisible"* to outsiders, which was considered to be very problematic given the vulnerability of the client group.

All participants agreed that there needed to be increased regulation and review from a governing body, but views differed widely on what and who this should involve. One participant felt that the issue was the reluctance that all regulatory bodies had in taking responsibility for MMT in BC:

> *"So the issue is not one of creating anther body. The issue is getting the bodies that currently exist to take the responsibility to act on the information that's available".*

Another central theme of discussion in regard to regulation and accountability was the role health authorities should have, given their lead role for addiction services across the province. A considerable number of participants wanted to see health authorities have more involvement in MMT, including having regulatory authority over the private clinics. Some participants viewed health authorities as being best placed to set common standards in MMT, for example:

> *"I think that this health authority should initiate some of those changes and, in discussion with other health authorities, get an agreement that we would all uniformly apply a set of rules to how we provide services to clients on methadone. But even more importantly, have a system built that is legitimate, because I have a real thing about legitimacy and regulations in providing services."*

Some participants suggested that health authorities should *"buy out"* the private clinics because of the public health nature of the task and the complexity of the health care needs of the clients:

> *"I think the health authorities should buy them out. If there's a group of people that require methadone maintenance, there's a high probability they have complex health problems overall so what they really need is comprehensive care."*

Other people suggested that private clinics should stay as separate businesses but that the clinic fees should be billed through the health authorities with a centralised revenue stream from government. One participant describes the accountability levers that this may provide in making quality improvements:

> *"An option would be for MEA* [now Ministry for Housing and Social Development] *to stop funding the clinics directly and rather for MEA to direct that money through the health authorities to the clinics or for MEA to transfer it to the Ministry of Health, and for the Ministry of Health to fund it. In some way, to use access to that revenue stream as a lever to make the clinics accountable to the health authorities. The health authorities ought to have the clinical expertise to set up accountability levers tied to funding that relate to quality of care. Because the challenge in Canada now, not everywhere, not uniformly, but especially in bigger cities in BC and Ontario, is about quality of methadone care, as opposed to access to care. There still are people who need methadone and can't get it, but the access is not as big a problem as it was 10 years ago. So we need to figure out ways of having quality of care structure."*

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Other participants did not agree that health authorities should have more power and control with MMT, largely because they felt that their particular health authority, or health authorities in general, had not demonstrated effective leadership with addictions per se.

Increasing the regulatory framework was suggested by some participants as a way for good quality clinics to increase their revenue, while making poor quality clinics change their model of working. Indeed, the *"reputable"* clinics were described as likely to welcome audits and standard checks because it would give them the credibility that they currently lack. However, building in regulation was described by some participants to be potentially very controversial. There was also a reported view that *"we can't impose regulations that will stop them from providing services, this would lead to addicted people on the streets."* In particular, there was sensitivity about increased regulation leading to increased costs. It was felt this would result in resistance from private clinic operators, as this physician commented:

> *"There would be a lot resistance from the clinic operators unless they could have some type of assurance that their revenue stream wouldn't stop. And then building in some type of accountability structure into their contracts if it demanded a lot of expenses from them that they're not currently incurring."*

No regulatory body has clear responsibility to monitor or evaluate standards in the private clinics per se. CPSBC only has responsibility to monitor *physicians* who work in private clinics. Even though the *Methadone Maintenance Handbook* recommends a comprehensive biopsychosocial and spiritual approach and suggests various partnership or referral arrangements (CPSBC, 2009, p.22-23), CPSBC does not take responsibility to monitor these relationships or the services provided.

Continuity of care concerns

Some private clinics have been in existence for over twenty years but others are reportedly only open for a few months and then close. This is partly due to the need for a critical mass of patients for the clinics to be able to make a profit and sometimes this critical mass just does not exist, or is slow to develop. Of concern to participants were examples of private clinics sometimes closing overnight, with no notice being given to clients. A number of participants working in private clinics described situations where a small group of physicians and staff would decide to relocate MMT services elsewhere, without knowledge of the clinic management. These scenarios were described as *"coups"* which destabilized the whole clinic, sometimes forcing them to close completely. Reports were that physicians would *"take their patients with them."*[24]

Clients of these clinics were reported to be left following signs left on walls, or taking directions from *"rebel"* staff members standing on the street next to the old clinic, redirecting patients where to go. Participants reported the chaos that can ensue for patients in situations like these when their clinic closes or moves, either at short or no notice. For a group of health care users, dependent on their methadone prescriptions, and seemingly voiceless in the health treatment system, these situations are of concern. One of the central aims of MMT is, of course, to provide the opportunity for client stabilization.

Connections between private clinics, pharmacies and support and recovery houses

The last concern was the reported financial links between some private methadone clinics, pharmacies, and other parts of the MMT system. One clinic manager stated that their business had been approached by pharmacies six times over a period of three years, to form a beneficial partnership. They had refused these offers, but, the manager suggested, many other clinics had formed such partnerships enabling them to effectively subsidize their work. According to some participants, partnerships may involve directing clients to use a particular pharmacy in return for a financial donation to support the work of the clinic. Partnerships were also reported to have been

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[24] Patients are registered with a named physician with CPSBC and therefore "belong" to a physician rather than a clinic.

formed between private clinics and non-licensed recovery houses. Sometimes these recovery houses, pharmacies and private methadone clinics are, allegedly, jointly owned and managed.

A number of participants described these partnerships as *"inappropriate."*

"we have heard some pharmacies, the directors of the pharmacies own rooming houses or non-licensed recovery houses and then as part of the tenancy agreement to stay at those recovery houses they direct them to their pharmacy and actually tell them that they have to get daily dispensing of all of their meds so it's broader than methadone but most of them are methadone patients. It's ways that the pharmacies get the business but it's also very lucrative for them to do daily dispensing and physicians have told us and they've written specifically on the scripts that they're not medically necessary to have daily dispensing but as part of the tenancy agreement, so that these people don't get evicted, that's what they need to do."

"I do know that there are also situations where recovery houses that are run by, essentially run and owned by pharmacies, exploit addicts and the ultimate motivation here, in my opinion, is not the wellbeing of the addict, but it's to make a gazillion dollars. I find that unethical."

"Some pharmacies were picking up client fees in the private system. And that raises a kind of a grey area to me about, both the clinic and the pharmacists having a vested interest in keeping the methadone going."

"these practices do go on and I think they are inappropriate. I think that they undermine the rights of the patient, first of all, but they undermine, you know, the methadone program in general."

"I think there's a somewhat unholy relationship between certain so-called recovery houses and pharmacies and methadone clinics ... it would be my understanding that if you are a physician providing medical care for any illness ... you should not try to profit from that patient's illness by steering them towards services that are provided by, for example, yourself, or a holding company, or your wife, or your friend, or whatever ... I would find that unethical."

"I think there should be an audit ... of the relationships between some of these well-known pharmacies that deal with these well-known recovery houses ... sometimes also in cahoots with, you know, some methadone clinics and certain private practicing physicians, and just see where all the money trail lies. Because I think the money trail feeds back on itself. And the addict is a cash cow that is being milked heavily by certain unscrupulous people to the detriment of the taxpayer."

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

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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

This chapter will discuss MSP, PharmaCare, user fees, and MHSD subsidies with special consideration of the issues raised about private methadone clinic financing. Health authority funding will not be covered because MMT financing is not separated from other service expenditure in health authority budgets. First Nations and Inuit Health arrangements are covered in Chapter 12 on Aboriginal and First Nations peoples.

It was not possible to collect complete and accurate information on the costs of MMT in BC. MSP payments to physicians for the financial year 2007/2008 amounted to $6,804,591. PharmaCare payments for methadone prescriptions for the calendar year 2008 were $28,780,000. PharmaCare also has a contract with CPSBC to administer the program. The amount of this contract, according to correspondence with PharmaCare staff, is subject to a confidentiality clause and cannot be reported. No information was available on costs related to the other funding streams.

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.

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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. Some people argued that the comprehensive system for MMT, believed to be necessary for a good program *"had never been connected and implemented,"* because *"the champions of the methadone service moved on leaving methadone treatment to sit outside regular systems."* One of the issues was the lack of consistent central coordination for addiction treatment more generally in BC. What has been consistent is that the administration of MMT has always been separate from the administration of other addiction services leading to a lack of integration. The multiplicity of separate funding streams, according to some participants, has contributed to a lack of accountability within the program.

The MMT fee item 00039 for MSP payment schedule

A specific methadone treatment fee item was added to the MSP payment schedule when the program was ramped up in the mid 1990s. Initially it was intended to be temporarily, but it remains in place today and is the only fee payable for any visit or service associated with MMT other than the dispensing fees paid to pharmacists. There is no other fee item for a specific treatment in the province. MMT has, in this regard, been viewed as *"sitting outside of"* other health care provision, despite the original intention to have it integrated into universal family physician services. Even though the evidence suggests the need for other professional roles and functions within MMT such as counselling, nursing, social work, case management, and outreach, MSP has never covered the costs for these services. For these reasons, some participants voiced their dissatisfaction with the decision to fund MMT from the *"common pot"* of health care, rather than create a ring-fenced funding system.

The methadone treatment fee reportedly started low because there was a fear from within government that physicians would abuse it.[28] According to participants, prior to revisions to the fee in May 2007, MMT prescribing physicians were commonly billing MSP for eight visits a month, yet only doing one face to face meeting with clients. This was done, reportedly, to compensate physicians for the many tasks that they, or clinic staff, were required to do to effectively manage a client's MMT. This might include making phone calls and sending faxes to other providers. These were activities that took place between client visits, were frequent and time consuming and yet made an essential contribution toward the client's overall experience of care. This practice of billing was, however, contrary to the MSP Payment Service Preamble, which stated that a physician must see a patient each time they billed. There was therefore a mismatch between common practice and MSP requirements which physicians described as *"uncomfortable,"* some talking about a *"code of silence"* around billing where *"everyone had to be fraudulent to get paid for doing methadone."* The College of Physicians and Surgeons was also described by some participants as being *"secretive"* about billing arrangements.

When the matter was reviewed in May 2007, the methadone treatment fee was increased, and guidelines were spelled out that provided an exemption to the MSP Payment Service Preamble. The fee could now be billed once per week, did not require a patient visit but was to be inclusive of all MMT-related services.[29] The change in the fee amount was intended to be revenue neutral but resolve the discrepancy between MSP policy and the common billing practices. The new guidelines further entrenched the unique status of MMT within physician services by

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[28] The fee item was reported to be approximately $10 prior to May 2007 when the amount was changed to $21.04. The fee has since been increased to $22.23 (see Appendix 3).

[29] Participants described the MSP model as a fee-for-service model, but given the way this fee and the related services are structured, it is more accurate to call it a fee-for-client model.

going beyond defining the scope and applicability of the fee to stipulating matters of clinical practice (e.g., requiring "at least two visits per month with the patient after induction/stabilization"). According to MSP staff, the General Practice Services Committee and CPSBC were actively consulted on these new arrangements.

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]

One physician stated:

> *"our patients have jobs, they go to school. If they have to come in too frequently they're quite likely to lose their job for missing an afternoon twice a month. Most employers are going to have difficulty tolerating that. Don't get me going, it's insane, you can quote me. That's the nicest word I can think of."*

After these complaints, an exception clause was added that states: "Exceptions to this criterion are where the patient resides/works in an isolated locale which is a significant distance from the prescribing physician" (see Appendix 3).

This exception only responds to one of the many concerns raised by the rural physicians, noted above, who state that a chronic disease management model would be the best method for reimbursing MMT. Interior physicians have therefore stated to MSP staff, and other bodies, that they cannot comply with these MSP requirements and want the twice a month visit for stable patients clause to be removed. If not amended, some physicians have stated that they will have no choice but to stop providing MMT and there are reports that a number have stopped taking on new MMT patients until this issue is resolved.

To sum up this section, methadone billing through MSP was described by many participants, including physicians, as *"ambiguous,"* if not *"purposely obscure."* A lack of transparency and clear protocol around physician billing was

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[30] See Appendix 3 for excerpts from various Canadian guidelines on frequency of clinic visits within MMT practice. Expertise in the field of MMT suggests that there is no known evidence that stipulates the frequency of clinical visits for MMT once a client is stable. *"It is a clinical judgment what each patient needs in terms of how many visits are needed"* (personal correspondence with Dr Bijan Nassirimanesh, 2009).

[31] There are only 18 current prescribers of MMT in Interior Health.

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evident. It should also be highlighted that in discussions with review participants who were billing MSP, such as clinic owners, clinic managers and prescribing physicians, many stated that they had no knowledge of the changes and requirements for physicians to see clients two times per month and were billing as per the pre-May 2007 practice.

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:

> *"When I take a urine sample I don't get a result for almost a week. Point-of-care is available. I can do it with someone who is pregnant, I can do a pregnancy test, but because of the politics in BC they tell me I am not qualified to put a dipstick in the urine like I do at the in-patient recovery centre or Corrections, everybody that comes in we dip and test for five or six things, anybody could do it but because of the laboratory lobby, it's huge business, it was worth $5,000,000 in a year and so they don't want to let go."*

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

There were a wide range of views on the subject of whether physician compensation was adequate or not. It must be emphasized that there is a wide variety of practice and a plethora of different models of MMT in operation in BC, as described in Chapter 2. Physicians work as sole practitioners in their own practices, with partners in shared practices, in non-profits, in private clinics, in health authority programs or clinics, and in hospitals and correctional facilities. The physician's remuneration for providing methadone services will differ dramatically depending on the model in which they work. Most non-profit and health authority programs have sessionally funded physicians who are paid by the time required. Other models use fee-for-service in which client caseload impacts the amount paid.

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:

> *"The billing system is not set up well for people with chronic, complicated, multi-system problems."*

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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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The fact that the MMT standard fee item payment is approximately $6-7 less than a standard visit for another health issue, was also an issue for physicians:

"A patient on methadone you can make $80 a month. With normal billing every patient visit you bill for $27-28. You can see the disadvantage. If you do that over a month times 4, it's $110 an hour versus $80 an hour. You're saying $80, I'm busy, there's no incentive for me to spend more time to help this person more. They need to be a little more flexible for billing that makes it comparable to other medical conditions."

This participant connects physician remuneration with a lack of provider willingness to provide support and counselling interventions as part of MMT, something the CPSBC guidelines state must occur. This relates to concern, repeatedly raised, that MMT in many service contexts has become a prescription writing service, rather than a comprehensive MMT service. It was generally agreed by review participants that community physicians who are doing the comprehensive care, as well as the MMT work, are not reimbursed well enough. As described below, the current system rewards physicians for seeing *"a lot of patients in a short amount of time."*

"I've always been amazed going around and doing methadone audits and seeing a lot of the patients that community physicians are managing. They're very difficult patients and they're not getting paid very much."

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. One participant commented that inadequate compensation for physicians was leading to fewer physicians being involved with MMT:

"There have been new physicians authorized but the actual number of physicians prescribing has gone down. And why is that? Are we giving the right amount of compensation?"

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:

"When I say cash cow I'm actually referring to the fee-for-service process at the physician level. And with insulin or dialysis, we don't manage it that way."

Participants described the BC Methadone Program as having a *"money orientation"* that had been set in place at the start of the up-scaling attempt in the 1990s. This orientation was reported to have skewed the direction of the program and created a vast and complicated array of problems in its wake. Many participants said things like, *"My perception is that this is a profit making job."* At least a proportion of physicians prescribing MMT were described by stakeholders as *"driven by profit."*

Problems with the current funding system

A wide variety of problems were reported to be due to the many perverse incentives or disincentives that the current funding system encouraged. Because the majority of physicians believe that the fee item for MMT is insufficient, as described above, the result tended to be a *"sloppy practice"* by some providers. Examples of this were clients feeling *"rushed in and out of care,"* or physicians who were not sufficiently monitoring or reviewing clients. Some physicians were described as *"not providing an optimal treatment or patient management environment."* Indeed, some went as far as to say that physicians were *"not practicing medicine according to any standard whatsoever."* A number of participants, including physicians, felt that the many MMT services were *"just writing prescriptions."*

Participants suggested that the current funding model encourages minimal contact with MMT clients because of the *"constant drive to take on more patients"* and encourages providers to accumulate a group of stable clients that do not require too much attention and where *"doctors barely interact with clients."* Some felt the fee-for-service system attracted physicians who were *"only interested in methadone as a second job,"* rather than physicians who were interested in providing MMT from within a paradigm of integrated and comprehensive care.

The unique methadone fee item appears to create a disincentive for physicians to provide comprehensive care to clients. Methadone clients, as described in Chapter 1, have many co-occurring physical and mental health problems and long-term conditions, alongside opioid use. Under the current system, appointments for MMT cannot be used for discussion of any other health condition so clients have to re-schedule another appointment for such needs, if their methadone provider is also their health care provider. Many clients have separate methadone care through clinics or other providers because of the lack of availability of family physicians who provide methadone. The general lack of availability of family physicians was seen as a problem affecting methadone clients. People taking methadone often find it difficult to make the links with services themselves and therefore continue to be physician-less, despite some help by clinics in this regard. A prescribing MMT physician spoke about an example of this separation between MMT and primary care services, and the way that clients can *"fall through the gap"*:

> *"I had a patient who was a reliable, likable methadone patient but had no GP. He had some other undefined health problems. I happened to be going through Emergency one day and noticed he was in. I stuck my head in. He had had a period of unconsciousness that was diagnosed as a drug overdose but said 'I didn't use anything, just my methadone.' Then shortly after that he was found dead. Nice guy, no GP. I feel badly now that I didn't pick up the challenge but he wasn't my regular patient. There are no GPs and he died. It's easy to talk about a system but there is a human impact of people who just can't get medical care."*

Many believed that MMT should be well integrated into primary care, rather than be *"out on a limb,"* and that fiscal arrangements need to be in place to support this integration.

The fee-for-service system was described by participants as very problematic for MMT and good alternatives are much needed. Some participants suggested that a capitation model would fit MMT well, primarily because of the number of hours in non-patient care. Many participants, not only those within sessional models of MMT, strongly believed that physicians prescribing methadone should be on salary:

> *"the best way to do it is to divorce yourself from all this, I'm getting 10¢ for looking at a nose and 50¢ for an arm. The best thing is to say pay the physician a sessional fee, and pay them well because it's hard work and you'll get good physicians doing good care."*

A few critics argued that if the money incentive was lost there would be a loss of physicians, but that *"the upside of that is you are probably losing the ones that you should have lost to begin with."* Audits were seen as a good way to identify physicians who are taking advantage of the system. Better audits, rather than using restrictive policies, would be effective in preventing abuse and cause less interference with good practice.

Finally, MMT in BC was viewed as far too physician dependent. It *"can't just be about acute care and doctors."* Many spoke with passion on the urgent need for wide non-medical involvement including expanding the role of nurses, counsellors, case managers, social workers, outreach workers and other professionals. This was for two main reasons. First, MMT needs to be realigned with best practice evidence that links psychosocial support to improved client outcomes. Secondly, the system needs to relieve the workload on physicians and provide them with support for their role. Many review participants wanted MSP to pay for these essential non-medical supports as a priority.

A solution: taking a Chronic Disease Management approach

Many review participants, in particular prescribing physicians, wanted the province to move towards understanding problematic substance use, or addictions, as a chronic illness or disease:

"We haven't taken a chronic disease management approach to addiction in the way that we have for other chronic diseases. We haven't resourced it in the same way, we haven't educated communities, we're not educating the patients about it in the same way. The difference is likely due to stigma and bringing morals into it."

Chronic disease management (CDM) has been established by MSP for physicians that are helping patients to manage long term conditions in the community, through new funding arrangements and criteria. Many review participants wanted MMT to be considered under these new arrangements. The CDM model is one way to link remuneration with provision of better quality care. In this model physicians are paid for activities that directly improve client's treatment outcomes or quality of care:

"It links physician remuneration with better quality care. It would, therefore, take away the financial incentive to restrict yourself to easy patients. It could be one of the things that helps push people towards individualized optimal dosing, as opposed to sub-optimal."

Another physician talked about the potential of CDM modules to help physicians to follow evidence-based practice:

"There are chronic disease management modules that help physicians know exactly how often you have to see the patients and what tests you have to do and you get paid more if you follow the guidelines."

Yet another physician described an associated benefit of taking a CDM approach to MMT as a way of gathering better data on patient outcomes in MMT, something that is needed to better inform policy and practice in this area of work.

PharmaCare payments for methadone dispensing

In May 2001, the BC Ministry of Health Services, Pharmaceutical Services Division and PharmaCare, made changes to the arrangements for reimbursing pharmacies across BC for dispensing methadone. These revised arrangements were put in place to address various anomalies in billing and to bring new pharmacies into methadone dispensing to address access problems across the province. Access to MMT prior to 2001 had been limited by the lack of involvement of pharmacies in methadone dispensing, particularly in rural areas.

The new arrangements set the drug cost of methadone at 2 cents per mg, the dispensing fee at $8.60 and a monitoring and interaction fee of $7.70 for people on daily witnessed ingestion (see Appendix 5). For clients on carries (a take-away dose of methadone), the pharmacist can only claim the drug cost plus the dispensing fee. Participants stated that the new funding formula initially resulted in budget savings for PharmaCare, but costs per annum are now rising.

A number of review participants described these new arrangements as having been effective in bringing pharmacists into methadone dispensing and improving access for clients. In fact, the number of pharmacies dispensing methadone nearly doubled, from 250 in 2000 to 487 in 2008.[33] There are now many more pharmacies dispensing methadone in rural areas of the province as well (Nosyk, et al., 2009). Without dispensing pharmacies spread widely across the province, access to MMT would remain severely limited.

Problems with the current funding system

However, the new arrangements may also have created problems. Many participants believed that levels of reimbursement had been raised too high and were distorting MMT in significant ways. These comments were almost wholly made by participants based in urban areas of BC where there are significant numbers of MMT

[33] Statistics provided to the review by the College of Pharmacists, October 2008 in personal communication.

clients, such as Surrey and the Downtown Eastside of Vancouver. So while the new PharmaCare arrangements seem to have greatly benefited Northern, rural and remote areas of BC, problems may have been created in urban areas possibly indicating a need for policy interventions that target different geographic areas or sub-populations.

Many of the reported distortions of care regarding pharmacies are reported in detail in Chapter 8. However, a few brief comments will be made here because of the direct relationship between these problematic practices and the fiscal systems for reimbursement. Some participants felt that the new financial arrangements brought some pharmacists into methadone dispensing purely because of the fees that are paid by PharmaCare. Methadone is now being described as a *"multi-million dollar industry."* There was historically a cap on the number of patients pharmacists could have on their books but this is *"no longer operational."*

Pharmacists are generally satisfied with current reimbursement levels but some described being concerned with the *"hugely inflated payments,"* for the role and tasks they provided. These pharmacists believed that having this much public money tied up in dispensing fees directly impacted the amount of resources available for other parts of MMT, such as psychosocial support and case management. One pharmacist, who provided services to many people taking methadone, commented:

> *"I don't think it's a wise use of resources to have people with the methadone plus all their other medication on daily dispense, because it's a significant amount of money invested in the pharmacists rather than invested in housing with a support person."*

This person believed that frequent contact with MMT clients who still had chaotic and unstable lives, and perhaps continued drug use, was a good opportunity for regular positive and supportive interventions and that there should be a clear linkage between daily dispensing and the provision of other support services in a *"one-stop-shop"* arrangement.

One issue reported in urban areas was pharmacies requesting MMT clients to go on to daily witnessed ingestion even if their physician was not requiring this level of observation. This practice was also reported to be occurring for other prescription medications where not clinically required. Participants reporting the practice associated it with a fiscal incentive related to dispensing fees. These requests were sometimes connected to the payment of incentives to MMT clients,[34] or to other "benefits" to clients, such as unauthorized carries (see Chapter 8). Physicians working in urban areas in the Lower Mainland described the damage created by these practices, including the breakdown of good working relationships with clients and clients leaving treatment if physicians did not agree to prescribe daily witnessed ingestion. The vulnerability of MMT clients to poor quality practices by pharmacists was emphasized by one participant:

> *"They know that the addict is likely never to complain. They know that even if the addict complains, no one's likely to believe them. They are easy to exploit. The system is so easy in terms of billing. It's just so lucrative, it's just like printing money."*

The current fee system is creating an incentive for clients to be placed on daily witnessed ingestion whether they need it or not. A wide range of stakeholders described this as a *"systemic issue"* affecting a large number of pharmacists and pharmacies, rather than a *"few bad eggs."*

Suggestions for change in PharmaCare reimbursement for pharmacists

Many participants felt that the current PharmaCare dispensing fee system should be disbanded because of the extent of the negative effects on clients, providers, and the Methadone Program as a whole.

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[34] See CBC and other press reports in September-November 2008. Available at: http://www.cbc.ca/canada/british-columbia/story/2008/09/11/bc-methadone-kickbacks-investigation-downtown-eastside.html

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There were those that felt that pharmacists would be *"resistant to change,"* and would *"stop doing it if they don't get paid this amount."* Others believed that only the ones motivated purely by money would leave, and that this would be a good thing for clients and the program as a whole:

> *"It would definitely change the number of pharmacies involved. It would probably close down a few because that's their whole business model. Is that necessarily a bad thing? Not necessarily. It is one of those things that is probably one of the leading causes of the excess."*

Some believed that pharmacists needed to be required to do more for the money that is being paid to them for methadone dispensing by becoming *"medication management experts."* This would involve them spending more time with clients and establishing supportive relationships. A number of pharmacists are reportedly already playing this role that is highly valued by clients and other service providers. It was felt that increasing levels of training and education for pharmacists to enable them to employ best practice should be a priority.

Having a fee similar to the Health Canada First Nations and Inuit Health Non-Insured Health Benefit plan would likely *"close the door to abuse"* according to some. That fee is set at around $8 per methadone dose with no extra payment for daily witnessed ingestion. Others suggested that specific fiscal arrangements are needed to ensure rural pharmacies, which rarely get a critical mass of methadone patients, are compensated adequately.

User fees

User fees are one of the most contentious issues related to MMT in BC.

> *"they're mostly poor, they're marginalized, they're struggling and to sack them with $75 a month just to walk through your door does seem to me to be quite against everything that I would believe to be right and proper for people who need treatment."*

Many participants felt that user fees for MMT services were contrary to the Medicare Protection Act. According to respondents, British Columbia is the only province in Canada where methadone clinics are able to charge individuals a monthly fee.[35] Nonetheless, user fees are charged in almost all private methadone clinics, and in some other models of methadone provision. They have to some extent become *"normalized"* in BC, in a way that they do not seem to be elsewhere in Canada.

The majority view among study participants was that user fees in MMT are *"unethical"* and unfair in comparison to the way people with other chronic diseases are treated.

> *"What would the cardiac patient say if he were charged a fee for going to cardiac rehab?"*

According to clinic managers, payment plans and fees can be individualized, especially when clients are finding it difficult to pay and end up owing months worth of fees. Managers described processes where the clinic sometimes chooses to *"write some of it off."* However, it was also noted that *"prescribers get fed up when the patients don't pay."* Clinics will often stop care if unpaid fees get too high and these amounts differed between clinics. There were many accounts of clients being taken off MMT and asked to leave the clinic because they could no longer afford their fees. One private clinic was reported to have doctors who *"don't tolerate any fees owing."*

Some commentators were very concerned that an evidence-based treatment, with clear societal cost-benefit analyses, was being provided to people on very low incomes on a pay-for-service basis. Others were clearly

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[35] While this has not been verified, when clinics in Ontario similarly tried to charge clients for counselling services, the College of Physicians and Surgeons of Ontario stated that it was against both the Canada Health Act and the Ontario Medical Association guidelines to have a mandatory fee for an optional service.

frustrated that the success of MMT as a harm reduction strategy, provided to improve the public health of the population, was being negatively impacted by the presence of user fees.

> *"When I speak to those private clinics, I ask them how can you in good conscience do this? These guys are living a marginal existence, they probably have had to steal to get that money. What's the deal with harm reduction if they have to steal for a living to pay your fees?"*

User fees act as a more substantial barrier to those population groups who are very economically marginalized, for example Aboriginal clients. The "working poor" were also viewed as a particular risk group, related to user fees:

> *"the working poor have to pay for their methadone prescriptions and that's criminal."*

For people not on income assistance, full clinic fees of between $55-80 a month are required. This is a substantial amount for those earning a minimum or part-time wage and possibly still facing mental health and substance use problems:

s.22

Fees create stress for people who get back into work and wonder how they are going to pay for their methadone treatment fees and prescriptions. This was reported to be a disincentive to get into work, as this client describes:

s.22

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. Participants raised concern about the lack of verification of the psychosocial services that clients receive in MMT. Some stated that much of the funding was being used for clinic overheads, such as staff costs, administration and infrastructure, instead of being used to provide counselling or other psycho-social support.

In practice, the MHSD supplement tends to be associated with private clinics. Private clinics charge user fees that range from $55 to $80 per month that must be paid by the client. For eligible clients on income assistance a proportion of these monthly fees can be paid with the alcohol and drug treatment supplement, with the remainder coming directly out of a client's support/shelter allowance. This supplement is paid by MHSD directly to the clinics and there is no real accountability for how the money is used. MHSD also administers a medical transportation supplement that normally does not apply to MMT, but there was reportedly a *"grey area around how it's being used."*

Financing for private methadone clinics

Private clinics are not supported directly through the BC Ministry of Health Services, or the regional Health Authorities. Physicians at the clinics are paid through MSP under the standard fee-for-service arrangements. A group of physicians usually cover a clinic or group of clinics and generally a physician will come in once a week, for a whole or part of a day, to see their clients. Each client has an assigned physician who has to register the client on the Methadone Program and bills MSP the weekly fee.

Physicians in the majority of clinics are required to pay part of their MSP payments as a contribution towards clinic overheads. According to participants, this amount varies between clinics but is generally about 10-30%. One

clinic manager said that it was difficult to ask physicians to pay more to the clinics because the clinics were so dependent on their physicians.

Private clinics usually also collect user fees either directly from clients or from MHSD as described above. The official reason that clinics charge user fees is for the counselling and other non-insured health benefits not covered by MSP. Some clinic managers said that they would much prefer not to charge user fees:

> *"It's also very difficult for our clients to pay their clinic fees and I hate charging their clinic fees but in order for us to be here, the bottom line is we have no choice. There should somehow be more government support for these clinics and there really isn't. It doesn't take a lot to do the math and see what the clinic fee is and what your operational fees are so I certainly don't see them as moneymaking ventures."*

Clinic managers report what they consider to be a *"substantial under-funding"* situation, leading to a difficult *"balancing act"* of maintaining the quality of treatment for clients with the money that they receive.

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/british-columbia/story/2008/09/09/bc-080909-peoples-pharmacy-evictions.html

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Chapter 5: Accountability and Regulation

> *"The way we have organized methadone does not facilitate addiction care. I'd like to see a program that's framed within human rights, the concept of a chronic relapsing illness. It's not clear to me whether the way the methadone program is implemented is because of ideology or the real requirements of The Single Convention. That's one of the very serious issues for the Ministry … to sort out whether current practice is driven by a subset of practitioners who have a very narrow view of what to our patients is a ball and chain, and prohibits re-entry into the community in a functional way. It's so restrictive. We make it impossible for social reintegration. We're highly punitive around the notion of chronic relapse. We would never treat diabetics the way we treat people with an addiction problem but there's not a lot of difference between not staying on a diet, not getting enough exercise but, okay, your insulin needs adjusting. We don't say you get less and you're going to have to work harder."*

Many participants were of the opinion that there was no methadone "program" as such, because there was *"no consistency"* and *"no clear governing structure."* Stakeholders stated that neither professionals nor the public were sure who was in charge of the program. This chapter seeks to explore the critical issues related to the regulation of the program and accountability to stakeholders. In particular, it outlines participant comments and concerns regarding the roles of key partners:

- Provincial ministries (in particular the ministries of health)
- College of Physicians and Surgeons of BC (CPSBC)
- College of Pharmacists of BC (CPBC)
- Health authorities

While municipalities have some involvement in methadone, largely from the perspective of regulating licensed premises using bylaws, very little was said by participants about this involvement so this is not discussed in detail.

Provincial Ministries

The BC government has had a chequered history with regard to MMT. Methadone is designated a banned substance by Health Canada, and physicians who wish to prescribe methadone for opioid dependency require an exemption granted by the Federal Minister of Health under Section 56 of the Controlled Drugs and Substances Act. As detailed in the introduction to this report, BC may have been the site of the first MMT program in the world. During the 1960s, 1970s and 1980s, MMT was regulated by the federal government with service in BC provided primarily by private physicians. The introduction in 1972 of national guidelines for prescribing methadone led to a sharp drop in the number of people receiving treatment from 1972-1975. This was further impacted by the failure of the provincial government's short-lived Compulsory Heroin Treatment Program in 1978-1979 (Fischer, 2000). Then, in 1986, the BC Ministry of Health sought to obtain a monopoly on methadone treatment for opioid dependence and to confine it within the abstinence orientation of its alcohol and drug programs. While the monopoly was never obtained, many of the misconceptions and practices contrary to evidence that have plagued methadone treatment in BC were reflected in the 1986 program rules (Alexander, et al., 1987).

In 1996 the federal government began devolving regulatory responsibility for MMT to the provincial level. While responsibility for the licensing of physicians and administration of methadone prescribing practices were assigned to CPSBC, the Ministry of Health was involved in setting up a more liberalized regulatory system. While a clear account of responsibility for MMT is absent from government websites, provincial ministries continue to be involved in both fiscal and clinical policy through MSP (see Chapter 4) and their joint sponsorship of committees such as the Guidelines and Protocols Advisory Committee and the General Practice Services Committee.

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Review participants felt that substantial problems within the current program resulted from government expecting widespread up-scaling in response to the HIV crisis of the 1990s without taking responsibility for managing or monitoring the process. Many participants believed that this lack of oversight from government has been instrumental in creating what they regard as a crisis of confidence. Provincial government policy was described as *"toothless,"* and unable, for example, to address the many pharmacy-related problems. In fact, participants described the provincial government as being *"indifferent"* to the program, and as *"unresponsive"* to complaints:

> *"The ministry is not interested in taking action on any reports of poor or corrupt practice."*

Many participants viewed the ministry as being *"very bureaucratic"* and *"sitting on the sidelines,"* when it came to MMT. The lack of action on complaints was repeatedly cited, and according to participants has led to despondency, apathy, exasperation and a feeling that *"there is nothing that anyone can do."* Municipalities felt that they had little power to address the problems *"on their doorstep."*

Participants were divided on the leadership role the Ministry of Health Services should play in the future. Some did not believe that the Ministry alone was capable of providing the leadership and direction required to address the problems that exist in MMT. Others believed that ministry involvement may lead to too much regulation that would ultimately have negative impacts on client care. However, many participants believed that new standards and protocols for the program could and should be set in place by the province and the Ministry of Health Services, rather than delegating responsibility to any other body whose mandate does not extend to all aspects of the needed comprehensive program.

College of Physicians and Surgeons of BC (CPSBC)

Licensing of physicians and federal drug policy

As described earlier, the licensing of physicians and administrative responsibility for methadone prescribing was given to CPSBC in 1996. CPSBC makes recommendations to the Federal Minister of Health on behalf of physicians in BC who wish to prescribe methadone for either pain or opioid dependency. CPSBC maintains a register of patients receiving methadone for the treatment of opioid dependency.[37] In order to receive authorization to prescribe methadone for opioid treatment, a physician must complete a one-day workshop and two half-days of preceptorship. Hospitalists are authorized to continue MMT for patients who had previously been on MMT in the community. While CPSBC took responsibility for the Methadone Program from the federal government, it was described as *"historically conservative towards methadone."*

There were diverging views on the appropriateness of the existing controls and regulations surrounding methadone treatment in Canada. Some participants felt that it was time *"to raise the bar around licensing,"* to address what they considered to be poor standards of physician practice on MMT. Others believed that the main problem for MMT was its special status as a licensed treatment and that MMT is currently over-regulated. This special status contributes to the ongoing stigma of MMT and people taking methadone, as well as to creating additional barriers to access by limiting the numbers of physicians who can prescribe. Having two separate exemptions, one for pain and one for dependency, was also considered to be *"arbitrary."* Methadone for pain is not as strictly regulated as methadone for opioid dependency.

Mandate and role of CPSBC

Even though CPSBC recognizes that evidence supports a comprehensive approach to methadone treatment, its mandate is limited to those aspects related to methadone prescribing by individual physicians for individual

[37] A similar list is not kept of those receiving methadone for analgesia.

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patients. Therefore CPSBC does not monitor counselling or other support services included in MMT or any other aspect related to clinic functioning or financing.

According to CPSBC, no other College system of surveillance is as intense as methadone, *"nothing gets more scrutiny,"* and they view themselves as a *"vanguard of prescriber correctness in Canada."* CPSBC is under contract to administer the MMP for the Pharmaceutical Services Division, Ministry of Health Services. An annual report is produced for the ministry and information regarding the methadone program is made available to members through the College Quarterly.

The work of CPSBC *"is enhanced and facilitated by the expert advice provided by the Advisory Committee on Opioid Dependency* (CPSBC, 2008)."[38] This internal body is centrally responsible for the MMP. In early 2009 there were nine members of the Committee, all of whom were physicians. ACOD has no representation from other professionals, patients/clients, family members or advocacy organizations.[39] Reports and proceedings of the committee are not communicated or available to stakeholders outside the College.

ACOD's role is to provide education to physicians (and to a limited extent other MMT providers), undertake peer reviews of prescribing physicians' practice, review complaints and mentor or match new prescribers with experienced prescribers. ACOD provides support for physicians experiencing challenges.

ACOD uses peer reviews, PharmaNet data, complaints and coroner reviews, to monitor prescriber adherence to guidelines. CPSBC reviews all deaths where methadone may have been a contributing cause. "Audits, or peer reviews, are an integral part of the program and are essential in maintaining standards of care" (CPSBC, 2008, p23). ACOD peer reviews prescribers after their first year in practice, and as necessary thereafter. The peer review process is based on physician and patient records and on physician documentation. Clients are not involved when gathering information. During 2007, 27 peer reviews were undertaken: "16 physicians were deemed satisfactory and 11 physicians were required to take corrective action prior to a repeat review" (CPSBC, p23). Failure of peer reviews is commonly due to documentation problems or for giving carries too early. Correspondence with CPSBC noted that methadone maintenance physicians are referred to the Executive Committee if the methadone maintenance physician continues to have several severely deficient audits, aberrant or unsafe methadone care and has already met with either ACOD and or Registrar staff and no changes are apparent. For the most part, physicians that are referred to the Executive Committee for disciplinary action have issues beyond just methadone maintenance deficiencies.

Comments about CPSBC management and leadership

Some participants stated that CPSBC was providing effective leadership for the MMP with comments like *"it provides responsible oversight," "the College offers a wonderful opportunity for expansion and education and real room for improvements."* One participant stated that CPSBC had *"made it easier to facilitate getting people registered on the program, with same day registration."* Another two participants stated, *"I can rely on College to respond to my questions"* and *"I find their guidance conservative but reasonable."* Some participants said that ACOD peer review processes had improved over the past few years. One physician stated that ACOD was a *"very collegial committee."* Peer reviews were considered to be helpful when *"reviewers are encouraging and proactive."* One person stated that *"audits are not as scary once you go through the process."* Another physician appreciated the training program which was *"informative, a fairly rigorous program."* Good communication between the College and the corrections system was also valued.

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[38] In 2009, the name of this Committee was changed to the Methadone Maintenance Committee, however, given that the information detailed in this report was gathered prior to this change, Advisory Committee on Opioid Dependency (ACOD) will be used throughout.

[39] This is despite several formal and informal representations made directly to the College regarding patient/client involvement, for example, a letter from the Canadian HIV/AIDS Legal Network sent in 2006.

There were also many complaints and criticisms made of CPSBC and ACOD, and the majority of these were made by physicians. The dominant complaints made reference to the *"anti-methadone"* and *"ultra-conservative"* stance adopted by the College. The College perspective on methadone was considered to be dominated by a fear of diversion and a *"preoccupation"* with the potential of the program to bring physicians and the College into disrepute through media reporting of methadone deaths. One participant suggested, *"If that's their only interest in methadone, they shouldn't be in the business."* Two physicians commented:

> *"When methadone patients die it's obviously very sad but it's very common. I have a sense that as soon as one of my patients dies, for whatever reason, the College is looking over my shoulder, well where did you screw up?"*

> *"The College gets worried about diverting methadone and so do I. I said, you make it sound like when I have a patient on methadone, I don't worry about them. When I give them carries I don't worry about them going out and diverting it. But you also have to understand that diversion of medication goes on everywhere, it's not just methadone."*

A number of people talked about the methadone program being *"an abstinence-based program, cloaked in harm reduction,"* observing that it was *"strange that the College methadone power stakeholders are abstinence focused,"* given the central recommendation of the program that methadone treatment for opioid dependence be delivered with a maintenance-oriented, rather than abstinence-oriented, philosophy. According to these observers, one outcome of this *"anti-harm reduction"* perspective was a *"high threshold"* program, administratively heavy, with many barriers to access and retention for clients. One person spoke about how helpful it would be if the College explicitly supported harm reduction:

> *"I think they could be more clearer around harm reduction because right now they're unclear in general and it needs to be more clearer, more harm reduction and actually coming out saying it's okay."*

A lack of leadership was a significant complaint from many stakeholders. One person suggested there was *"not a lot of receptiveness in the College to think about challenges in the system."* One example offered was the lack of support to providers in northern, rural and remote areas who felt, *"basically you are on your own."* CPSBC reportedly had *"no recommendations"* when it came to particular rural and remote challenges. Due to the extent of stigma faced by people taking methadone, many participants believed that CPSBC should be doing more to *"promote methadone or in supporting methadone docs proactively, in terms of awareness."* The MMP was described as *"disorganized, fragmented and money-oriented."* One participant talked about a desire to organize regular multi-professional development workshops on MMT, *"but they* [CPSBC] *weren't interested."*

CPSBC was viewed as a *"closed group," "protective of members," "secretive," "lacking in transparency,* where *"facts, statistics and information aren't readily available."* The College's internal complaint processes were reported to have been *"hijacked by methadone doctors, it is the police investigating themselves."* Some participants said that CPSBC ignored the complaints and concerns of methadone clients and advocacy groups with comments like *"the stories were just endless at that point and they didn't have the courtesy to reply."* One physician said of their College that they are *"very passive, very apathetic, we never hear from them."* Some participants were clear that CPSBC had a very difficult job in regulating the MMP but felt that the best approach would be for the College to work together with other agencies to improve it. One participant suggested the need for CPSBC to develop clear mechanisms to deal with criticism:

> *"If we went back to basics and said, what are we trying to do with methadone treatment? What are the imperatives of treatment? What are the gains? What are the things that we know happen? … And we redesigned it almost from the bottom up again. People get very sensitive about this though because the BC system is very vulnerable; it's the first in Canada and in many ways it is a good system compared to the States and many other places, it's a much better system … it's been around a long time and the people that run it are very sensitive to criticism which is sad because it's important that they be able to take constructive criticism and to have a mechanism to develop it, whereas at the moment that just doesn't seem to exist."*

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Physicians that were seen as giving good care by other stakeholders were not necessarily the ones that ACOD approved of:

> *"The best doctors are ones that accommodate patients but are punished by the College. The worst doctors are approved by College because they will always refuse patient requests."*

Some participants described many physicians as being unwilling to *"accommodate patients because they are scared of the College."* Many comments referred to the College work-style as being a disincentive to potential prescribers, *"People don't want to do methadone because of the College."* Physicians felt that there was a lack of clarity to the guidelines:

> *"we are getting punished for working with vague guidelines, we get conflicting messages from the College."*

> *"the guidelines are covert, not direct."*

> *"They call them guidelines but at the same time when they audit you, they slap your wrist for it."*

Some participants stated that the guidelines are informed by MMT in the Lower Mainland and *"are not applicable to other areas where there is a need for flexibility, as for rural northern communities."* Following the guidelines was described as challenging in contexts where access is scarce.[40] Because of this ambivalence towards methadone and the MMP, and the desire of many participants for a more multi-disciplinary program, a number of participants wished to see leadership of the MMP become a multi-disciplinary activity.

College of Pharmacists of BC (CPBC)

The BC Association of Pharmacists is a membership organization whose mandate is to promote the profession of pharmacy. This Association has been involved with the methadone program, through negotiating with the Ministry of Health Services, Pharmaceutical Services Division, when the reimbursement policy changed in 2001, and prior to this in 1996 when the program was first being up-scaled. According to conversations with staff of CPBC, the College took over the pharmacy portion of the regulation of the MMP from CPSBC in 2004 but they do not receive money from government or from CPSBC for this role. CPBC has a regulatory function with regard to MMT in BC which includes the licensing, training, directing, and assisting of pharmacists who dispense methadone. They are also responsible for developing guidelines for pharmacy practice.

There is no formal training required or provided for pharmacists who dispense methadone, although some pharmacists attend CPSBC's introductory and advanced workshops. CPBC has four Quality Outcome Specialists who have the authority to visit pharmacies and review practice. CPBC's, *Framework of Professional Practice*, describes methadone stabilities and dosing and is used by the Quality Outcome Specialists to examine a pharmacist's practice. CPBC states that legally pharmacists need to document every step with MMT and review, for example, *"how they're handling methadone, preparing methadone and doing the initial patient assessment. Any discrepancies need to be documented and communicated in writing."*

The payment of incentives to MMT clients for prescriptions was one issue of concern to review respondents during the period of data collection, through 2008. These incentives were described as contravening the PharmaCare policy that pharmacists need to sign before being able to claim for dispensing costs.[41] CPBC has

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[40] All of the cited comments were made prior to the release of the revised *Methadone Maintenance Handbook* in 2009. The new handbook has attempted to address some of the issues and to provide improved clarity around the guidelines.

[41] *PharmaCare/Pharmanet Policy and Procedures Section 6.3 Fees and Payments Methadone Fees* states that pharmacies who elect to participate in the MMP and receive the interaction fee payment must "agree not to offer cash or incentives *of any kind* to methadone clients. Without limiting the generality of the foregoing statement, incentives include, but are in no way limited to, air miles, loyalty points, bus passes, etc." (see http://www.health.gov.bc.ca/pharme/generalinfo/policy/feesandpayments.pdf). The CPBC

received many complaints about the practices of their members in relation to methadone dispensing (see Chapter 8) but report seldom having sufficient evidence to be able to take these complaints forward. CPBC has the power to ask pharmacies about their financial practices and has a process for dealing with problematic practices. The first step of this process is called 'Consent Resolution' where CPBC asks a pharmacist to consent to implementing different practice. After this the matter goes to a Discipline Committee and can result in CPBC taking a pharmacist's license away, if they have enough evidence. CPBC stated that they must have formal complaints in order to move forward into the disciplinary arena and that complaints are not able to be kept confidential. CPBC constantly receives concerns about MMT dispensing and described working collaboratively with the Ministry of Health Services, CPSBC, police forces and a range of other bodies to try to effectively deal with problematic practices by pharmacists dispensing methadone.

The review heard many comments on the regulation of pharmacists by CPBC and these were predominantly critical. The following are representative:

> *"One of my main, main issues is that the treatment of methadone requires more than one discipline doing its job and one of my main issues is with the pharmacies and the dispensing of methadone in the province of British Columbia. It is nothing short, in my estimation, of criminal in the sense that it continues to keep our clients from the ability to get better and I'm so tired of these fly-by-night pharmacists, these out-the-back-door pharmacists and the inability of the College of Pharmacy, the unwillingness of the College of Pharmacy, to address those issues. I have no problem with the fact that we've got bad prescribers as far as physicians out there, there is a way of dealing with those and they can be dealt with, but there doesn't seem to be any will in this province to deal with the issues around pharmacists."*
>
> *"I do have concern that the College doesn't have enough clout, or doesn't exercise their muscles enough at times. But I don't know. I guess this is the challenge that a lot of self regulating professions have."*
>
> *"The College of Pharmacists needs to step up to the plate to be held accountable for the actions of their members."*

Some stakeholders acknowledged that CPBC had undertaken more monitoring of pharmacists *"since Gastown."*[42] For example, one participant stated that CPBC had been monitoring one pharmacy frequently because of claims that they were watering down their methadone. However, the majority of participant comments were concerned with the lack of action on the part of CPBC to address the problematic practices that were occurring across the Lower Mainland:

> *"We would send evidence to the College of Pharmacists, like a forgery, but never got any response until a week before the issue started showing up in the papers."*
>
> *"The College of Physicians and Surgeons has tried to address issues around deliveries because the College of Pharmacists hasn't."*
>
> *"The College of Pharmacists is unable or unwilling to address the unethical practices of pharmacies."*

One participant commented on the couriering of methadone by some pharmacists which the College was apparently aware of but ineffective in addressing. CPBC was described as being *"in denial," "completely ineffectual"* and *"paternalistic."* Many physicians spoke about their frustration: *"The College of Pharmacists will not do anything, it seems to be completely powerless."*

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is governed under a set of bylaws added to the Health Practitioners Act of BC. Bylaws Schedule F - Part 1- Section 3 states that pharmacists must not enter into agreements with patients or practitioners that "limit a patient's choice of pharmacy" (see http://www.bcpharmacists.org/library/D-Legislation_Standards/D-2_Provincial_Legislation/5078-HPA_Bylaws_Community.pdf).

[42] Participant is referring to the Crown's investigation of Gastown Pharmacy for alleged over-billing for methadone dispensing (Bellet, 2007).

Conversations with the College of Pharmacists indicated that they were well aware of these criticisms and the extent of them. They compile information and works with multi-agency partners to try to gather sufficient information for a case to be brought. They try to have a presence in the DTES and Surrey and regularly follow up with the methadone-focused pharmacies that have been the focus of many complaints. CPBC has to have a formal complaint to be able to proceed with an investigation. If they receive complaints the person complained about needs to know what the complaint is and who made it. As a result, CPBC finds it hard to get "evidence" related to the complaints about incentives.

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).

All health authority stakeholders consulted expressed a desire for health authorities to have a greater role in MMT. A stumbling block to development is having *"no regional leadership for methadone,"* and poor resourcing of health authorities was seen as a major barrier to the development of MMT and integrated services. Many noted a lack of capacity for mental health and addiction services across all health authorities: *"We're in a very constrained environment."* Health authority managers stated that should financial resources become available they would be willing to become more involved in MMT.

Other challenges were noted. Some participants pointed out the lack of access, for both service providers and clients, to information on MMT prescribers in some areas. The gap in knowledge and understanding in terms of how to deliver methadone services was also a matter of concern for some. The Provincial Mental Health and Addictions Planning Council was suggested to be the appropriate body to take stock of the challenges and guide health authority involvement. According to participants, this would require being more proactive in creating opportunities for sharing the knowledge, experience, and evidence of "what works" across the province.

Some participants were very critical of the current lack of integration and ownership of MMT within health authorities. While there is no legal imperative for health authorities to respond formally to

Case in point – Recovery houses

Participants repeatedly highlighted significant problems with some recovery houses. While they were noted to be an important part of the support system for many people on MMT, they were reported to be *"almost completely unregulated."* Participants described *"horror stories"* where clients were being poorly cared for, or *"extorted."*

> *"Received call today regarding a female client who was feeling ill and needed to go to the doctor. She went and was told to return to get results of blood work. House refused to let client go to follow up appointment and client chose to go anyway. Received diagnosis of hep C and when she returned to house was evicted. Not clear if eviction is related to leaving despite house not allowing it, hep C or both. Major problems with this house."*

Complaints frequently come to health authorities about poor practices in these houses but there is little they can do. Most are not funded by the health authorities, and there is no regulatory infrastructure. Participants reported that houses taking people on MMT often have *"strong links to pharmacies,"* and sometimes also to a prescribing physician.

There are many unlicensed, unregulated and non-funded recovery houses that are *"highly ethical facilities trying to survive."* Citing the problems with some houses is only meant to highlight the lack of regulation within this part of the MMT system and reinforce the vulnerability that clients face in these somewhat 'invisible' services.

concerns about MMT in their regions, some participants suggested that they should have been more proactive in acknowledging service gaps and responding to them. One participant stated that *"Health authorities haven't really been held to the fire"* around their provision of mental health and addiction services generally. Participants were concerned about the *"lack of connection between mental health and addictions counselling services and prescribing physicians."* According to some, health authorities were not operating in a mode that was collaborative, innovative or entrepreneurial, and had not created the links necessary between primary care, mental health and addictions, public health and community agencies. They were described as having ineffective communication and as limited in their ability to *"get things done."* One person stated, *"It's too big, it's too arthritic."*

One particular concern voiced related to the harm reduction philosophy. Health authorities were seen as *"relatively new to the concept of harm reduction,"* having traditionally had an abstinence focus. Other participants believed that health authorities were beginning to embrace harm reduction now, citing the provincial harm reduction road shows and Fraser Health's Harm Reduction policy as examples.

There was a lack of trust and respect between some physicians and health authorities. Both the provincial government and health authorities were viewed as silent on *"this problem of untreated addiction which is not being taken with the seriousness that it should be."* There was a concern that MMT, if integrated into health authority programs, *"would stagnate."* One person said, *"You might as well throw it into a bog."* While giving whole or partial responsibility for MMT to the health authorities was an idea that many participants suggested, others felt that this was not something that would necessarily improve MMT in the province if done alone.

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

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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 af[f] their gratitude that the MMP existed. Several made comments like. s.22

s.22

One woman described how methadone helped her to transition to a new life:

s.22

Regaining a work life was very important to people taking methadone, and participants said things like, s.22

s.22

Methadone helped some people to reconnect with family and children again. Statements like, *"She managed to get her children back"* and s.22 were common. Methadone was seen as able to s.22 *and "open a door to recovery."* One person said: s.22 People reported being *"stabilized"* and *"freed up"* to get on with their lives as productive members of society. Methadone is able to *"deal with the heroin"* (or other opioids) to allow people time and space to get their lives back together, as this woman describes:

s.22

People described the way that methadone had helped to give them confidence: *"you start to believe in yourself a bit more."* One woman living in the north of BC and reliant on a sole prescriber talked about the way methadone is helping her to respect herself:

s.22

In terms of methadone's relationship to health benefits, there were many comments made concerning the reduced anxiety associated with withdrawal and being *"dope sick"*: s.22 "Some people said that they had been able to stay off heroin completely: s.22 'Other people said that methadone helped them to stay away from other drugs, like crack cocaine:

s.22

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Strengths

People taking methadone talked about the way that it had helped them to create more safety in their lives and take steps to reduce harm related to injection drug use. Clients commented that methadone s.22 "Five women in the Downtown Eastside of Vancouver talked about the way in which methadone had decreased their need to engage in sex work: no longer s.22 "The impact on health care costs was also acknowledged:

s.22

Methadone clients also spoke about the impact of methadone on their engagement in crime:

s.22

People spoke about the importance of the program in providing a routine for in their lives, and about their appreciation for the human connections and relationships they had forged as part of the program.

Women Report Positive Experiences

s.22

Women with positive experiences described providers that were flexible in making sure that if a physician was not available when needed, that an alternate physician would get a dose arranged for the day. Women prefer having a methadone doctor who is also their family physician and value doctors that are knowledgeable in addictions and in methadone:

s.22

(VANDU Women CARE Study, 2009)

What clients like about physicians

One of the major strengths of the MMP lies in the physicians throughout the province who are supporting people to access methadone services. A few representative quotes demonstrate the importance of having a good doctor:

s.22

Physicians were valued most when they tried to help clients and when they provided good care. Two people talked about how much they appreciated being able to monitor their own dose. Clients valued the following qualities in their physicians: caring (s.22 respectful and non-stigmatizing, enthusiastic (wanting to make a difference), supportive, easy to talk to, willing to listen and be responsive, trustworthy and sympathetic.

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. One former client who is

s.22 talked about the importance of this in his journey to recovery, particularly in the initial treatment encounter:

s.22

The physical environment where MMT is provided is also important to clients. Clients liked not having to wait too long for their appointment and having relaxed waiting environments. Improvements to waiting rooms and doing general renovations to improve clinic environments to make them more cheerful and uplifting, is also appreciated. Care and respect can be demonstrated through an office environment, such as having coffee or water available.

What clients liked about pharmacists

s.22

One client said that they s.22

s.22

Some clients said that they feel more positive about their pharmacist than about their physician. Indeed, for some people the strongest care relationship is with their pharmacist.

Strengths of the MMT system according to professionals

> *"We are contributing. We need to be proud of our impact."*

> *"I went into it reluctantly but soon discovered that the program worked. I saw people doing really well."*

> *"We provide a wonderful service to this community considering there are only two of us."*

Many professionals highlighted the strengths of MMT, and a central strength is the ability of the program to save lives by enabling clients to *"turn their lives around,"* as a physician in a town in northern BC reported:

> *"We have had some spectacular successes. Clients who have come back into town, literally from living in a dumpster, and have rehabilitated and wound up working in responsible positions, turned around and become very productive members of society again."*

Methadone can act as a *"gateway treatment"* to better health and health care, and an *"excellent window of opportunity for stability and access to counselling."* One physician stated:

> *"Those folks who are extremely disorganized in their thinking, and very vulnerable to a variety of both mental health and criminal justice challenges, methadone can be that opportunity to help with stabilization and get them to a place where we can engage them."*

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Methadone can help clients break the cycle of their substance use where *"getting people's lives manageable and just getting off illegal opioids goes a long way in addictions."* Methadone can be an aid to motivate clients by giving them more control of their substance use and other areas of their lives. It also has the potential to bring other people into treatment:

> *"Hey I want some of that too. I want to have a few bucks left in the bank and a roof over my head."*

Many providers emphasized the benefits of methadone as a harm reduction tool:

> *"We are managing to keep a lot of people out of emergency, out of acute care, out of jail. We're managing to improve their health, to help them to reconnect with their families and their support network. These are benefits which I see in most of my patients."*

Many stated that MMT had played a substantial role in reducing the HIV and drug overdose rates:

> *"we've brought the overdose resulting in death numbers way down"*

> *"reduced rates of HIV infection, reduced rates of illicit drug overdose death, there was some marked success there"*

> *"It's really rewarding. I probably save more lives through methadone than anything else. People don't overdose, people don't get HIV, people don't get involved in accidents or suicide."*

Some professionals compared the program favourably to others, both in Canada and the rest of the world. The number of pharmacies involved across BC was a key strength, along with higher numbers of licensed physicians who were *"confident in methadone"* compared to other jurisdictions in Canada. A number of practitioners felt very positive about the program and their involvement in it. One physician talked about her passion for methadone work:

> *"I enjoy it. This is the most rewarding part of my very multi-faceted family practice. You change somebody's course by two degrees and they land in a different country."*

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

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Chapter 7: What Clients Do Not Like

"I have had doctors who really threaten. You've got to go into detox, you have cocaine in your pee. I just went back out on the street."

Methadone as a "full time job"

Methadone was described as a *"straitjacket"* or *"ball and chain"* by both clients and service providers. Unfortunately, this sense of restricted freedom has been associated with MMT for a long time (Bourgois, 2000; Johnson & Friedman, 1993; Neale, 1998; Rosenbaum & Murphy, 1984).

"Methadone does not have to be a strait-jacket yet I see it as a strait-jacket for a lot of individuals. It's one hell of a big price to pay for what's supposed to be the goal, physical and emotional health and change of lifestyle."

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, as this advocate describes:

"methadone fundamentally structures almost every aspect of people's health care experience, but also almost every aspect of their lives beyond their health care experience. We have a program that moves people from a life that is ordered around getting a drug and doing what you need to do to maintain your life on that drug and shifts them over to being in a situation where life is just about getting another drug and doing all the things you have to do to maintain your life on that drug. It's so disheartening on so many levels."

s.22

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.

Controlling and punitive practices

No matter how client-centred a physician may be, resentment can easily build up because clients are so fundamentally dependent on their provider to feel well and to be able to live a more normal life. Some clients felt s.22 "by their physicians and had been s.22 " Attendance at counselling was described as often being forced on people:

[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).

s.22

Clients wanted counselling to be available but not to be forced on them:

s.22

Some people viewed carry policies as deliberatively punitive:

s.22

Some clients went so far as to suggest that methadone was being used as a deliberate strategy to try to control drug users in the Downtown Eastside:

s.22

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. One client advocate reported that if an advocate sat in on an appointment, and supported a person's request for pain medication, that " s.22 s.22 "The VANDU Women CARE study (2009) found that many women drug users who are refused prescribed pain medication end up buying the medications they need on the street. One reason for a reluctance to prescribe pain medication was physicians' fears of CPSBC peer reviews:

> *"The College will audit them like crazy. If you're giving pain meds to someone on methadone, they're hassled and harassed about it and they don't want to lose their license to practice medicine to some junkies scamming or not scamming them."*

Lack of psychosocial supports and information for clients

In BC, as in other jurisdictions (SACDM Methadone Project Group, 2007), there is a lack of holistic supports to promote wellbeing and "recovery"[44] from frequent and harmful opioid use. Such supports are deemed essential in helping people to gain insight into their drug use and create changes (National Treatment Agency for Substance Misuse, 2005a). The provision of methadone prescriptions alone, particularly in the context of the Downtown Eastside of Vancouver, was seen as a *"losing game,"* largely because of the need for other types of health and social supports. Although CHCs provide comprehensive primary health care services, including substance use prevention services, there is a clear need for more specialized services that can respond to the complexity of a client's needs.

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[44] A term much disputed in the substance use literature is used here to mean the moving away from unstable, frequent illegal drug use and associated harms towards goals and aspirations for improved health and wellbeing identified by the person as important to them.

There was also a concern that people on MMT, once stabilized, are *"left on the shelf,"* receiving very little follow up, as this family member describes:

> *"There seems to be an attitude like, 'OK we've done that, great now we can just put them on the shelf.' What I feel they need to do is move to the next level. To think about, do we really want people on methadone to become productive, functioning citizens or do we want to just put them all on welfare and say, 'OK that's it for the rest of your lives'? Because the various aspects of the system make it hard for somebody to live a normal life. They don't have to be contradictory to each other, it's like stage one and stage two."*

A client said similarly that:

s.22

A lack of information for clients on methadone was a key criticism.[45] One client asked:

s.22

Many clients, advocates and providers felt that a great deal more information should be provided to clients and their significant others:

s.22

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. This is illustrated by the following quotes:

s.22

> *"… 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.'"*

s.22

[45] In BC there is no standard information booklet for clients about MMT. This compares unfavourably with the Ontario program where CAMH has developed a 73 page client handbook as well as several shorter summary documents (available at http://www.camh.net/Care_Treatment/Resources_clients_families_friends/Methadone_Maintenance_Treatment/index.html). In the UK clients receive a detailed but accessible handbook from MMT providers (available from Exchange Supplies at http://www.exchangesupplies.org/drug_information/the_handbooks/the_methadone_handbook/methadonehbk/methintro.html).

s.22

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. A woman prescribed methadone for pain describes some of the side effects she experiences on methadone:

s.22

One of the most passionate criticisms advanced by MMT clients was how difficult it was to come off methadone. Tapering off methadone was described as being an extremely slow process, viewed by many clients as *"far more* s.22 *"* Many clients felt that they were on too high a dose of methadone, or wanted to reduce and eventually come off methadone, but believed that they were not getting the support they needed for this:

s.22

Many complained that their doses were s.22 or had a fear that their increased tolerance to methadone would make it even more difficult to come off. This said, clients were also clear that under-dosing with methadone was equally problematic. Comments on dose, which is so critical to treatment success, tend to indicate the need for greater client education about MMT and greater client involvement in treatment planning and review. For example, some clients spoke about how much they appreciated being able to have a direct input into their methadone dose through close collaboration with their physician and care team.[46]

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

[46] See Robles, et al., (2001) for a discussion of client-regulated methadone dosing and associated outcomes. This study examined MMT treatment practices that allowed clients to set their own dose and found that doses did not escalate to excessive levels and that flexibility of dosing can eliminate a potential source of friction between patients and staff and improve outcomes compared to less flexible regimes.

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]

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

- 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

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[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).

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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. While some of the fiercest critics were MMT prescribing physicians in the DTES, the following quotes come from pharmacists:

"You have tons of pharmacies, I don't know if you have visited any of these pharmacies, but when you step into them you don't even get the idea that this is a pharmacy. It's just a hole in the wall, dirty. It just looks like a legal drug dealing business … You can see what the chaos is now, they buy and sell, and then they don't care."

"didn't have to send an inspector we could see it … there are bottles of methadone unlabeled getting out of the pharmacy … There were a bunch of drug dealers sitting in front of those pharmacies, and people they were coming out of those pharmacies handing it to the drug dealers. They didn't need a camera. It's so open."

"Have you heard that they are selling it overseas? They are selling it to the states. They are smugglers … This is big … Nobody comes and helps you and at the end of the day I sit down, and there is a bunch of money going down the drain and I felt responsible and it was getting … it was too much. On one hand I feel I am a professional and I live in a country that is lawful, and on the other hand that is what I am dealing every day with, and I couldn't take it."

Some participants who had been involved with MMT for a lengthy period observed that the issues about pharmacies *"had been around for a long time."* Pharmacies that allegedly engaged in the problematic practices were talked about as *"rogue pharmacies"* distinguishable from *"reputable"* pharmacies that were not implicated in such practices. One quote effectively sums up many of the problems described by other participants:

"So there's inducement, there's unauthorized carries taking place, we've got a whole bunch of issues around deliveries, there's rumours with deliveries that methadone is left in barbecues for patients to pick up. That it's left on the door step, that it's left with somebody else and even if it's delivered, if it's daily witness ingestion, it has to be witnessed ingested by a health care professional. We also hear that they are having non-health care professionals witness. That's not allowed but again it's getting evidence they do that. Unlabelled methadone bottles going out."

Incentives

PharmaCare policy stipulates that no incentives can be given to encourage clients to use a particular pharmacy (see p. 48, footnote 42). However, one of the most frequent concerns voiced by people interviewed for this review was that pharmacies are breaking this regulation by offering financial and other incentives.[48] These incentives were variously described by many participants as involving cash, bus-passes, food, coffee, store discounts, chocolates, movies, cigarettes, jobs on construction sites, other drugs such as benzodiazepines and Tylenol 3s.

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[48] The issue of incentives was profiled in a CBC hidden camera investigation in September 2008 on one pharmacy in the Downtown Eastside of Vancouver, which led to other press reports around the same time (see http://www.cbc.ca/canada/british-columbia/story/2008/09/11/bc-methadone-kickbacks-investigation-downtown-eastside.html).

Some pharmacies were also reported to be acting as *"bankers"* for MMT clients by providing personal loans in exchange for regular prescriptions. Some participants felt *"the majority"* of pharmacies in Vancouver's Downtown Eastside were offering incentives in the Summer of 2008:

> *"There are two pharmacies down here that don't provide incentives."*
>
> *"Every pharmacy down here does it."*

According to participants in focus groups and interviews held in Vancouver during April to September 2008, in the months preceding the press reports of these practices, the incentives were becoming more *"blatant"* and out in the open. Incentives were also reported for Surrey, Victoria and Nanaimo. These practices are taking place in high density urban areas where there are many people on daily witnessed ingestion and attracted to incentives by being poor, street-involved or otherwise vulnerable. There were no reports of pharmacy incentives in rural areas of the province.

Some participants linked the motivation for pharmacies to provide incentives with the increased PharmaCare payments that have been available since 2001, in particular with the payment for daily witnessed ingestion (see Chapter 4). Urban areas with a high number of methadone clients who must return regularly for daily prescriptions may be creating a lucrative market for which pharmacies are competing. One observer commented on the situation in the Downtown Eastside of Vancouver:

> *"This morning at X there was 40 or 50 people standing outside the door, like before he has even opened the door for the day he has made like $1000."*

Participants reported that sometimes the money given to MMT clients is used to buy drugs from dealers just outside the pharmacy. However, some clients stressed that not everyone receiving incentives would be spending money on drugs but instead would simply be using this money to supplement their limited incomes. Service providers, recognizing that *"for clients on welfare and disability $10 or $20 is substantial,"* did not blame people on MMT for taking these incentives. Clients were described as not wanting to come forward and report these incentives for a range of reasons, including being fearful of repercussions.

Incentives were problematic for participants for a number of reasons. For example, some participants were concerned that clients *"are going to turn around and go buy other drugs"* or that pharmacies were *"taking advantage of a population that really needs extra money."* One physician outlined several problems related to incentives and other issues related to pharmacies:

> *"Recognizing that our clients are probably substance dependent, stating that when Safeway quits giving air miles we'll quit giving money for your prescriptions knowing that standing outside the door is a dealer and you know that your clients are poly-substance dependent and use crack as well. Coming in with the prescription and walking out with $20 which immediately goes to the dealer, which immediately is a couple of rocks in hand, that is not doing our clients any good. Not providing seven day service, not providing qualified people to witness the ingestion, not adhering to what the prescriptions say. Your clients will tell you what's going on in the community and they have no vested interested in really lying ... You hear this story over and over again."*

Client views were split on the practice of incentives. Some felt strongly that they were not unethical because *"people really need the extra money."* Others believed them to have a negative impact on MMT, citing issues such as: consumers traveling across the Lower Mainland to go to pharmacies offering incentives, pharmacies out of Vancouver delivering methadone to the DTES, pharmacies encouraging clients to request daily prescriptions for all their medications, *"rogue"* pharmacies pushing ethical pharmacists out of business and the fragmentation of care

where clients get their HIV medication from an approved pharmacy and their methadone from another because it offers incentives.[49]

Physicians in Vancouver (mostly from the Downtown Eastside) had a litany of concerns about how pharmacy incentives were undermining the work they were trying to do with methadone clients and destabilizing MMT:

> *"For me as a practitioner I feel unsafe prescribing methadone down here and that's because of the plethora of unprofessional pharmacists that there are … It's just grown and grown so whatever you order you're not sure that someone actually is going to get it as prescribed. They are certainly going to get incentives, financial incentives. They will probably get drug incentives as well, T3's and Valium, whatever it takes. There's no guarantee though of witnessed ingestion or that you'll hear if they're impaired before witnessed ingestion. You'll have lots of delivery people who will leave methadone, etc. They're no longer part of the therapeutic team. They're part of the problem because their issue is profit and this is a dangerous situation."*

> *"It's getting worse, it's not getting any better and it really is one of the major, major downfalls of the methadone program in British Columbia … If it's left to continue it could ultimately harm methadone treatment over time. It's eroding away at the ability for us who want to be able to better monitor clients that are on methadone, help them do certain things. This is eroding away at that."*

> *"I've stood in line in those pharmacies and watched them dispense methadone without a prescription, 'Oh I'll come back later with the prescription.' Then another person get their methadone, not witness them and sell it to someone else in the line. I would really like to talk to the pharmacist and say she's totally unstable, we need her to come to the clinic, will you stop it? I'm worried that she's going to die. I've worked hard to put all the pressure on the patient … It is not the population's fault, they are victims ultimately and they are going to be victims of losing good pharmacies and they are going to be victims of substandard health care."*

Other problematic pharmacy practices

Another problem cited was *"interpretive prescribing or dispensing,"* where clients are given methadone without a script, or carries without a physician's authorization. Professional discretion in emergency situations is sometimes required in order to respond to the complex needs of this client group. In an interview with the College of Pharmacists of BC, such professional discretion was explicitly supported when needed in order to keep a patient continuing with their treatment. The underlying motive behind problematic "interpretive dispensing" reported by these participants was described as the self-interest of the pharmacist to keep clients coming to their business by giving them additional privileges not sanctioned by the client's physician.

Pharmacists were also described as sometimes *"making their own decisions"* on how much methadone to dispense and how. There were reports that pharmacists would *"start to wean the patient off methadone, at the patient's request, but without the provider's knowledge, in order for the patient to come off methadone but still get the financial incentive."*

Some informants reported pharmacists making PharmaNet claims before a client receives their methadone, or billing even if a client did not come in. The following comment was representative of several physicians who reported situations when they knew their client had not taken their methadone (for instance, when the person was in jail or hospital) and yet the pharmacy continued to bill PharmaNet:

> *"The other thing that pharmacists do on a regular basis is enter in their dose of methadone prior to giving the dose of methadone which is very confusing especially working in the prison system. It's not unusual that we'll have a methadone client who is arrested and when we look to see whether or not we can give them methadone, we find out that he got methadone that day. The crutch of the matter is he's been in for 36 hours, how did he get it that day from the pharmacist? But how do we*

[49] Research indicates that delivering ARV medications with methadone improves adherence and is therefore deemed a best practice (see Chapter 1). For a variety of reasons, incentives are likely to be most attractive to many of the clients for whom adherence is particularly challenging and for whom integrated care is most critical.

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now go about giving him the methadone? That's laziness on the part of the pharmacist. Its daily witnessed so he knows he's going to get paid for that."

Some clients on daily witnessed ingestion said they were given their methadone in a cup and allowed to walk outside the pharmacy with it, sometimes *"giving it to drug dealers waiting outside pharmacies."* Unauthorized carries were described as *"throwing out the whole purpose of witnessed ingestion."* A professional based in the Fraser Health region reported these practices were happening in the majority of small independent pharmacies.

Some delivery practices were also viewed as being problematic. Delivered doses that were supposed to be witnessed were reportedly witnessed by non-healthcare professionals or left unattended on doorsteps or at the front desk of hotels. One physician described what was taking place in this regard:

"The newest thing on the block, of course, is deliveries ... there's no guarantee and often there is no witnessed ingestion, it's often by a person who is not even qualified to witness the ingestion. It's often ... left with the next door neighbour because nobody was home, left on the back porch, on the stoop ... delivered by cab ... In neighbourhoods with kids. We're talking about if it's ingested by the wrong person, it's probably lethal."

Witnessed dosing was also reported to be taking place at Skytrain stations. Key informants, when asked about these unauthorized deliveries, attributed them to competition and the pressure to retain clients with a particular pharmacy: *"it's another way of retaining patients."*

Some pharmacies were reported by both clients and health care providers to be watering down their methadone:

s.22

"We can't be sure clients will get what is prescribed."

s.22

Irregular or inconsistent dose strengths of methadone were reported between pharmacies, some too strong and some too weak. As a result, clients reported, s.22 or getting sick when switching between different pharmacies. Some clients stated that they believed methadone was being watered down for profit, or leaked to the black market.[50] Some participants believed that organized crime is involved in some of the practices described above. Fear of organized crime involvement was said to be preventing clients and professionals from coming forward with their concerns.

Many participants described the impact of these practices on clients and on the health service system more generally. The main theme raised was the ensuing "wedge" placed between providers and patients:

"The other big issue that I'm sure you've heard lots about are pharmacies, corrupt pharmacies. How that puts a wedge between the provider and the patient, and, you know, one of the greatest therapeutic things that you have in addictions is the relationship with a patient and that's torn when you are arguing with them because of the pharmacies ... the pharmacy intervention. That's a major problem."

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[50] This difference in methadone strength between pharmacies may also be due to variations in dilution ratios (suggested in personal correspondence with review adviser) or the methadone mixture not being thoroughly rotated or mixed through sufficiently, allowing settling to occur (rationale suggested by some clients).

Response to complaints

Many informants had complained to authorities about problematic practices, but reported that *"nothing's being done."* A selection of comments is provided here:

> *"Have tried complaining to Colleges," "have been speaking to City Council," "we were told of an investigation and to wait," "We keep sending complaints to the College* [Pharmacists] *but nothing happens," "Complained to PharmaCare," "College of Pharmacists is not doing anything," "College of Physicians is supportive but doesn't want to take a stand," "PharmaCare feels powerless, government is not doing anything." "BC PharmaCare wants to have a hearing around X, but I feel this hearing is a knee jerk reaction to show action is being taken, but is not looking at big picture," "The Attorney General's office is taking two pharmacies to court but they'll just show up elsewhere with different names," "Clients who have been asked to speak in the court case are fearful for their lives."*

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. While these alleged connections could not be verified in this study, the frequency of the reports suggests the possibility of a systemic problem as is clear from the comments of one Downtown Eastside physician:

> *"there should not be a conflict of interests between the treatment and the management of the patient … you should not have a relationship with another service provider, whether that be a pharmacy, or whatever it is … where you're steering your patient toward that one pharmacy or company. There should be some strict ethical guidelines as to how far pharmacies and physicians should be removed from other services, like recovery houses. How close can you be financially to these other services and not be in breach of ethics? That should be made clear and people should be made to practice by those ethical guidelines. It would help to get rid of some of the sleaze that's happening out there. Again, the money is too much. It's just too easy. How do you want addicts to be treated? Just do anything … get them out of my face … whatever. People know that."*

Clients and health service providers reported that some physicians were restricting clients to particular pharmacies. Some clinics had devised lists of five or six pharmacies that they told clients they were required to use. A number of clients said that their provider had told them that if they changed pharmacies they would be cut off their methadone.

Various reasons for these restrictions were suggested ranging from personal gain because of financial links with the pharmacy to *"concerns about pharmacy ethics"* and client safety. Whatever the reason, some providers felt that denying client's access to MMT was inappropriate. One provider said, *"cutting them off from this clinic is like severing a life line for many people."* Clients were not always aware of why their prescriptions were being restricted. To them the motivation for the restriction was not that important. Instead they felt that this was just another dimension of coercion and control that many had to contend with on a day to day basis. Clients were upset or angry for a variety of reasons: being prevented from receiving incentives, inconvenience in not being allowed to visit pharmacies near to where they lived, disruption of established and trusted relationships with pharmacists, or breaking their routine.

Some providers stated that they were aware of clients, particularly young Aboriginal women, who felt coerced to go on methadone by their physicians:

> *"They go in and they get stuck on methadone and then they get sent out to these recovery houses where often there are these huge problems. They are attached to these particular pharmacies. They don't really want to be on methadone."*

A number of clients and providers (mostly in the Downtown Eastside of Vancouver) spoke about people they knew being put on methadone for cocaine use:

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s.22

An unhealthy system

As reported in the chapter on private clinics, some participants saw an *"unholy relationship"* between some recovery houses, methadone clinics, physicians and pharmacies. In 2008, CBC documented claims of financial links between some non-licensed recovery or rooming houses and pharmacies.[51] Participants reported similar links in the Vancouver and Fraser regions involving methadone clinics, physicians, pharmacies and housing or treatment programs. One pharmacist said:

> *"That's what happens ... in the Downtown Eastside. Most of these pharmacies ... the person who owns them, owns SROs and hotels and they have their own drug dealers going at night to the patients, selling drugs and in the morning convincing them to come to get their methadone in their pharmacies. So, it's just too corrupt."*

s.22

Tenancies were reported to be conditional on using a specific pharmacy. Landlords were reported to have threatened or evicted tenants when they did not use the landlord's pharmacy. Some recovery houses were reported to be denying access to clients unless their physician agreed to daily dispensing of methadone:

> *"What those non-licensed support recovery houses will tell you that if your patient is on an antidepressant, an antiepileptic, let's say some medication like that, that unless you prescribe it on daily administration and daily dispensing, we won't take that client. You have your choice. You have a client who desperately needs some sort of support in housing, and hopefully some degree of stabilization in one of these places who may be on as many as three, four, five different medications for whatever the reason may be, medical reason or an unidentified mental health issue or something of that sort, so multiply five times $9 and you get an idea of how lucrative it is if there's 30 patients in that recovery house, how lucrative it is to have a contract, an agreement with one of those non-licensed support recovery houses. And I see it every time, every time. ... I have my choice. Does my client get the opportunity to go here or do I deny him that opportunity when he's basically on the street if I don't. What do I say?"*

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.

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

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[51] See http://www.cbc.ca/health/story/2008/09/09/bc-080909-peoples-pharmacy-evictions.html.

- 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
- A multi-stakeholder mechanism to ensure system-wide planning, monitoring and evaluation is desperately needed
- MMT clients should be represented on all bodies that provide advice and oversee professional practice related to MMT in BC
- Local communities should be represented on regional MMT committees to ensure community involvement and responsiveness to local needs

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Chapter 9: Access

"How do you say no to someone?"

There are many dimensions to the barriers clients face in accessing MMT in BC: physical, attitudinal, financial, systemic, relational and cultural. Many of these issues have surfaced, and will surface, in other chapters. This chapter, however, brings together comments that illustrate these various dimensions related to access in an attempt to provide both description and analysis that can inform change.

System capacity

There are no accurate data on the actual numbers of heroin or other opioid users in need of treatment in BC. Some experts participating in the study offered numbers of between 16,000 and 20,000 illegal/illicit opioid users in BC. Estimates suggest that only 30% of Canada's illicit opioid using population will be enrolled in MMT at any given time (Fischer, et al., 2005). With the number of MMT clients just over 10,000 at the end of 2008 (see Table 2), the MMP is reaching well over the Canadian average. The number of prescribing physicians increased in the early to mid 1980s, and rapidly in the initial years following the up-scaling of the program in the late 1990s, and has again increased almost 20% in the five years from 2003 to 2008.

Table 2: Numbers of Patients and Prescribing Physicians Involved in the MMP (CPSBC, correspondence February 2009)

Year	# of patients	# of licensed physicians	# of physicians with MMT patients	# of new physicians
2002	8273	594 (A & OD)*	Unavailable	Unavailable
2003	8124	301 (OD)	Unavailable	Unavailable
2004	8270	299 (OD)	205	27
2005	7465	339 (OD)	188	20
2006	8207	353 (OD)	196	26
2007	8985	321(OD)	199	15
2008	10103	359 (OD)	214	38

*A= licensed to prescribe for analgesic purposes. OD = licensed to prescribe for opioid dependency.

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.

Despite these positive developments, methadone provision is unevenly distributed, and need often exceeds capacity. One expert, with reference to the lack of provision outside of urban centres and existing pressure on urban prescribers and clinics, suggested that in some areas as many as 75% of the population who could benefit from MMT were not able to access services.

Some participants spoke of:

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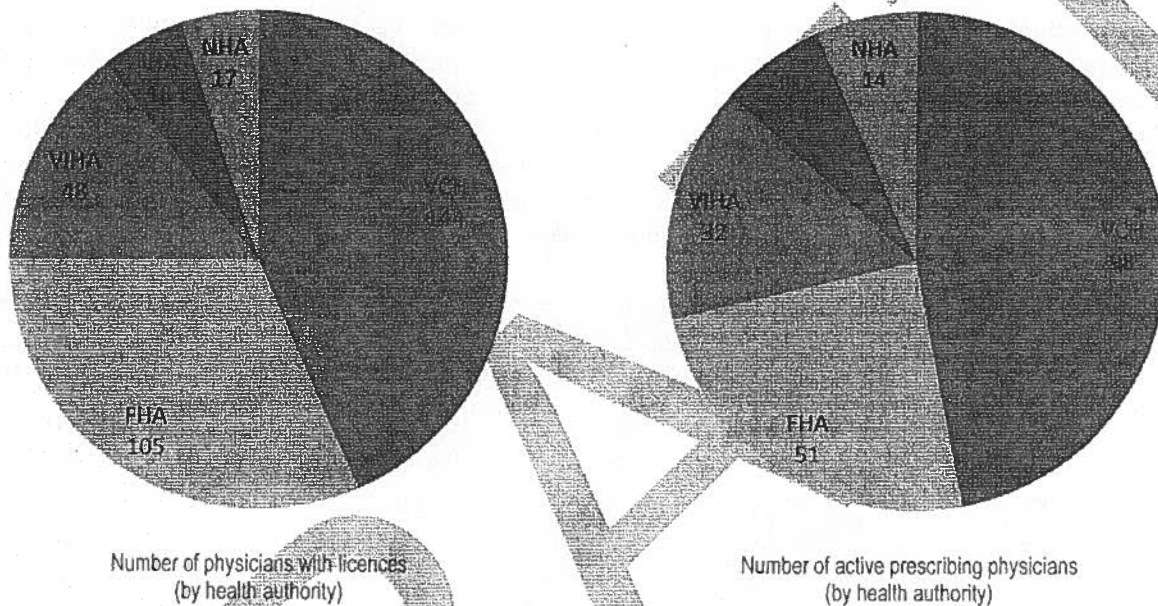
- a complete lack of treatment availability in certain parts of the province, particularly northern, rural and remote areas
- clinic and physician capacity being at a maximum with waiting lists and caseload caps in place
- the *"revolving door"* and clients being inadequately retained in treatment so that the numbers at any given time includes many patients who may be on MMT for a matter of days or weeks, rather than reflecting people who have been retained on the program for any length of time

Figure 3: Physicians in BC with Licence to Prescribe Methadone for Opioid Dependence (CPSBC, correspondence February 2009)



Number of physicians with licences (by health authority)

Number of active prescribing physicians (by health authority)

Urban BC including the Downtown Eastside of Vancouver

There was a wide variety of views on access in Metro Vancouver. There was agreement that the development of community health clinics throughout the city[52] has improved access significantly for MMT. Some participants felt capacity was no longer a problem:

> *"unlike in Fraser, the North and the Island, I don't think waitlists are an issue anymore"*

> *"I'm still there to try people out. But they are not coming right now, I have space still for two, and I haven't taken anybody new in quite a long time."*

Others felt that access was still problematic in Vancouver, with comments such as:

> *"600 to 1000 treatment spots are needed in Vancouver alone, immediately"*

> *"there aren't enough access points in Downtown Eastside"*

One Health Authority manager agreed:

[52] Nine community health clinics are operating (eight run by Vancouver Coastal Health and one by Vancouver Native Health) and provide integrated access to primary care, public health, mental health and addiction services.

"Our treatment spots for methadone compare favourably for most jurisdictions, so you would think that there shouldn't be unmet demand for methadone. But certainly there is. There are people from the supervised injection site asking all the time for referrals and can't get in."

The downtown community health clinics were reported to be *"saturated."* Shortages or high turnovers of physicians in the clinics have an impact on access to MMT. Sub-groups of clients are prioritized for access, even if services are at capacity, for example, pregnant women, street youth, homeless people, people with HIV, particularly unstable people, sex workers and Aboriginal people.

There is less capacity in the Fraser Health area and a significant amount of the capacity is in private clinics charging user fees. Many participants talked about their frustration with the lack of availability of low barrier and no-cost MMT. As a result, Vancouver MMT services reported receiving clients from the Fraser area:

"Fraser Health needs to demonstrate more leadership. We get clients coming from West Burnaby that we provide service to; we're not going to send them away."

Northern, rural and remote BC

Stakeholders reported a substantial access problem for MMT in non-urban areas of the province. Some people have to leave their communities for methadone. There are very few clinics outside of the lower mainland where MMT is provided. Indeed, some communities have never had availability of MMT so local Health Authority managers have little concept of client need:

"Methadone is not something that's been identified as a huge need here. Because they haven't had it people are making do without it. Some of them are never getting clean."

Some providers in rural areas felt that local communities did have a need for methadone:

"People knew I had a license and were stopping to ask me about methadone everywhere."

Some stakeholders held the view that access to MMT, as with many other health services deemed a specialty,[53] would necessarily be limited in rural areas. The lack of access to primary care for MMT clients must also be set alongside the broader problem faced in BC in relation to access to primary care. Many highlighted the thousands of unattached patients for primary care across the province, and noted that this impacted marginalized populations of health care users, such as people with problematic substance use, more seriously than the general population. Although this was not by any means limited to rural and remote areas, participants spoke about being *"leery of advertising"* their MMT services:

"We don't advertise because we've already exceeded capacity, advertising would drown us."

While not advertising was partly due to fear of a community backlash, providers were also trying to keep methadone *"under the radar," "afraid of an avalanche."*

Community opposition to methadone, was apparent in discussions with northern, rural and remote providers, and in Fraser Health. Participants spoke of methadone clients as *"not being from this neighbourhood"* and *"whole medical communities dead set against methadone."* This attitude was noted to be gradually shifting with progress made over the past couple of years in many traditionally "hostile" parts of BC. The need for more proactive work with local communities to address the stigma and stereotyping related to MMT clients or people with problematic substance use was emphasized by many respondents.

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[53] In some jurisdictions, MMT is not considered a speciality. In the UK, for example, all General Practitioners are able to prescribe methadone without a special licence.

Access

The lack of prescribing physicians in smaller towns, or rural and remote areas of BC, leads to huge pressures on solo or small groups of physicians providing service across large geographic areas. Recruitment and retention of staff are significant concerns. With no other providers being able to prescribe, responsibility falls solely to rural physicians where recruitment is difficult generally: *"It is hard to attract physicians to some areas in general, let alone methadone prescribers."* For areas with only one or two prescribers, worries abound that they would *"get sick, retire or move away."* In one location an advisory committee met for two years to try to recruit a physician with a methadone license. When an area loses a physician this can be devastating: *"we lost everything that we had gained over 14 years, we tried to find another provider but couldn't."* CPSBC has previously tried to support those in rural communities to find new physicians willing to become licensed prescribers, but, according to one provider who asked for help, the College no longer feels it is their role to do this. Some individual physician leaders within ACOD continue to play key roles in championing MMT and trying to encourage physicians to become licensed.

Doctors in rural or remote areas can feel pressured to take on new clients, even though their workload is at capacity. Many are reportedly overworked: *"dead on their feet,"* or close to burn-out. Feeling stretched to the limit, some rural physicians reported limiting access to protect themselves and their existing client caseload: *"I'm only taking on low risk clients, not high risk in faraway communities."* There were some communities where methadone prescribers existed but had capped their patient load in order to be able to provide a better quality of service to their existing clients. In these cases, those wanting or needing MMT would be placed on waitlists or turned away. Some providers reported six month waitlist estimates. In smaller communities access is also more dependent on maintaining good relationships with providers: s.22

s.22 A provider spoke about the same challenge, but from the other side of the relationship: *"In the interior, we don't have the luxury of sending people somewhere else."*

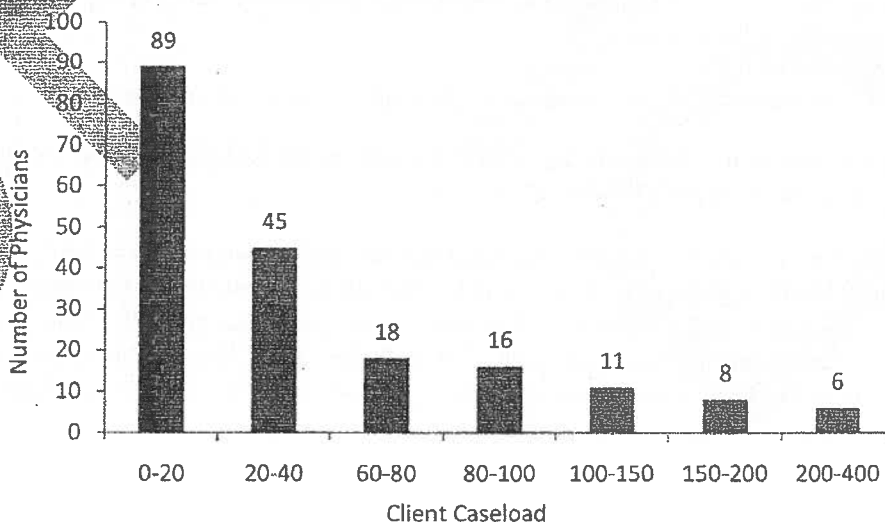
Caseload and workload

Data from the CPSBC indicates a wide spread in terms of physician caseload (see Figure 9.2). Some providers try to emphasize the quality of the services they provide, and in doing so, access to new clients can be reduced: *"We do very thorough visits so we see 10 patients in the time it takes another to see 60."* In Vancouver Coastal Health CHCs there are clinic caps in place due to workload issues. MMT workload was reported by some providers to be *"overwhelming,"* and many talked about their frustration in trying to keep track of their client caseload:

"You're supposed to see patients regularly but I can't see 120 patients regularly."

Many rural providers, serving large geographic areas, report wanting to make MMT as accessible as possible for their population but find it difficult to cope with the resulting large caseloads. Often they report other local physicians being either unable (i.e. do not have licenses to prescribe) or unwilling to share in MMT provision.

Figure 4: Physician Caseload for MMT in BC (CPSBC, correspondence 2009)



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Some physicians like being involved in MMT and see it as a challenging and interesting role. Others may wish to have a large caseload in order to make a good income, as this rural physician describes:

> *"either because they believe in it and the people they prescribe for, they think it is a human right, or because it pays. But it only really pays if you can get over 150 patients and have people that can cover for your patients when you are away, which means mostly urban. So those prescribing rurally tend to be the ideologically motivated physicians, they get burned out, retire, give up and then the community is without again."*

Access to pharmacies

Access to pharmacies dispensing methadone was described by most participants as good, or certainly as having improved markedly over the past few years: *"there is almost a pharmacy in every geographic area now."* The opening up of larger chain pharmacies has significantly facilitated access. Many urban pharmacies are open 7 days a week with extended hours. The provision of methadone through community pharmacies was supported by many respondents as an ideal model. One participant said having a *"pharmacy based in communities is a good aspect, so people don't have to go so far."* However, in response to some of the pharmacy-related problems reported in Chapter 8, other respondents wanted methadone dispensing to move "in-house" to clinics and become more tightly integrated with other MMT services.

Access to pharmacies was reported to still be problematic in some areas. Clients can be seen as an *"extra workload,"* due to the fact that the methadone liquid requires mixing up in advance, and also because of the witnessing and multi-agency communication elements of the role. Shorter business hours of rural pharmacies were a barrier according to some participants. Small family-run or sole proprietor pharmacies tended to be 9-5, Monday to Saturday, creating problems for people who are working. Examples were provided where clients have to travel 1.5 hours to get to the pharmacy for methadone. For clients on daily witnessed ingestion this means that MMT is not an option for them. Even for those with carries, this is significant. Due to a lack of access to dispensing pharmacies there can be pressure on physicians to allow carries earlier than usual. Some communities have methadone shipped/mailed to them, or the pharmacy delivers. Others were reported to be using courier services to deliver methadone to outlying areas *"like a mail order."* Rural methadone providers reported working with the College of Pharmacists to find solutions to addressing rural and remote access.

Some pharmacists still choose not to dispense methadone, reportedly to avoid being stigmatized by other health professionals in the community by associating *"with the seedy side."* The view of some pharmacists was that methadone clients are *"bad and will scare away other customers."* In some urban settings there is a congregation of MMT clients around pharmacies which can fuel this stigma.

Other systemic barriers

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

> *"Clients are not aware of the red tape of bureaucracy that goes in when they come in in crisis. When they're initiating you say, 'Sorry, we've got to fill out all these forms, and then fax it away, come back tomorrow.' That impacts everybody. They go away frustrated."*

However, other physicians said they were able to get potential clients on MMT the same day they came in for treatment, commenting that CPSBC processes are now very efficient in this regard. Transferring patients between physicians and the follow-up paperwork with CPSBC was also seen as a barrier that can result in the *"treatment window"* being lost.

Transportation in northern, rural and remote areas was identified as a barrier to service. Many MMT clients, do not have cars, live in areas poorly served by public transport, and are already struggling with low income. There is no

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support for transportation costs for MMT clients.[54] Travel can be especially difficult in winter or poor weather conditions, or in areas of very isolated terrain not covered by public transport. Some MMT clients reportedly travel over 250 km to receive MMT services:

> *"We're seeing much greater distances than we used to. Some people have to hitchhike which can be dangerous and access is now affected by gas prices."*

> *"You wouldn't say go from Merritt to Kamloops to get your insulin. Reduced access wouldn't be accepted for other treatments or medication. Asking people to cover such large distance for methadone is unreasonable."*

A number of stakeholders reported increased access to methadone for maintenance in hospitals and acute care. Recent efforts to enrol hospitalists in the MMP were reported, and more hospitalists now have both regular and temporary licenses for MMT. Health authority managers described a new problem emerging since access had improved on the acute care side:

> *"Starting them isn't a big deal, it's how are they going to be maintained in the community when the community is at capacity. That's probably the bigger challenge."*

Lack of community access, through lack of capacity or lack of rural prescribers, was also reported by those working in the corrections system.

Factors limiting community prescribing

The original vision for the MMP was reportedly for widespread provision through local family physicians. To a large extent this has not occurred, mainly because of the limited number of trained and licensed physicians. While the number of prescribing physicians has increased as noted earlier, the numbers of licensed physicians with current MMT patients remained virtually unchanged from 2004 to 2008. This is despite the number of clients having increased by more than 20% in the same period (see p. 69, Table 2). The possible reasons for this "prescriber plateau" are likely to be many and varied but two were repeatedly referenced by participants.

Stigma and discrimination

The stigma of the population group was reported to impact physician motivation for MMT work. Physicians reported being treated *"the same as abortion docs,"* or like *"political footballs,"* and having to take *"a lot of flak"* for this role. There was a perception from physicians not involved in MMT that *"some physicians who prescribe methadone are drug pushers."* Many doctors were viewed as wanting to *"avoid addictions because it is a difficult population,"* as this prescribing physician describes:

> *"There's a holier than thou attitude with some physicians in town that I've spoken to about their patients who are addicted, 'I'm not going to have anything to do with that.' Maybe you don't like doing rectal examinations, you're not going to have anything to do with that sort of thing either? It's part of medicine."*

People with active substance use problems were reportedly viewed by some physicians or health care providers as *"horrible"* or *"threatening."* According to participants, some physicians were unwilling to advocate for this population; they did not want to *"step into this kind of swamp,"* and thereby tarnish their reputation in the community. Race, ethnicity and class were also named as relevant factors to physician decision-making regarding taking on certain patients. Some physicians were described by their peers as preferring to *"stick with white, middleclass, Caucasian"* patients. One rural physician, with a license to prescribe methadone for pain but not for opioid addiction, described his reason for not getting the additional license:

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[54] MHSD transportation allowances are used for MMT clients in some rural areas but this was reported to be against policy.

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"I'm concerned that as a community, it would attract people. Rural areas attract needy people anyway and the network of people who are seeking drug prescriptions for opioid addiction is fairly good at conveying information as to who prescribes and who doesn't. If X was known as somewhere that had a prescribing doctor, I would be a little concerned for the community and the implications that that may involve, given that we already have a significant drug-taking minority and a significant crime rate associated with that."

Lack of support from colleagues was also noted to be preventing licensed physicians from becoming active prescribers. This was due to a stigma regarding having MMT clients in family practices: *"We don't want those scary people in the waiting room."* Clinic partners were sometimes described as being vehemently opposed to the provision of MMT in their practices, as one participant explains:

"Whether this doctor is willing to take him on or not, we won't have him in this clinic."

A nurse described a situation in her local area where a clinic lost one of three prescribing doctors when he moved into a practice where other partners refused to let him prescribe MMT:

"Dr. X moved into a practice that didn't allow him to see methadone clients. It's a bummer, a real bummer. The other partners didn't want methadone clients and these clients accessed that clinic long before they were identified as 'those people.'"

The impact of physicians moving practices and then being unable to prescribe was reported to be devastating in a small town with few other prescribing physicians. This impacts caseload because other prescribers in the area then have little choice but to pick up these *"orphan"* clients and integrate them into their existing workload.

Sensitivity to stigma is reflected in the lack of public access to a list of physicians who prescribe methadone for opioid dependency in BC. According to both CPSBC and two physician respondents, physicians do not want their identities known. Some felt publication of the list would be potentially damaging to communities because of the type of people (i.e. criminal and drug seeking) that might be attracted. There was also fear that this knowledge would negatively impact on a physician's reputation, and that other patients might leave a practice if their physician was involved in MMT.

Licensing requirements and College guidelines

The need to undertake training and get a license acts as yet another disincentive for physicians to come into MMT. Doing the training was seen as *"taking time out of practice,"* and the aspects of having to travel and pay for the training was not appreciated, especially by those outside of Vancouver where the majority of CPSBC training workshops are provided. One participant was clear about the connections between licensing requirements and the lack of physicians:

"How can you encourage physicians to practice in remote communities if they have to train, get audited and travel for training?"

Even providing training does not necessarily lead to physicians taking up their licenses. In 2007, 75 physicians enrolled at Vancouver Island Health Authority's MMT training session at an Addiction Medicine Conference. However, this was reported to have led to *"no or very few new licenses,"* despite the fact that physicians had also been paid a significant sum to attend this training event. Then, even having a license is not necessarily leading physicians to start having active caseloads. One physician stated, *"50% try it and say they're not interested."* Instead of being motivated to become prescribers, the opposite seems to be occurring, where interested physicians are being put off. Some insights emerged from the data that may help to articulate why.

One is the CPSBC requirement that all MMT physicians will provide 24 hours a day, 7 days a week, 365 days a year coverage for their clients on MMT. This requirement may be possible to organize for a prescriber in an urban area with close colleagues who also provide MMT (e.g., working in a CHC or private clinic where there may be an on-

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call service and where providers are on rotation). However, many rural physicians emphasized how this alone puts them off providing service: *"It doesn't work for sole prescribers."* A large number of rural physicians could be considered to be sole prescribers, covering substantial geographic distances. Attempts to receive help and coverage from other physicians in a surrounding area, even temporarily to cover holidays and trips away, was reported to be very difficult. The outcome of this was rural physicians feeling isolated and lacking support, unable to get away from their work unless they had good multi-disciplinary arrangements for coverage with nurses, for example.[55] The likelihood that physicians who do not have straightforward coverage arrangements will be put off coming on a CPSBC training course seems reasonable. Certainly one prescriber commented that this was a strong disincentive to prescribe:

> *'Why is there nothing better in place than, 'You must give 24hr/7 days a week/365 days a year coverage to your patients?' which is what the College asks of people, with no support in helping physicians think through ways of addressing this.'*

MMT was also viewed as unattractive because of the general shortage of family physicians. Demographics of medical school, with more women doctors *"less interested in methadone,"* may also be relevant. Financial reimbursement was also considered by some to be inadequate. If MMT only pays by having high caseload numbers, this is unlikely to be possible in small town or rural office-based practices.

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

[55] This is the model used in Fort St John where there is a sole prescriber.

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Chapter 10: Retention

"Short term treatment of methadone doesn't work. And the mantra in methadone programs is 'retention, retention, retention,' until the person has had a significant amount of stability."

Retention in MMT beyond 12 or 24 months is often cited in the literature as important for positive treatment outcome for people with opioid dependence (Simpson, Joe & Brown, 1997). Literature also suggests that efforts to retain patients when they first appear for treatment are necessary if patients are to derive full benefit from MMT (Strike, et al., 2005). In MMT, the most important factor is clients remaining in treatment rather than having been in treatment for a long time (Zhang, et al., 2003). Some practice implications of literature on the importance of retention is to increase the proportion of clients sustaining treatment, to try to encourage treatment re-entry when people drop out (Goldstein, et al., 2002), and to take steps to clarify and deal with concerns and misconceptions in MMT programs (Drug and Alcohol Findings, 2004). A summary of the literature on retention provided by Drug and Alcohol Findings (2004) suggests that some broad principles can be determined as encouraging client retention in MMT:

- Establishing an organization and counselling style responsive to the client as a human being with needs and ambitions beyond those related to drugs
- An organizational ethos and interpersonal style which conveys understanding, liking, warmth, and optimism in the client's ability to benefit from treatment
- The ability to "get into the client's shoes" and attend to the personal apprehensions that an individual may have about MMT given their past history in treatment, low self-esteem and self-confidence and feeling of being a failure

This chapter details the specific issues that impact client retention on MMT in BC. Many of the systemic and practice issues have already been described in other chapters of the report (particularly Chapter 7), so will not be reported in detail.

Despite Anderson and Warren's (2004) analysis of BC PharmaNet data from 1996-1999 indicating a retention rate of 52%, participants were concerned about retention in the methadone program. This concern was described in a number of different ways but a key phrase was *"the revolving door"* phenomenon. A rural prescribing physician in northern BC observed:

"The pattern provincially is people are on and off. That's the norm. It's not a failure of methadone, it's a failure of the rest of the program. Methadone works. Very few people once they maintain on methadone have problems."

An *"on and off"* pattern of client retention on MMT across a jurisdiction means that while new people are coming into the system to start on methadone there are also many people re-entering MMT:

"There are some indications that the quality of care in BC is not optimal. When you have relatively low doses and relatively poor treatment retention, it means that there are a lot of people who start methadone, stay in for a while and then leave, so always at the front door you have new patients knocking on the door who've never been in care. But you also have the people who've been in and fallen out. If you are able to improve the quality of care you're able to eliminate those cycling people and accommodate new people. The other thing is that some people who have trouble accessing methadone have difficulty doing it because of things like mental health problems or serious persistent stimulant use. They struggle because of not being able to keep appointments or show up at the pharmacy every day to get their dose. Low threshold access points could help with access for those people."

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Factors that decrease retention

Lack of supports, services and information

Providing a prescription for methadone is only one part of MMT that needs to be in place to offer clients the best opportunity for success in stabilizing their lives and moving towards recovery. According to participants, success for clients was dependent upon helping a person rebuild their life. Some suggested that too often the program set people up for failure by not providing the psychosocial supports alongside methadone prescribing. A government stakeholder explained:

> *"A methadone maintenance program that's operating in isolation of other community resources to help individuals build linkages to things like affordable housing, income support, basic social needs, having those attended to or having some work happening to start to manage some of those challenges ... I think you're setting people up for failure."*

In addition, while targeting supports for particular sub-populations is not a new idea in substance use interventions (Parkes, Poole, Salmon, Greaves & Urquhart, 2008), this was an approach largely absent in MMT.

Problems with methadone continuity

The many access issues that present barriers to MMT in BC have been outlined in the preceding chapter. In particular, the scarcity of prescribing physicians in rural areas was identified by participants as negatively impacting retention. People who had been stabilized on methadone in one community (or in hospital or prison) were often unable to access a prescribing physician when they moved. This can result in a person being tapered off methadone prior to moving or being released. This is a serious problem because of the need for continuity, once a person has been initiated on methadone.

One of the most challenging aspects of MMT provision, for both clients and professionals, was the frequent movement of clients between different geographic areas of a city, town, or across the province more widely. While CPSBC has reporting requirements in place to try to ensure that providers inform both the College and other providers of a new client accessing their service for methadone, in practice there are still gaps in communication that leave clients vulnerable to continuity problems.

There were a number of reports of the punitive and dismissive ways that people on MMT are treated in Emergency Departments or other acute care settings. Below are quotes from clients or professionals in each health authority, to illustrate how pervasive and widespread these reports were:

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I've never understood what the fear has been. Someone is trying to get their 40mls of methadone. I mean if our concern is trying to help people, we make the barriers so great, it forces people to go out there and use illicit heroin." [Fraser]

These statements suggest a deep-rooted stigma held by those working in health care services towards people with substance use problems. They provide a window to view how health services are being delivered to, and experienced by, those with complex, challenging and painful lives and histories. Severe social inequalities, marginalization, lack of user voice, stigma and discrimination seem to combine in everyday scenarios to leave people with opioid dependency highly vulnerable. These statements can also be triangulated with other data where professionals describe a fear that clients on MMT have of using acute care, sometimes specifically due to concerns about their methadone continuity (VANDU Women CARE, 2009). Interruptions in methadone continuity are also closely linked to clients seeking street methadone or other street opioids in order to manage their withdrawal.

Links between retention and MMT dosage

Recent analysis exploring the relationship of methadone dosage to client retention is instructive at this point (Nosyk, Sun, Sizto, Marsh & Anis, 2009). Several stakeholder statements provide important contextual information on this issue. For example, one prescribing physician talked about physicians being afraid of a College rebuke if they prescribed higher dosages of methadone for clients:

"There are physicians who are really antsy about increasing the dose of methadone because they're feeling the College breathing down their neck. It sets up for bickering and not very good patient/physician interactions because you're always on their back, people want to stop the program, they're tired of arguing with their doctor."

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.

"If you can't give somebody enough methadone then you're chasing your tail because they're going to add what they need of heroin or morphine or whatever so that they feel okay."

Systemic problems and controlling practices

There are many *"hoops to go through"* to get onto MMT, despite a determined push from CPSBC to streamline the paperwork and procedures required to bring someone on to the program. Some clients have *"struggles in keeping appointments, schedules and routines,"* or as one client said:

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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). People are *"turned off by the program"* or by previous experience with the program.

As described in other parts of this report, if methadone services are too controlling it is very hard for people to live a normal life, as one provider described:

"Methadone can be very frustrating ... you have to have that methadone and it's very hard to live a normal life if you have to go to a pharmacy every single day. I think sometimes they go off it just for that reason."

Many physicians spoke about their unease with the many restrictions that MMT created for client's lives. Indeed, a significant number described their willingness to work in ways that responded to *"where a person was at,"* reflecting an openness and flexibility of approach that attempted to keep people in treatment, sometimes in defiance of College guidelines:

> *"I find myself struggling when I'm dealing with my patients because sometimes I have to just ignore the guidelines and say it's more important that I keep this person coming back to see me every week because I know in a year or two, it's a waiting game, they'll come back and see me if I'm being open like that and then I can make some slow progress over time."*

Another participant said:

> *"It just seems that people trying to go through the right channels have to bang on the door so loud and feel judged and stigmatized. They think 'What's the point? I have tried working with the system. It's more onerous and punitive and shaming. I better go back under the table, because at least I feel comfortable there.' And I have seen that happen, where men feel the system is not working, so they go and create their own system."*

One aspect of current practice was viewed as particularly problematic. Relapses to other street drugs, or other prescription drugs accessed from another health provider, were reportedly *"punished"* by some MMT providers, by expulsion from MMT. A physician commented:

> *"one of the problems in the past, that is happening still in certain areas, as soon as somebody experiences relapse in treatment, they kick him out! Imagine the kind of damage that does because people, what do they do? They just return to the same."*

Another prescribing physician, working in the Downtown Eastside, commented on what he perceived as punitive practices by fellow physicians:

> *"Some physicians take a punitive attitude. If somebody screws up they'll drop them. That's not the answer. You don't withdraw someone from methadone. I've seen people withdrawing really quickly. I've taken them on sometimes. They come in physically ill because some physician's cut them off. It's never appropriate to cut somebody off, or to force them into a rapid taper. It's appropriate to say, 'I can't work with you,' if that's how the physician feels, but 'I'm going to give you so much time to find somebody else,' rather than 'I'm going to cut you off' … which is medically inappropriate. People need to understand that."*

This is in opposition to the recognition within the clinical literature that relapse is part of the natural process of health behaviour change:

> *"It's the complete opposite of what the whole approach should be. It is, 'I don't really care if you succeed or not.' But you really want to say that, 'I'm on your side but please don't stay away if you fail. Always come back here. You're always welcome here.' Instead we have this 'How dare you do that to me, I almost lost my license.' Who are we running this program for? It's just nuts."*

> *"If we follow a stages of change* [approach], *then our task is simply to move with them to go from precontemplative to contemplative or preparation to action. That's good work and in the alcohol and drug world we've done some good strides in going forward. It's been a much better match to the client's needs and desire."*

Lack of information for clients

Some clients reported feeling deceived about MMT; that they were not supplied with enough information prior to starting the program to make an informed choice:

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A medical student in Northern BC conducted a quantitative study with people using a clinic and shared his conclusions:

> *"The larger comment that was repeated over and over again was the poor understanding about methadone. Several times people mentioned that they were deceived and that reflected that people were not as informed as they would have liked to have been regarding the challenge that being on methadone is, and how difficult it can be to come off. I think people thought, 'Oh this is my step towards abstinence.' Whereas, by and large, they found that this was stabilization, and substitution therapy, rather than a progression to abstinence. It seemed to be a recurrent frustration to the program. Now they are stuck on methadone."*

Financial issues and the "two-week rule"

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. One client described his feelings of having to find money for both clinic and prescription fees from his small earnings:

> Interviewer: *You think it's a disincentive for people to have to pay?*

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A provider described how clinic fees would be paid from MHSD (see Chapter 4) for a period of time, but when the $500 allowance was used up they would have no choice but to leave treatment:

> *"Some patients will use up their $500 in six months and then drop out."*

Another issue relevant to retention is the "2 week rule" discussed in Chapter 4, that requires physicians to see their clients for a routine appointment twice per month, regardless of level of stability or other life circumstances. Rural physicians in BC are lobbying MSP, the BC Medical Association Tariff Committee and CPSBC to reconsider this rule because of the impact it has on client access, retention and satisfaction with services. Rather than helping, physicians argue that this rule impedes their ability to deliver quality service to sometimes large caseloads of MMT clients. This rule seriously affects clients in rural or remote areas but is likely to also apply to clients in urban areas with jobs, children, transportation problems, disabilities, or other significant health problems such as chronic pain and long term conditions. A provider in an urban location in the Interior highlighted this impact:

> *"Even if they live in town, if you have a job and you need to leave your job twice a month for an afternoon, it's putting your job at risk. It's inconvenient. It's encouraging people to abandon methadone because they're making it overly onerous, overly difficult."*

Physical health impact of methadone

Some clients reported becoming tired of the physical impact of methadone, or tired of the taste:

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Many clients reported not liking methadone as a medication or treatment. According to one research adviser for the review, individuals may also use methadone as a *"bridge"* when they have nothing else, or are too sick or too tired to chase the drugs that they do want. This feeds into the *"revolving door"* of MMT, and supports the need for alternatives to methadone for opioid dependent people (see Chapter 14).

Environmental triggers

The difficulty in stopping use of street drugs is a widespread problem for clients on MMT. Environmental triggers, such as being back in the same area and meeting up with the same people a person used drugs with, are common threats to stability and recovery. If MMT is delivered in a setting where many other clients are being served who are continuing to use street drugs, this can be a problem:

> *"They say 'I don't want to go there because that is where all of the druggies are, and if I go there I'll use.' So ones that are serious about getting clean don't want to go to the places they are told are available to them for support."*

Even people coming back from treatment can find it hard to abstain if they return back to their home town:

> *"We've had clients who have come back from treatment and have stepped off the bus and the dealers have been waiting as a welcoming committee at the bus depot. They're vultures."*

Clients were reported by a number of participants to "drop off" attending NA/AA groups because they were sold drugs there:

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Factors that increase retention

> *"One concern is to the need to give people enough options so that they stay on the program."*

Many of the factors that increase client retention are simply the opposites to conditions described above. Commonly reported factors included:

- Staying in one's own community and not having to travel
- Having supports and involvement in one's community
- Using an approach where relapse is normalized and there is an understanding that recovery is a process over a period of time; expect people to *"screw around at first"*

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- Flexibility in provider practice that respects clients' circumstances and is willing to *"cut some slack"*

  "the College need to get back to basics and remember the population they are serving. And the population they are serving are people who need structure, but need flexibility as well. And being rigid is not going to work, I believe the program needs structure, people need structure, but people also need to be cut some slack at times."

- Offering programs where people with substance use problems have opportunity to *"give back to the community,"* to increase confidence and reduce stigma
- The importance of having a treatment plan but allowing people to influence their dose

  "Allowing each individual person to be in control of their dose. It's awesome, you can increase if it's not working. That is the best thing because I really think it's different for everyone. Just like every individual is different, every addiction is different. What works for one is not necessarily going to work for another."

- Initiating partners on methadone at the same time, if desired, to encourage best chances of stability[56]
- Providing alternatives to methadone to create choice for people who are opioid dependent but do not want to take methadone

"that's why we need more than one treatment option, because not everybody is willing to take methadone."

The NAOMI Trial

Participants viewed one of the strengths of MMT in British Columbia as the North American Opiate Medication Initiative (NAOMI). NAOMI was a two centre, parallel, open-label randomized controlled trial testing whether heroin assisted treatment offers benefits over and above optimized methadone therapy for individuals with chronic addiction. It was co-located at St Paul's Hospital in Vancouver and in Montreal. The trial included long term follow up of participants over 24 months and this phase was ongoing through 2009. Interestingly, and relevant to this systems reviews, is the fact that the control arm of the trial received optimized methadone maintenance therapy.

Optimized methadone maintenance therapy (OMMT) was defined as including:

- Interdisciplinary care (physician, nursing, social work and addiction counsellors)
- Low patient-to-staff ratios
- Client-centered counselling including case management
- Outreach supports including accompaniment to specialty care
- Targeted primary care for common physical and psychiatric conditions
- Highly trained clinical team including all physicians certified in Addiction Medicine
- Linked dispensing of psychiatric, HIV and antimicrobial medications
- Average methadone doses at least 50% higher than the community average
- Effective pain management for acute or chronic pain
- On-call and weekend support to prevent missed doses in the event of missed appointments or unexpected release from correctional institution or hospital

This trial of OMMT in Vancouver offers an opportunity to see the benefits of providing methadone within a broader context than is currently standard within the MMP. When the treatment phase was completed in June 2008 the primary outcomes of the trial were published and demonstrated a retention rate for OMMT for 12 months of 54.1% (North American Opiate MI Study Team, 2008), higher than the current retention rate for the MMP (see Nosyk, Sun, Sizto, Marsh & Anis, 2009)). In a group of clients who were deliberately sampled as "chronic opioid-dependent treatment-refractory injection drug users," this is a significant and positive finding in support of OMMT. Participants involved with the trial cited the key strengths of the OMMT as an average dose of 100 mg, individualized care, lower patient-staff ratios, case management and active support, an on-site pharmacy and an extended role for physicians:

"The physicians thought it was part of their role not just to write the prescription and deal with the methadone, but also to do motivational interviewing, try and get people engaged with the counsellor, and do a defined range of primary care."

[56] This practice was reported by the Sheway project for substance using pregnant women.

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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

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Chapter 11: Gender and Age

"Everybody's worry is somebody overdosing on methadone but you have to put it into a context of who you're dealing with. I had a patient who was found dead in her apartment. Her methadone level on the toxicology was high so the Coroner called me up and said, 'Tell me about the patient.' I told him that she had been admitted to the hospital with multiple suicide attempts and overdoses previously. He said 'Well, is it the methadone that killed her?' I said 'No, it's not the methadone that killed her. What killed her was that she lost two of her kids to foster care, her mother wouldn't let her see the kids. She's been traumatized all her life from abuse. That's what killed her. Methadone was just a symptom.'"

Few participants talked about gender or age without being prompted to do so. This may be because review discussions were taken up with matters considered to be very problematic in relation to pharmacy practice or lack of access to MMT, for example. Some participants did raise issues in relation to the needs of women taking methadone, but few spoke about the specific needs of men.

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."

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

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. Some considered there to be a *"disproportionate lack of access for women."* However, this view varied depending on where a participant was located in the service system. A female physician commented that due to a priority within Vancouver to prioritize women and Aboriginal people:

"unfortunately it is the guys, the Caucasian guys, who get shafted."

Reasons for accessing MMT appear to be different, to some extent, for men and women. For women, MMT was sometimes sought in order to exit sex work, s.22 Professional commentators said that some women in the sex trade use methadone to do *"fewer tricks"*:

"It's a safety mechanism using the methadone. They will still be using other drugs but because they're using the methadone they can reduce their cravings and not have to put themselves in dangerous situations."

It should be noted that given the levels of violence experienced by women with addictions who work in the survival sex trade and, in particular, the violence experienced by women in the Downtown Eastside, even a temporary respite from the streets, through methadone managing a woman's withdrawal, may be a crucial safety mechanism.

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:

> *"The male population of clients are most interested in getting a job to support their families and themselves. Their counselling is getting a job."*

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

> *"Female patients are a bit different. They are the ones I find have to have counselling for, the sexual abuse counsellor."*

For many women who have experienced, or are still experiencing violence, patterns of substance use are closely linked to this violence and abuse (Bensley, Van Eenwyk & Simmons, 2000; Jantzen, et al., 1998; Martin, et al., 1998; Whynot, 1998). Having access to a female physician was noted to be very important by a number of clients and professionals:

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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:

> *"To make the assumption that everyone who is currently using an opiate doesn't need or doesn't want some kind of therapeutic intervention does people a huge disservice. A lot of women will talk about the fact that nobody asked what they wanted. There are a lot of people out there that are very wedded to the 'don't ask,' particularly around the intersection of addiction and violence. Well, I am a great believer that it is a disservice and disrespectful not to ask."*

Professionals were also very concerned with the amount of inappropriate prescribing. A manager working in residential substance use treatment commented:

> *"I am really concerned about the number of women who are on a combination of methadone and benzodiazapines. What is that about? Why are physicians putting those two things together for women? Unfortunately we fought that battle in the seventies and I think won for a little while and are losing again. You are talking about a double whammy for numbing someone when you have that combination."*

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:

> *"Five, ten years ago these women would hide."*

Participants noted an increased *"burden"* on pregnant women, however, because of the requirements of MMT and prenatal care, in part because of the need for close monitoring of dosage. There were different levels of knowledge concerning pregnant women and methadone by health care providers. Best practice in this area clearly indicates that opioid dependent pregnant women need to stay on opioids until they have their child (Health Canada, 2002). However participants reported that some pregnant women were being advised by healthcare providers to go into detox programs, something that has been associated with miscarriage in women that have been using opioids at

high levels. There was an expressed need and desire for best practice guidelines in this area, and CPSBC has addressed this within their revised Methadone Maintenance Handbook (2009). There was also seen to be an urgent need for better education for women regarding MMT and pregnancy. For instance, during a focus group, one woman on methadone said:

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A number of researchers and clinicians talked about their desire to see heroin prescribing, in addition to methadone, particularly for pregnant women:

> "*Heroin actually has the least long-term and short-term impact* (on the fetus) *than the prescribed stuff, but physicians do not have the choice to use it.*"

> *"they see it at Fir Square all the time. The babies who withdraw and who withdraw hard, those are babies that have been on methadone. It's much easier for a newborn to withdraw from heroin than it is for that newborn to withdraw from methadone."*

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.

> *"There was a lot of angst expressed at this round table from women in particular, who were afraid to admit that they were using methadone because they were afraid that their children would be taken away from them."*

This is another important gender difference to underscore. For men, methadone was connected to being able to get a job and provide for their family. For women, reprisals connected to the stigma of being on methadone could substantially undermine a family's stability. While one man talked about methadone helping him to reconnect with his child, no men talked about their vulnerability to being harshly judged as parents (due to taking methadone). In comparison, women repeatedly made such comments (cf. Radcliffe, 2009).

For women that live separately from their children, visits to children can be very important to their stability and recovery. However, as described in Chapter 7, it is often very difficult to get sufficient carries, or carries at all, in order to travel. One woman living in the Downtown Eastside of Vancouver spoke about the impact of being denied carries on women that she knew with children:

> *"Like four carries to see their children at Christmastime. They don't get carries, their doctor won't give them a four day carry and they can't get methadone. They either get off the program and get heroin so they can go and see their children, or they don't go. And people, when they don't go, are more likely to commit suicide because of the depression."*

Gender specific programming and women-centred care

There was support for gender specific substance use treatment settings, including ones provided through primary care services, such as community health centres.[57] Women are less likely to come in for services, for example, when there are many men present:

> *"they may shy away from them because of fear of some of the others using those services, who may have victimized them in the past, prey upon them, pimps."*

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[57] Gender specific or gender sensitive care has been a theme in substance use prevention and treatment literature for a number of years (see Cocazza, et al., 2005; Parkes, et al., 2008; Poole, 2000; Poole & Isaac, 2001; Salmon & McDiarmid, 2006; Schliebner, 1994: Watkins & Chovanec, 2006; Whynot, 1998).

"We developed, for example, a women's night pilot a few years ago in an attempt to attract more street involved women who don't come in during the day when it's full of men."

Although addictions services were viewed by participants as being better than mental health services in terms of providing women-specific programs, participants felt there was still a lack of trauma-informed, women-centred day programs. One counsellor emphasized:

"Both the girls who died would have done well on day programs, both very intelligent but severely damaged people. They needed an environment with stability, they know that they can go there and be safe. It's needed and it's just not available."

While the availability of counsellors can be a problem in methadone services, a number of participants spoke about the need for both male and female counsellors. Some believed that there needed to be: *"a different culture for women that is more supportive."* Others felt that providing methadone as part of comprehensive care was particularly important for women, because of the importance of good reproductive health services.

Age and Methadone

Youth and Methadone

The MMT Guidelines by CPSBC are clear that young patients considered for methadone should have failed repeated attempts at detox, be over 18 years old, and have been addicted to opioids for over a year. However, there were a range of views on youth access to methadone, as the quotes below describe:

"We prioritize youth."

"We are seeing more young people now yet there is a lack of youth services in this area."

"The youth piece and how that is being handled is a big question mark ... there's some challenges around youth not being able to access it anywhere but at an adult clinic and whether or not the way we work with youth should be different. Even in youth detox, who work with street-entrenched kids, they hardly ever see any youth on methadone."

One physician from the Downtown Eastside of Vancouver, reported on the experience of a group of colleagues:

"There are not so many youth that are primarily long-standing opiate dependent (stimulants are more of an issue) and of those very few are interested in starting MMT. Mostly for youth we try methadone for detox, or to stabilize and a slow taper. Sometimes people want to get on methadone due to fear of detox, or misunderstanding what methadone can do for them (i.e. help with stimulant abuse or to lessen the negative side effects of stimulants)."

Another physician from the Interior commented similarly:

"My general principal is that the first and best option for all my patients regardless of age is detox and follow treatment with subsequent close relapse prevention and long term sobriety. Having said that, this is not what I manage to do for the average person. In the youth I would push all the harder for this though. Methadone is a long term 'ball and chain' for anyone, and even more so for the youth as there are more years ahead of them."

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.

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Seniors and MMT

Older people are an emerging population in need of treatment and support services for problematic substance use. There is a small but growing population of high need, long term drug users who are now aging:

> *"There were emerging numbers of people who are now aging out addicts who lack access because they are seen as seniors. It's probably a small population but a high need. Long term methadone users who are now aging and have other health concerns."*

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.

The following consideration emerges from the discussion summarized in this chapter and has informed the recommendations at the end of this report.

- 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

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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). One Aboriginal participant described how intergenerational experiences of colonization, and the ensuing social suffering, continue to impact the Aboriginal people she worked with:

"never mind the mental health diagnosis, we can't get focused and address their chronic illness because they're wrapped in the trauma from residential school, sexual abuse, poverty."

A non-Aboriginal prescribing physician noted similarly:

"The barriers are astonishing for the Aboriginal community, and this was particularly poignant last week with the Federal Government apologizing for the Residential Schools. Every one of my Aboriginal people that comes in has had huge, unbelievable effects from that process, disruption of the communities, lack of structure."

Many Aboriginal and non-Aboriginal participants stressed that this context must be taken into consideration in any discussion about harm reduction and treatment services for Aboriginal people in BC. The implications for how substance use is understood, and the connections between substance use, mental health problems and short and long term trauma, are profound. The chapter weaves these themes together, using the words and views of participants and ends with suggestions for change that are based on the centrality of core values in service systems and that attempt to respond to these interconnections.

Access

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:

"Mental health and addictions services fall short of meeting the needs of our Aboriginal people. The mental health piece is all about DSM-IV and often that is not the major cause of mental health problems in our people. They do not provide a service that really addresses what the issues are around trauma. The addictions services are horribly under-funded and there's a huge waitlist for folks to get in. If we miss the window because there's a six or eight week or a three month waitlist, we have missed the window of opportunity."

Indeed, one of the main complaints about mental health as well as addiction services in BC is that they are not trauma-informed, something that impacts more significantly on Aboriginal people, particularly Aboriginal women,

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than on the general population (Aboriginal Justice Implementation Committee, 1999).[58] The need for trauma-informed services was believed to be essential:

> *"We certainly have identified in our Aboriginal Health Plan that mental health and addictions is the issue and that it really is trauma not DSM-IV."*

Aboriginal people talked about their belief that addiction services in BC were not culturally fit for them. One example of this was medical detox:

> *"There's no detox, there's a couple but they're medically driven. In those kinds of programming, people are not being served."*

Not only is the Aboriginal lens or viewpoint missing from existing health services, but Aboriginal people are underrepresented in most mental health and addiction services. This, of course, varied across the province with one substance use service in northern BC, for example, having 50-55% Aboriginal people in their client cohort.

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).

Off-reserve access to MMT

The off-reserve Aboriginal population makes up more than fifty percent of Aboriginal people in BC (Wardman, Clement & Quantz, 2005) although there is much movement between reserve and non-reserve communities (Buxton, et al., 2007). Review participants commented that mental health and substance use resources were not reaching the off-reserve population, in spite of attempts to prioritize this population in services, especially harm reduction, HIV and substance use services. In the Downtown Eastside of Vancouver, participants working in health care services said they would *"take anybody Aboriginal,"* or *"any Aboriginal woman."* Many clients of the community health centres in Vancouver and downtown Victoria are *"marginalized street-entrenched people, and a lot of those folks are Aboriginal."* Although Aboriginal people have been prioritized for access to MMT, substantial barriers are still reported:

> *"People that are multi-barrier and struggling with addiction aren't getting access to primary health care therefore aren't getting access to methadone."*

MMT providers in the interior and northern BC, serving both on- and off-reserve communities, emphasized the small numbers of Aboriginal people who came looking for MMT. Recent provincial research supports this finding by indicating that Aboriginal ethnicity is negatively associated with MMT use in opioid users (Callon, et al., 2006). The Cedar Project study of young Aboriginal people between 14-30 who use injection and non-injection drugs in Vancouver and Prince George also indicates that MMT uptake among off reserve young Aboriginal people is relatively low (Yang, et al., 2008).

On-reserve access to MMT

MMT is not available on reserve in BC (Buxton, et al., 2007). One participant stated:

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[58] Knowledge about the prevalence and impact of trauma has grown to the point that it is now widely understood that the majority of people seeking services in the public health system have trauma histories. Trauma-informed care provides a new paradigm under which the basic premise for organizing services is transformed from "what is wrong with you?" to "what has happened to you?" Trauma-informed care is initiated through an organizational shift from a traditional "top-down" environment to one that is based on collaboration with consumers and survivors (National Centre for Trauma Informed Care, n.d.).

"There's theoretically no methadone prescribed on-reserve as there isn't any harm reduction supplies on-reserve. But on the other hand if you're taking it on a daily basis and you don't have carries then there can be a lot of to-ing and fro-ing."

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:

"It takes them about two hours depending on how far out. There's quite a few little communities and they're anywhere from 60 miles to 90 but you're not on an expressway, you're on a small paved highway so it takes longer. The furthest that we have coming in is two hours.

The impact of the lack of MMT on-reserve and in small communities on HIV infections was highlighted by participants:

"if you look in the smaller communities outside Vancouver, Surrey or Prince George for instance, they have no services. This is one main reason not to be able to stop the HIV epidemic. If you have intravenous drug use in a small community, you need someone who provides substitution. If not you have a major problem around severe infections and that's what we see. We see a major increase of HIV cases on-reserve."

Aboriginal communities located in closer proximity to a large urban centre had more flexibility in terms of how substance use services are accessed. Communities and reserves that are most remote are ones clearly most impacted by lack of access to MMT. People are hitching rides because there is no transportation assistance to go to the pharmacy, even if they are able to get a prescription from a physician for methadone in a local town. Health Canada's Non-Insured Health Benefits program does not cover travel for methadone prescriptions and a number of participants suggested that there was a lack of parity for people who need to access transportation costs for methadone, as opposed to other health problems where costs are covered, such as diabetes:

"If you were going for dialysis, and you were a First Nations person on-reserve and you lived a substantial distance away, you would qualify for some km coverage paid through Non-Insured Health Benefits or through MSP."

Offering methadone services much closer to reserve communities or actually on-reserve was viewed as an expense unlikely to be manageable for the health system, as one pharmacist outlined:

"There are some very remote communities that don't have access to doctors or pharmacies but do have individuals that would benefit from methadone programs but short of having that person move, there is not much that can be done."

On-reserve health services vary widely and are based on a number of factors including how large a reserve community is and how much money is available. Health services are federally funded although this will be changing with the new policy of self-determination connected to the *Tripartite First Nations Health Plan* (First Nations Leadership Council, 2006). On-reserve health personnel may be community health workers or community health nurses, and often staff are part-time. There was a lack of knowledge, even amongst specialist Aboriginal health leads, as to the extent to which substance use prevention support was provided on-reserve. Some First Nation communities have also negotiated physician services. This regular if temporary physician contact was seen as a possible resource for methadone prescribing but this was something that would depend substantially on a range of factors, such as whether a physician had a methadone license, how consistently they are traveling out, whether harm reduction and substitution treatment was an area of medicine they were interested and competent in providing and, naturally, whether the First Nation community wanted MMT to be a service offered to their community.

A number of additional barriers feature in on-reserve communities. Firstly, Aboriginal leadership, both provincially and on-reserve was described as: *"not being very amenable to accepting methadone."* A commonly held belief within

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Aboriginal leadership, and Aboriginal communities more generally, is that methadone is *"enabling addiction,"* as this Aboriginal substance use manager describes:

"We had one young man, about 26, [who] *had been a heroin addict since he was 14 and been on methadone for about two or three years. Within a year he had weaned himself off methadone, was abstinent from all drugs and had taken his first year cake in the NA program. He wrote back saying 'I'm doing great. I'm following up on my plan. I've gotten back into school. I'm doing really well.' And he was. Going through the program for him was the first time that methadone wasn't an issue because we choose not to make it an issue. It becomes an ethical debate, 'You're enabling them to stay high on methadone,' there's a real anti-methadone sentiment out there yet these guys are hooked on heroin when they're 13, 14 years old."*

One solution to lack of on-reserve access to MMT is people leaving their communities and moving into the nearest local town where methadone is available. However, this is a solution with important ramifications.

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The issue of payment also arises when an individual has to move off-reserve and have their health needs taken care of in a different community. Given these challenges some participants argued strongly that methadone could and should be provided on-reserve:

"If we can do TB on reserves, we can do anything."

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.

"How do we prepare communities and get them to get their people away from the Downtown Eastside, or off the streets of Prince George? How do we get them back home so we can take care of them? You can't take them home if there are no services to take care of them."

Stigma, trauma and lack of culturally appropriate and sensitive services

There are other less visible factors that inhibit access to MMT for Aboriginal people both on- and off-reserve. For example, there is often a stigma about using MMT or other harm reduction or substance use treatment services. In urban settings, such as the Downtown Eastside, participants described people getting access to MMT services and then *"being so turned off by them that they did not want to go back."* Some health professionals are aware of the intersectional nature of multiple oppressions, and the consequent impact on poor health outcomes:

"Aboriginal people who are already up against racism and discrimination come up with this level of oppression and they're never sure what it is. Is it because they're Aboriginal? Is it because they're male or female? Is it because they're substance-using? Is it because they have a mental illness? Most of the people I see have all the above. Is it because they're HIV-positive? Is it because they have hep C? What is it? Those intersecting oppressive forces come to bear on care. This person is dehumanized by the experience of waiting in line-ups, long waiting times that are so disrespectful of people's time and their lives."

Funding complexities and inequities

"Federal agencies responsible for Aboriginal health have not been as supportive as they could be around methadone."

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. Non-insured health benefits are paid for a range of prescription medications including methadone. While methadone is an open benefit in NIHB, there is a clause that allows administrators to stop a person's methadone after a few months. For Aboriginal people who do not or cannot identify as status, either they have to pay for their own prescriptions or, if eligible, they can receive assistance through PharmaCare.[59] The NIHB fee for methadone is approximately $5.40/$5.50 a day. This fee is considerably less than that paid by PharmaCare and does not vary between carry or witnessed doses. Pharmacy representatives were keen to stress what they felt to be a problematic differential between the Non-Insured Health Benefits and PharmaCare reimbursement, highlighting the impact on pharmacists as well as the client group being served:

> *"it is very much too low … and it's obviously a large issue for* [pharmacists] *who are servicing First Nation populations because the reimbursement that's established at the provincial level sets the standard so when the NIHB diverts from this and unilaterally decides that something different is what's offered, there is obviously resistance, and a sense of unfairness. The real challenge for pharmacists is recognizing, particularly with existing patients, that there is a need. They are being put in a very difficult position of accepting what they see as a reimbursement schedule that is below their cost of providing service for that patient group, but also recognize that that patient group needs the service. What I have a sense of, and it's only that, is that many pharmacies concluded that they could not in good conscience cut off their existing patient group but they wouldn't accept any more."*

If this report is correct, then clearly the inconsistent policy is creating a barrier to access for some Aboriginal clients. One reported outcome of this difference in policy between the federal and provincial pharmacy reimbursement systems is pharmacists *"switching over"* Aboriginal methadone clients' coverage from NIHB to the provincial PharmaCare program:

> *"The whole switchover, it does happen ... pharmacies are billing, and then the patient disappears off the face of the earth. It doesn't mean that the patient is not getting their drugs any more, it just means that [they] have switched over to the provincial program. If they are on social assistance this is a way that pharmacists are able to switch people over and bill PharmaCare without it having to go to NIHB, not exactly sure how but it happens a lot."*

A large number of participants, including pharmacists, described their discomfort with the high levels of compensation that the provincial PharmaCare program paid pharmacists for dispensing methadone. One participant viewed the disparity between programs as PharmaCare overpaying for MMT. A number of participants suggested that federal and provincial government representatives should work together to develop more consistent, if not identical, reimbursement arrangements in order to address this situation.

Culturally-appropriate services

> *"There may, in fact, need to be a culturally discreet model for First Nations."*

Although the need for culturally competent, sensitive and appropriate services has been discussed briefly above, it deserves further exploration. Aboriginal people experience high levels of problematic substance use and this is intimately connected to experiences of colonization and associated poverty and oppression and multi-generational trauma (Aboriginal Justice Implementation Committee, 1999; Salmon, 2007a; Salmon, 2007b). One Aboriginal

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[59] One participant emphasized that not all Aboriginal people are comfortable with seeking welfare assistance from either the federal or provincial governments because of a suspicion, distrust or dislike of welfare colonialism. Many Aboriginal people are very sensitive to dominant discourses where they are represented as *"just wanting to be on the dole"* and for this and many other reasons do not want to engage with the associated systems.

health lead commented that this knowledge had still not effectively been translated into the development of appropriate, holistic services for Aboriginal people across BC:

> *"I would like to see a more holistic model. There is a place for the medical component of detox, absolutely, but it is so oriented to that way that it's missing the other pieces. And often it's seen as punitive. Those things are not open to us as people, never mind Aboriginal people. And then we have all this addiction going on in our communities that is not being addressed. I think that we've really missed the boat on what we're doing here. It's just a horrible mess and it's probably the most prevalent health issue in our communities – trauma and addictions, and the fallout of those two things. I don't see anything happening … It's DSM-IV, mental health diagnosis, schizophrenia, psychosis. Those are the ones that get the funding attention. There needs to be acknowledgement that the issues that Aboriginal people have are different. We need to start looking at these things through a lens of equity rather than equality, then we are able to see that what we're doing, even though it might be equal, isn't meeting the needs of the people who need it the most."*

There was agreement amongst participants on the need to *"tune"* mental health and addictions services to the needs of different sub-populations. Some reported that structures and systems work against this. An Aboriginal health lead noted:

> *"there are definitely physicians that want to work with this population but the structure and the current way that they are actually expected to work doesn't fit with the needs of this population. They would like to see a centre where people could access when they are able, something that wasn't so driven by appointment times and schedules."*

Participants described different ways that services could be *"tuned in"* to the needs of Aboriginal women and men. For many people, recovery from life experiences of violence, abuse and trauma, and social inequities of all forms, is a slow gradual process that should not be rushed or directed by outsiders. One Aboriginal woman described the learning she had gained from working closely with women who had experienced abuse and violence:

> *"as outsiders we cannot go into our communities and say to our women, stand up for yourself. It's a gradual, ongoing process of support."*

Another person described research conversations with Aboriginal people on what they valued from health care services and was keen to stress three core factors that were most commonly mentioned:

> *"Kindness goes a long way, compassion and respect. These are the things people talk about."*

While these factors or values should, arguably, underpin all health/substance use services, these were features that are frequently mentioned when undertaking research with Aboriginal people about what they value from health services (see Browne, Fiske and Thomas, 2000). This can be understood most clearly in the context of research that has detailed the many invalidating and dismissive encounters Aboriginal people can experience (Browne, Fiske and Thomas, 2000; Salmon, 2007a; Salmon, 2007b; VANDU Women CARE, 2009). Browne, Fiske and Thomas suggest the use of "conditions of cultural safety" to address the culturally unsafe practices that Aboriginal people continue to encounter in BC health care services:

> cultural safety is concerned with changing attitudes and with gaining an awareness of the political and historical forces shaping the dynamics of health care interactions with Aboriginal people … Cultural safety can be achieved only through meaningful participation in decision making, that is, decision making that moves beyond marginalization to enhance rather than dismiss or violate cultural values and social practices (p. 9).

These authors also include a discussion of the health care encounters experienced by Aboriginal women as "affirming." In doing so, they illuminate some of the processes and practitioner/patient relations that have better served Aboriginal women:

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> Given the context of the recent colonial nature of health services and the difficulties that characterized participants' encounters with current mainstream services, it became apparent that descriptions of positive health care encounters were symbolic of what mattered most: sharing knowledge and power with participants over health care decisions, conveying respect for the participants as women with unique cultural heritages, and forming effective interpersonal relationships in ways that reduced the distance between participants and others in relation to the health system (p. 21).

Four central themes emerge from this work that can be used here to indicate the ways that Aboriginal women in this published study wished to imbue their health care experiences:

1. Actively participating in health care decisions
2. Feeling genuinely cared for
3. Affirmation of personal and cultural identity
4. Development of a positive, long-term relationship with a health care provider (pp. 21-26).

The VANDU Women CARE (2009) recommendations also align closely with the above. While these two pieces of research have been done with women, many of the implications for health care policy and practice seem to have transferability to working with Aboriginal men and have been described here as a way to give more depth to discussions of "cultural appropriateness" than is sometimes offered in policy and research documents. One piece of work that does attend to the needs of men and women, again undertaken in BC, tackles the issue of culturally appropriate means and ends of counselling for First Nations peoples. Through the use of qualitative, critical incident technique analysis McCormick (1996) describes balance, expression of emotion, inter-connectedness (including establishing social connections), and transcendence/spirituality as the most important means and ends of counselling, as described by First Nations people involved in the study.

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] It could mean hiring Aboriginal staff to provide health services or, where Aboriginal staff are not available, hiring non-Aboriginal staff who are able to combine *"western medical psychiatric with traditional cultural models."* Participants felt strongly that an Aboriginal perspective and Aboriginal input must be represented in all service and policy development. Aboriginal people having greater opportunities to become experienced and qualified in the fields of counselling, mental health and substance use, so that they could become part of the health service workforce, was viewed as essential. The need for sufficient resources for this capacity-building was also highlighted.

In terms of the culturally appropriate services available to Aboriginal people, there are only one or two Aboriginal residential treatment centres in BC that accept people on MMT. A provider at one of these Centres described its aims:

> *We tap into the cultural and spiritual, that is so much the foundation of who people are, and a lot of people lose that in addictions. By coming here they're able to pick up some of their cultural beliefs and practices, some of their spiritual background, like the sweats and the smudging every day and the Elders that come. They're touching their Aboriginal spirit and that's what gives us the healing component ... because they tap into all of the essence of the person. It's that essence of who you are.*

[60] Located in 24 communities throughout the province, BC Aboriginal Friendship Centers provide a number of culturally sensitive, quality programs and services to aboriginal communities (see http://www.bcaafc.com).

Aboriginal treatment centres for substance use have perceived the need to support clients to examine other life problems, such as violence and abuse as well as problematic substance use. The holistic approaches and models of *"culture as treatment"* that some Aboriginal treatment centres employ were viewed as best practice models for the development of substance use treatment generally, and MMT services more specifically.[61]

Integrating People Taking Methadone into an Aboriginal Treatment Centre

Approximately two years ago we began admitting clients into treatment while on methadone. Integrating clients into the treatment group has had its challenges. The ability to focus and participate in group without hyperactivity or drowsiness is essential to individuals and to the group as a whole. Each person on methadone is unique and how they access treatment is a personal journey. Any step toward helping oneself is important. It opens that window to change. While being here they begin to look at themselves, their behaviours, patterns and attitudes, and this awareness precipitates a better feeling about themselves. They start to access their own power. I believe the most important thing in incorporating methadone into a residential treatment service is to be open-minded and allow people to be where they are without judgment. Knowledge is such an asset and we need to be informed and educated on a regular basis in order to create a safe and effective environment.

Marianne Linthorne, R.N. Round Lake Treatment Centre, Vernon, BC

Moving forward

A number of bands and First Nations have taken on responsibility for their own health services from the Federal government and these transfer arrangements were noted to be taking place through the year of the data collection, 2008. *The Transformative Change Accord* (2006) and *Tripartite First Nations Health Plan* (First Nations Leadership Council, 2007) were discussed by a number of participants as potentially a key way of closing the large health gaps[62] between the Aboriginal and non-Aboriginal population of BC. Initiatives between the federal government, the provincial government, and First Nations governance have resulted in increased investment in the First Nations Health Council. The task was acknowledged to be large but many participants hoped that this new body would be able to create more cohesion for MMT for Aboriginal people in BC:

> *"the First Nations Health Council is in early days, but coordinated dialogue can be spearheaded by the Council. We can make headway in terms of encouraging communities to either be linked to methadone resources outside of Aboriginal communities in a more direct way, or to have the resources available to initiate methadone treatment within communities. That message is being delivered by Aboriginal leadership to Aboriginal communities, instead of being something that the provincial government is encouraging. It's always been at a cross-cultural slant that has inhibited open discussion about attitudes to harm reduction in methadone maintenance and defied a more coordinated approach to date."*

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[61] Other examples of models of care in substance use treatment that attend to culture are described in Salmon and McDiarmid (2006). Sheway, located in the Downtown Eastside of Vancouver, provides comprehensive health and social services to women who are either pregnant or parenting children less than 18 months old and who are experiencing current or previous issues with substance use. Sheway incorporates a focus on culture and healing through, for example, the incorporation of traditional parenting values in their parenting class, providing women opportunities to learn traditional crafting and ensuring that there are Aboriginal people on staff who can bring to their practice an awareness of how historical and contemporary conditions of colonization impact Aboriginal mothers who are struggling with addictions. An example of a substance use resource specifically created for Aboriginal communities is the *Crystal Meth Reference Guide: Remember Your Spirit*, available at http://nccabc.pmhclients.com/images/uploads/RememberingOurSpirit_crystalmethguide.pdf

[62] See, for example, Vancouver Island Health Authority, Aboriginal Health Plan (2006).

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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]

> *"here a physician would go to these communities and firstly have a face-to-face meeting with the patient, a physical, and would then set up the program, and after that it could be run by telehealth with sporadic visits to the areas in question. It could be a very rewarding thing for both the prescriber and the patient."*

There are a number of practical and systemic challenges that need to be addressed before telehealth can be rolled out in BC for methadone prescribing. One of these is the bandwidth required for fast data streaming and security. Another is the need for MSP to allow for telehealth billing. Yet another is the need to identify a critical mass of patients who want MMT in any one community in order for physicians to be motivated to provide this service and be adequately compensated for this work. One physician elaborated:

> *"How viable would it be? If I only get two people then what am I going to do? If I'm trying to build up a practice, what do I do? Go to telehealth and disconnect and then wait for an hour later? I just can't see that kind of coordination. Somehow you have to have economic scales, that you have to go to a certain size of a community where you say, I have ten people there I'll see them within this hour, then I'll go to another community so I only have two sites to visit."*

Participants also stressed the need to have a trained and experienced health professional working directly alongside the client on the community side, perhaps a nurse or community health representative. Telepharmacy was also raised by a rural pharmacist as having the capacity to support MMT provision across rural and remote areas of the province.

Shared-care models, like the ones being described here, would require workforce development but may be particularly attractive for communities to consider, to ensure a larger amount of involvement and control over what happens in their area. Shared-care models may also be a possible method to address the problems with long carries being given to clients in rural and remote areas:

> *"the issue is pharmacists are afraid to, or cannot, because of scope or because of rules, give someone more than a week's supply. Could that not be dispensed to a health professional in a rural community to dispense, with some fairly strict guidelines and rules?"*

Overall, the best delivery mechanism to provide MMT to both on- and off-reserve Aboriginal communities was considered to be primary care. However, bearing in mind the challenges that were identified, participants spoke about the need to train more health professionals, particularly physicians, in rural and Aboriginal health. They also explored the possibility of providing incentives to attract health professionals to rural and Aboriginal communities:

> *"There are some physicians whose heart is in rural health, or in Aboriginal health, and this speaks to a bigger systems issue which is the need to train more docs in rural and Aboriginal health and to provide incentives for them to do that kind of practice, because the numbers aren't currently there. I think they need to have incentive and support to go down that road."*

Toward recommendations

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

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[63] Ontario is using telemedicine to provide access to MMT across the province (see: http://www.otn.ca/en/physicians-hcps/). Telehealth was also mentioned by Wardman, Clement & Quantz (2005) in their discussion on increasing access to specialized services in rural and remote band communities.

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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

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Chapter 13: Corrections

> *"the prisons have a very active Methadone Program both of continuing methadone for patients who arrive in custody and also initiating methadone maintenance for prisoners during their term of incarceration. We consider that's an excellent window of opportunity for stability, reflection, access to counselling, and access to medical care such that people can start the program and do very well and stay out of jail."*

Potential and progress

In September 1996, the BC Corrections Branch officially adopted a policy of continuing methadone for incarcerated adults who were already on a prescribed MMT program in the community prior to incarceration (Canadian HIV/AIDS Policy and Law Newsletter, 1997-1998). This policy context aligns with evidence from research over the past decade that methadone maintenance has benefits for the prison population both pre- and post-release. Research indicates that MMT can, for example, reduce drug use and risk behaviour in prison (Dolan et al., 2003) and reduce re-incarceration and increase treatment uptake by ex-prisoners on release (Kinlock, Gordon, Schwartz, et al., 2008).

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

Access to methadone in corrections settings

Despite progress, some reported problems for people accessing methadone in correctional settings. Some participants felt that the provincial corrections system was *"more idiosyncratic"* and less predictable in its response to people on methadone. For example, there were reported challenges in initiating methadone in provincial corrections settings because a person's stay is often very short. Many felt that the corrections system was still a very vulnerable place for people on MMT:

> *"We would get these calls from prison, if you want to talk to someone who is a very, very frightened and frantic person it is someone who is realizing they're going to start going through withdrawal. They were calling me on weekends and evenings all the time and even parents weeping that their child was so sick when they saw them. The dehydration and vomiting, it is a life threatening thing, and it really needs to be recognized as such."*

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

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Town lockups were mentioned by a number of respondents as being particularly problematic. Suggested reasons for this lack of timely access to methadone varied. Some felt that policies and guidelines around methadone were not always clear to people working in correctional facilities and better information dissemination to staff was needed. An anti-methadone sentiment amongst some corrections staff, including physicians and nurses, also was reported. Convincing the corrections work force that implementing and extending access to MMT in corrections settings was a necessary medical strategy had not *"been a particularly easy ride,"* according to one participant. Given that anti-methadone sentiments are still strong in some community settings across the province, this is not surprising.

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:

> *"the doctor essentially put the person down and said, 'if that's your approach then, I am not renewing your methadone scrip.'"*

A nurse spoke about the implications of staff treating methadone like *"candy"*:

> *"I recently had a woman who went without meth for close to a week. She was in a small town lockup for the weekend and the staff did not get hold of her methadone prescriber until she was transferred to the larger jail. Sometimes the staff in the smaller lock-ups/police stations do not realize how essential this medication is. They see it as a perk something like candy and if the person has been "bad" and is in the corrections system they should definitely not receive any "candy." To break a daily methadone regime precipitates unnecessary suffering for the individual and can have devastating consequences. The person will often turn back to injectable heroin as soon as they are released."*

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, as this participant explains:

> *"Our main sticking point is finding a physician to assume the patient's care upon discharge. When we're initiating methadone in prison we have to find someone in the community who will accept that patient. That's a new, so to speak, burden on the system and is incredibly difficult. First of all some physicians aren't interested in taking patients who have been in prison. Second, many of our patients access methadone while they're in a custodial environment but then go back home to Prince Rupert, Kitimat or Fort St. John. There may or may not be either a pharmacy that will give them methadone on a daily basis or a physician who will prescribe for them. They might have to be weaned off methadone prior to discharge which is terrible. They may have to stay in a centre that encourages crime, someone who does wish to return to his family in Prince Rupert but instead ends up staying in the Downtown Eastside because that's where his methadone prescriber is."*

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.

Concerning situations were also reported where clients were released without a methadone prescription or anywhere to get a prescription, thereby risking using street drugs to cope with withdrawals. One positive development noted by prescribing physicians was the ability and willingness of dispensing pharmacists to dispense

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methadone at their own discretion for a few days when a person had been released from a corrections setting and before they are able to see their prescribing physician.

Another problem area raised by participants was the communication challenges that seemed to continue to plague relationships between corrections and the wider community, despite deliberate attempts to address these through clear policies and procedures. There is therefore a need for better communication from corrections staff to prescribing physicians, both when individuals enter the corrections system, and when they are released.

Illegal drugs and methadone in jails

A concern regarding the wide availability of drugs within the corrections system was also noted in the interviews. Methadone can be used as a currency in corrections settings, being diverted and traded. One client described being in jail on illegally obtained methadone for a year. There are guidelines in place to try to avoid diversion within facilities where the clients have to drink methadone, eat a piece of bread, drink a glass of water and then sit observed for a period of time. However, some noted that diversion was still occurring even in these restricted and monitored circumstances. One correspondent described how people who are diverting their methadone are often being *"leaned on"* to do so. Leadership has attempted to help prison staff understand these dynamics and react to these situations by treating the person diverting as a victim of bullying, and moving rather than punishing them.

The criminalization of drug use

Finally, the wider context of managing drug use, primarily through criminal justice interventions and policy, was a contentious topic in the interviews. Many participants believed that managing addictions through the criminalization of the user was ineffective at addressing the problem:

> *"The underlying problem with how we manage addictions is the criminalization of the user and we really have to break that paradigm. We're not achieving anything in fact we're making a lot of things worse. Every interaction with a powerful person is in the context of their most recent experience with the police."*

Participants were frustrated that there was not a stronger policy mandate to offer evidence-based health interventions, like methadone treatment, to those with opioid dependency involved in criminal behaviours. The connections between substance dependency, health problems, health service usage and offending behaviour, are linked in a compelling way by this client:

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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.

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

- 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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This chapter considers the medical alternatives to methadone treatment discussed by review stakeholders as necessary to ensure the best outcomes for people with opioid dependency in BC in terms of the central principles of access, retention, quality of care, effectiveness and equity.

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. A selection of quotes illustrates these views:

> *"There is a range of substitution therapies, methadone is only one."*

> *"We should have a choice. Buprenorphine or methadone."*

> *"It is taking government too long to adopt other treatments."*

> *"The government sees methadone as the big panacea and the be all and end all to anybody who has an opiate problem and I don't think that's necessarily the case."*

> *"The fact that it's our only drug is part of the problem."*

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).

Three issues, in particular, deserve consideration. First, the broader social benefits are not always measured in the studies. One French study demonstrated an improvement in the social conditions of patients receiving office-based buprenorphine treatment (Bilal, et al., 2003). This study found that patients receiving buprenorphine

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[64] Trade name used for the buprenorphine/naloxone compound available in Canada. Suboxone includes naloxone alongside buprenorphine in order to limit the potential for misuse and potentially lower the street value and the incentive for diversion. In this summary the names will be used interchangeably because participants used both terms when talking about the drug.

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experienced an increase in the number of relationships with people without alcohol or drug problems and a greater likelihood of spending time alone rather than with people using drugs. It also demonstrated a significant decrease in drug related hospital days and number of days engaged in criminal activity. Buprenorphine is commonly prescribed within primary care contexts. The reported social benefits of buprenorphine type medications are often considered to be derived from the mainstreaming of drug dependence treatment into primary care and the consequent opportunities that therefore arise to destigmatize the recovery process (Carrieri, et al., 2006).

Secondly, research is ongoing to examine the effectiveness of buprenorphine with specific sub-populations of opioid dependent individuals such as pregnant women, homeless people who inject drugs, prisoners, people with HIV/AIDS, patients with severe chronic pain. A review of the available evidence suggests that methadone and buprenorphine have advantages and disadvantages for different groups of opioid-dependent individuals and that more research is needed to understand the implications (Carrieri, et al., 2006). In the UK, for example, priority is given to prescribing buprenorphine to younger heroin users, heroin smokers and those not wanting methadone or who have failed in trials of methadone treatment (Effective Interventions Unit, 2002). The potential for buprenorphine for specific sub-populations was also referenced by systems review participants.

> *"Buprenorphine is a good remedy in certain places. We have a lot of immigrant populations in the Lower Mainland that 'chase the dragon.' They smoke it and buprenorphine is the appropriate drug for people who are the dragon chasers as opposed to injection drug users."*

> *"Buprenorphine has lots to offer, especially in this population of younger prescription drug dependent people. It's a better drug than methadone in that population specifically because it's easier to wean from … people won't have as much withdrawal and are less likely to relapse."*

The third debate in the literature that seems significant relates to cost-effectiveness. A very recent US based study concluded that buprenorphine monthly patient costs were higher in comparison to both clinic- and office-based MMT, in large part due to the higher drug cost (Jones, et al., 2009). However, the authors point out that clients "decide to enter treatment based on the availability of a treatment and the cost from their perspective, which includes time costs as well as out-of-pocket costs" and that "entry into treatment is the first step in a process and that treatments must appear acceptable at a variety of levels in order to engage [clients] in appropriate clinical care" (p. 139). Since, for some groups, buprenorphine appears to be more acceptable than methadone, the appropriate response, that will increase both effectiveness and cost-effectiveness, may be to explore ways to maximize access to both therapies and to minimize cost wherever appropriate, for example, through unsupervised dosing (Drug and Alcohol Findings, 2008; Jones, et al.).

Currently in BC, costs of Suboxone have to be paid by all patients, whether on low incomes or not, because the drug is not included on the PharmaCare formulary of approved medications. The drug is not covered under NIHB for First Nations people either. Many participants expressed significant disappointment over the lack of availability of buprenorphine in BC, for long term maintenance as well as withdrawal management:

> *"Buprenorphine is just a sad, sad story here. It really is. A big missed opportunity. The fact that it isn't a choice speaks to the fact that there just isn't enough interest in having cutting edge services here in BC. But there are certainly some patients who do want to be on something other than methadone and find methadone very difficult."* [Counsellor]

> *"I think that it's appalling that it doesn't get covered. When you think about it from a population-based perspective there could be such huge savings in the long run."* [Physician]

> *"You need a broad range of substances because methadone has a lot of side effects. It's especially difficult for people to work on methadone so you need substances available like Suboxone with less side effects."* [Researcher and clinician]

"It's a great drug, a really good tool and that's what we're doing in addiction medicine these days, sitting around waiting for tools. It is not panning out to be a practical option for any of my patients on account of it not being a Pharmacare benefit. I have yet to come across any methadone patients that I can switch over on account of this. A change in this policy would be high on my list of wishes in opiate addiction management in BC." [Rural physician]

Participants recognized that there are a number of important practice issues related to buprenorphine, for example the witnessing and induction stages of use which can be complex and demanding on existing systems. Despite these issues, many participants believed in the potential of buprenorphine suggesting that it:

- is easier to come off than methadone
- has less side effects than methadone
- is an effective way to increase access to opioid substitution treatment
- is safer because of a lower risk of overdose
- is less likely to be diverted
- is a good tool for detoxification/withdrawal management

Because of research suggesting that buprenorphine may be safer than methadone (West, O'Neal & Graham, 2000), some participants saw substantial potential in addressing the challenges of the rural/remote opioid dependent population. One physician said, *"If we are looking to increase access in a safe fashion, buprenorphine may be the answer."*

Participants also argued that buprenorphine was a very effective way to enable people who are stable on lower doses of methadone to come off opioid substitution treatment, should they wish to. A client expressed the following view:

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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.

A significant barrier to prescribing Suboxone is the need for physicians to become licensed to prescribe the medication. Currently, a physician has to receive their methadone license before applying for a Suboxone exemption, and the extra training online was described as *"time-consuming."* Many participants felt that the benefits of opening up access to Suboxone were so substantial that all barriers to wider access should be removed.

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.

"The Swiss study compared heroin and methadone, and said that heroin had advantages over methadone for three reasons, attraction, retention and compliance. Clients like heroin better, they will stick around and do what you ask them to do. They will stay with the program and will participate in the program in a way that they won't with methadone."

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. There were also marked declines in illicit heroin use for the injection group and the optimized MMT control group, although this was much more marked in the injection group. Many participants spoke about their views of heroin assisted treatment and the NAOMI trial, especially people in Vancouver who had seen the impact of the trial or who had actually been on it as clients. One client on the heroin injection arm of the trial commented on the benefits of heroin assisted treatment for her personally, compared to her 15 year involvement in MMT:

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The NAOMI trial has demonstrated the benefits of heroin assisted treatment for opioid dependent people and this study adds to the growing evidence base for this treatment (Oviedo-Joekes, et al., 2009). A counsellor drew attention to the reported success of heroin treatment in getting people off opioids completely:

> *"I have a very optimistic look at what's going to happen with the methadone and opiate substitution therapies. Hopefully they'll start prescribing heroin too. They call it treatment in Switzerland. People get their heroin every day, they're not just screwing around, they're starting to get bored, maybe I can do something with my life. The next thing you know they're working and then, 'I don't want to do this, I want to get off the heroin.' That's why in Switzerland they actually call it heroin prescription* **treatment."**

Many argued for a spectrum of resources and treatments including injectable opiates. The importance of being able to give clients a choice was stressed by another physician:

> *"Methadone is one option for anybody who's opiate addicted but they're still assuming that it's the only option which has led a lot of people into thinking that if they can't prescribe methadone or they can't take methadone then there's no help for them. Methadone is an option but in the context of being opiate addicted we should be able, as prescribing physicians and health caregivers, to offer the other options out there and that's basically prescribing other opiates, prescribing heroin, that's really where we have to move."*

Many argued that methadone is a lot harder to come off than heroin, another reason for providing heroin:

> *"I had a client that was really bright, very articulate and furious with the system for not telling her how addictive methadone was. It's hugely problematic. It is a brutal drug. Yes it is the gold standard, but the pharmacological quality ... You cannot get rid of the pain of withdrawing. It's a long time people have to experience the pain for. It's still painful."*

Some participants cautioned against heroin assisted treatment, particularly in light of the dangers of continued injection practices. Other participants believed that heroin assisted treatment would place *"too many demands on the system."* Despite the many reported benefits, participants described a prevailing stigma rather than openness even to discussing heroin as an alternative treatment to methadone in BC.

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.

On this last point a community pharmacist with many years experience working in the Downtown Eastside of Vancouver commented:

> *"There's this general assumption that methadone is sufficient. It isn't. There is a small but significant percentage of opioid addicts that methadone doesn't work for one reason or another. I don't know why we can't give morphine. What's the difference? We can give long-acting morphine. There are people for whom methadone just doesn't do the job and they fail over and over again."*

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.

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

- 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.

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Chapter 15: Stigma and Discrimination

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Stigma and discrimination were cited with reference to almost every topic discussed in this review. While issues of stigma and discrimination have been repeatedly noted throughout the preceding chapters, they now form the focus of the current chapter. An awareness of the pervasiveness of stigma and discrimination in the lives of people who are prescribed methadone, and in the lives of people who use illegal drugs, should inform the development of appropriate measures to address the many challenges that currently impact the effectiveness of MMT in the province.

Stigma, drug use and MMT

Societal view of substance use and illegal drug use

According to review participants, there is a view of people who use drugs as *"scourges to society," "useless to society," "subhuman,"* or *"throwaways of society."* In BC, like many other Western societies, there was noted to be a very negative view of addictions as *"one of those bad things"* that *"tarnishes"* communities. Drug use is still viewed primarily as a moral issue in the minds of the public and of the majority of health professionals. Misunderstanding and fear too often dominate in policy and public perception. A senior health authority manager provided an account of the societal approach to people with substance use problems:

> *"it is quite striking how, compared to mental health, even people with very severe disorders and mental disorders, people with addictions are really stigmatized, more so, because it's seen as their fault. And people with a mental disorder, 'Oh, it's a shame, something has happened to them.' Whereas the drug behaviour, 'No, you brought this on yourself buddy. It's your fault.' There's much less sympathy."*

A lack of understanding about the causes of problematic substance use, and a fear of illegal or illicit drug use, is fuelled by the media and methadone always seems to get *"bad press."* Traditional approaches to problematic substance use, such as the *"moral model,"* actively contribute to the stigma people face when using substances, particularly certain groups of people, such as mothers and pregnant women:

> *"People can't take a longer view of addiction and see that perhaps there were factors and things that happened in that person's life that led them to need the peace and tranquility that opiates can give to troubled people."*

Overcoming stigma on a community level was described as being a huge challenge. For example, finding space for new treatment centers was reported to be difficult because of the negative perception of addiction and addiction treatment. *"No one wants an addict in their back yard."* Participants acknowledged that not speaking openly about harm reduction or addictions colluded with this stigma but many felt the need to keep these service approaches *"under the radar,"* for fear of a backlash from their local community.

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

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Media representations of methadone contribute to this stigma by focusing only on the system failures. The negative publicity around methadone pharmacies in the Downtown Eastside of Vancouver in late summer 2008 likely perpetuated these stereotypes. During 2008 there was community opposition to new pharmacies opening in neighbourhoods in Vancouver if owners did not agree in advance *not* to dispense methadone. Private clinic managers found it hard to identify new clinic locations for methadone clinics because no neighbourhood wanted *"those people"* in their local environment. As reported in Chapter 9, stigma seems to lie behind the reluctance of many community-based GPs to prescribe methadone in their office-based practices.

The internalization of stigmatized identities

Because of the societal attitudes outlined above, addiction and problematic substance use is kept as a *"dirty little secret."* People with problematic substance use often wait, according to one advocate, six to seven years before trying to get help with their problem substance use, largely because of this stigma. Without opportunities to prove otherwise it becomes easy for people who use illegal drugs or who have problematic substance use to *"become the stereotype,"* developing behaviours they are perceived to have. The lack of self-respect of many people who use illegal drugs, was described by a residential treatment worker:

> *"Many of the people we are serving in addictions are highly vulnerable. There is this tape going on in their head about feeling demoralized about self, about society, 'I am a loser, I am a dirtbag.' These are words that men often describe themselves with. There's this inherent fear that somehow they don't measure up to other people. The internal voice is, 'So what's the point in trying?'"*

The self-fulfilling prophecy theory[65] describes how a set of negative external views gradually become accepted by people who are the subject of these views. The negative perception of methadone, and the associated labels, can be profoundly discouraging and demoralizing, and can severely negatively impact a person's ability to move towards recovery.

Stigma and discrimination in health care and addictions services

> *"I don't think there is anywhere in Canada where the whole issue of methadone has been settled to the point where it's just another treatment option."*

Many people prescribed methadone talked about the stigma and discrimination they experienced in their treatment. The stigma in wider society regarding problematic substance use and methadone is mirrored in health care and addictions services. One residential treatment provider described the stigma as being grounded in a contempt that some health professionals had for people with problematic substance use:

> *"There is a certain righteousness or contempt … without any legitimacy, many people walking around making some very strong statements about methadone. It's someone being less than, or illegitimate as a person, in this case, someone in recovery."*

A *"them and us"* dynamic was reported as existing between some professionals and people who seek help for substance use problems, as is sometimes the case in mental health services (Chambers, Glenister, Kelly & Parkes,

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[65] A self-fulfilling prophecy is a prediction that directly or indirectly causes itself to become true, by the very terms of the prophecy itself, due to positive feedback between belief and behaviour. Although examples of such prophecies can be found in literature as far back as ancient Greece and ancient India, it is 20th-century sociologist Robert K. Merton who is credited with coining the expression "self-fulfilling prophecy" and formalizing its structure and consequences. In his book *Social Theory and Social Structure*, Merton writes: "The self-fulfilling prophecy is, in the beginning, a *false* definition of the situation evoking a new behaviour which makes the original false conception come 'true.' This specious validity of the self-fulfilling prophecy perpetuates a reign of error. For the prophet will cite the actual course of events as proof that he was right from the very beginning" (1968. New York: Free Press. pp. 477).

2005). Stigma results in mistrust, and is detrimental to quality of care. Participants described *"game playing that goes on all the time."* Some professionals expressed a lack of trust towards people who are prescribed methadone, saying things like, *"they will take you to the cleaner."* One client said:

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Many participants believed that methadone should be viewed as an ordinary medication for a long term condition. *"Methadone is just another medication, and it needs to be treated as such."* If this happened, many felt that it would create more acceptance and better care for people taking methadone.

Inappropriate prescribing of methadone also was thought to influence and enhance the stigma people who are prescribed methadone experience. For example, under-dosing leaves people subject to withdrawal and needing to continue to use street drugs while over-dosing leads to people *"nodding off."*

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:

> *"A lot of people are so scared that there's going to be negative consequences that they're afraid to speak up, and they're totally justified in having those feelings."*

> *"people who are self advocates often end up with labels, borderline personality disorder and then end up excluded from all service. So I've discouraged people from self advocating because it will further marginalize them."*

As reported in Chapter 9, stigma is also experienced by providers involved in MMT and this may negatively impact the willingness of physicians, pharmacists, and even health authorities and government to become more involved with MMT .

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:

> *"It is the idea that there's only one acceptable outcome for addiction and that's abstinence. Substitution therapy or methadone maintenance is essentially enabling or delaying the inevitable … causing more harm than good. An all or none, abstinence or nothing, if you weren't going to be abstinent, it was your problem if you got HIV infected or you died of a drug overdose."*

Addiction medicine was noted to be *"very ideological and hampered by moralizing."* Participants reported that there was a significant number of physicians working in addictions medicine, as well as other specialties and primary care, who believed that with MMT *"you've just substituted one drug for the other ... you are not really getting healthier ... not getting better."*

> *"The local detox has 6 or 7 physicians, none of them are methadone prescribing physicians, so clients have to go through the onerous task of trying to get their physician to continue to provide methadone while they're in a unit detoxing. That's a fragmentation! Why hasn't that been remedied? Why is it that more physicians don't want to get methadone licensing? What is that about for them? Because that's a whole body of pretty important people."*

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One person related what he believed to be the view of many physicians, that prescribing methadone is an *"indulgence, rather than giving people a pharmacotherapy that their brains need."*

Residential treatment centres in BC still tend to be abstinence based. Some residential addiction services define methadone as a drug and do not admit methadone clients for treatment. This restricts an already limited range of options and clearly continues to stigmatize people[66]. An attitude prevails in many residential treatment settings, including recovery houses, that *"abstinence is not methadone,"* leading to people getting taken off methadone on entry to services, for example through the use of *"forced tapers."*

> *"We have a physician who doesn't believe in methadone. So, unless the client agrees to come in and begin a process of weaning off it, we can't take them. People finally get the call. They finally have that bed. They arrive at the door, you know, garbage bag in hand. Walk in. Wow, they are so relieved. 'I am finally here. It's going to happen.' And then it's this, 'Oh, by the way, we need to decrease your methadone. You can make a choice. There or here.' And it's this regimented decrease."*

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."* As described in Chapter 7, many participants described MMT as *"dehumanizing"* with *"cattle calls"* and long waiting times to see health providers. Participants described many structures in MMT that worked as barriers and disincentives to care, and pushed people back towards illicit drug use. The *"onerous," "punitive"* and *"shaming"* practices reported by clients can make it very difficult for people taking methadone to stay on MMT, or to want to come into MMT. The system structure can make social re-integration impossible because of the demands of frequent physician visits and daily pickups of prescriptions.

It is clear that many of the structures in place for MMT physician appointments and dispensing generate stigma for the clients. For example, the *"line ups"* outside pharmacies in the Downtown Eastside of Vancouver (cf. Anstice, Strike & Brands, 2009) or having to *"linger outside"* community health clinics to get appointments with physicians do not help the public image of substance use treatment or methadone provision (cf. Fraser, 2006). One counsellor commented on congregation and stigma and placed responsibility firmly at the door of service agencies:

> *"I'm interested in the social forces that happen around methadone, the social forces that are in congregation. We see these huge groups of clients that have to line up. They're drinking in public, the forced drink thing where everybody sees them. They're targeted, stigmatized, alienated and marginalized by the process. It's brutal. If our goal is social integration and inclusion and the absence of stigma, why are we doing this hugely stigmatizing process? It's really not healthy, all the most mentally ill,*

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[66] There is a growing literature on this access-to-care issue, For example, Hettema & Sorensen (2009) provide a policy commentary from the US and historical perspective drawing on Americans with Disabilities Act implications of such access inequalities. Sorensen, et al., (2009) report on a trial that found similar 24 month outcomes of residential treatment for matched MMT and non-MMT clients demonstrating the potential of equal access to specialised residential treatment for people taking methadone. They conclude that methadone patients fared as well as other opioid users in therapeutic community treatment. Work by Greenberg, Hall and Sorenson, (2007) describes a number of practical strategies that may improve the feasibility of including people taking methadone within residential treatment settings such as educating staff about methadone to eliminate misconceptions and reduce staff generated stigma, preparing staff to deal with certain situations that may develop regarding methadone such as nodding off behaviours, the need to educate other patients on methadone related topics and the potential of twelve step oriented MMT groups within treatment programs.

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addicted, criminalized people all hanging out together. Jail is crime school and Pender clinic is drug taking school. The small picture is they congregate but the large picture is we force them to do that."

Stigma and discrimination within peer group supports

Participants described *"fear and handouts"* as stopping clients from forming support groups to address common issues such as stigma and discrimination. There is a stigma even within the wider peer/drug user and recovery communities. Peer support groups can be unwelcoming for people taking methadone where they can be *"shunned," "judged"* or not allowed to attend because *"they're still under the influence of a narcotic."* This stigma and shame from within peer support systems appears to contribute to a lack of willingness for people taking methadone to come together to support each other. Clients who use harm reduction programs reported being stigmatized in their own community as *"outliers."* Peer leaders could also become *"phenomenally lonely, they stand out there as big targets."*

Creating change by proactively addressing stigma and discrimination

"Get on the bus. We're not debating this anymore."

Service delivery

How to move forward from this situation is a challenge indeed. Participants shared many ideas throughout this review. The major response to the question of how to address stigma towards people taking methadone within service delivery contexts, was to situate methadone services within the context of human rights. There was a desire amongst many participants for a shift in focus from *"how we deal with these drug addicts and get them off the drugs,"* to *"how do we instil wellness and allow people to reach their full potential."* Ideas of how to involve people taking methadone in the community to counter negative stigma was discussed, such as through employment projects and volunteering. Avoiding the creation of *"ghettos"* of specialist addictions services was a priority for some. The need for MMT to be better distributed throughout the province was also emphasized. In terms of tackling the ongoing lack of access to residential treatment programs, participants wanted the province and health authorities to have a clear anti-discrimination policy that all providers had to sign up to, enforceable through service contracts.

Public information and education and education for health professionals

That there had been few attempts or interventions designed to address stigma and discrimination towards people who use drugs, and people who are prescribed methadone, was seen as a significant contributing factor. An example of proactive work in this area is that of the harm reduction "road-shows," delivered across the province in 2008. Clients have a lot of wisdom and input that they could provide, but current structures of MMT do not allow for or facilitate this involvement. Information and education for the public on MMT was viewed as an essential step to trying to combat the stigma:

"There needs to be much more active engagement in promoting awareness and understanding of what these issues are, how prevalent they are, how they challenge many families. We have to understand that at a certain point there is no choice left."

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:

"We would like to do more effective monitoring and evaluation of our program and to do a cost-benefit analysis that will show to the community more widely our successes ... We need to get the public interest behind us. They need to get behind the harm reduction and give us positive support. There needs to be awareness-raising. We need to show the community how the methadone program is benefiting them and show them the partnerships that are going on. This goes for other professionals and agencies too. Instead of other professionals and agencies seeing us as competing with them for resources they should be helped to

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see what we do as supporting and aiding what they do. In fact, we save a lot of other resources and divert a lot of people out of more expensive service use, hospital etc. They need to know more about what we offer."

One health authority manager talked specifically about the importance of health authorities taking a lead in this area:

> *"there has to be a conscious desire to want to address the problem. We have to sit down as health authorities, have to do a massive PR campaign, in the same way as Fraser Health did around early psychosis intervention. You couldn't go into a bus stop or anywhere without seeing a big plaque that said 'psychosis sucks.' People who were feeling that way were feeling like it was being normalized. We've never done that about addictions or about clients on methadone. Why aren't we?"*

An important first step to overcoming stigma is education. Mainstreaming in-depth addictions education into the training of medical students, including knowledge about the principles and practices of harm reduction, was viewed by some as essential:

> *"It is about being directly clear about people's attitudes as to why they get involved and why we should be doing this. And explaining it to people in a way that is engaging. That should happen at UBC with all medical students. It should happen repetitively. So at the end of the day people will graduate with some kind of acceptance that it is part of their job. That it's okay. It's fine. It's just what they do".*

Continuous professional development was also recommended as one approach to help create cultural change in the health professions in order to address punitive, shaming and stigmatizing approaches to people with drug problems.

Toward recommendations

> "To the people of Canada, I say welcome us into society as full partners. We are not to be feared or pitied. Remember, we are your mothers and fathers, sisters and brothers, your friends, co-workers and children. Join hands with us and travel together with us on our road to recovery." (Roy Muise, quoted in Standing Senate Committee on Social Affairs, Science and Technology, 2006)

The report by the Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last* (2006), highlighted stigma as a key priority for action. Despite its aims to provide stabilization, harm reduction and recovery, the MMT system in BC often marginalizes and isolates the population of clients who use it. Proposed changes to improve the program must address the root causes if sustainable and pragmatic developments are to occur. Solutions that actively address stigma and discrimination, as well as the social determinants of health and illness such as poverty, social exclusion and marginalization, racism and colonialism, violence and abuse towards children and adults, must be identified and implemented.

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

- 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

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Chapter 16: Looking to the Future

"any step towards helping yourself is important. It's opening a door or a window. And that's the important part. If the window's open, then you've got somewhere to go through. Who knows what their journey is. Their journey is their journey."

This concluding chapter brings together many of the points discussed in the report into an agenda for change, drawing upon global evidence of best practice. The preceding chapters clearly illustrate how interconnected the issues of access, retention, quality, effectiveness and equity are for MMT. Policy and practice change needs to occur throughout the system simultaneously in order to address this interconnectedness.

Comprehensive "wraparound" care and optimized MMT

"Methadone is a "magic bullet," there is nothing else as powerful in addictions treatment" [Prescribing physician]

Some models of MMT are more capable of providing optimized MMT than others. Ideal models were those that had the capacity to closely link MMT with primary, comprehensive or public health care services, or with integrated Mental Health and Addictions services. Health authority Mental Health and Addictions managers were viewed as a key resource in helping to facilitate a greater collaboration between public health, primary care, and mental health and addictions, in order to build a stronger foundation for MMT in BC.

Services that are able to respond to clients by providing holistic and *"wraparound"* care are more desirable. Wraparound care was a component of optimized MMT in the NAOMI trial, although it was not described as such in the study findings. The NAOMI trial, as described at various points in this report, clearly offers a model for MMT in BC. Their version of optimized MMT produced good outcomes for clients, including a 54% retention rate at 12 months (NAOMI, 2008; Oviedo-Joekes, et al., 2009), for some of the most challenged individuals in the province. This review suggests that the NAOMI model of optimized MMT should be used to develop the province's MMT services. While there is no ideal model of MMT in and of itself, the work of NAOMI shows that a combination of program characteristics, such as adequate dose, psychosocial interventions, multi-disciplinary working and case management, can enhance outcomes for clients. According to Oviedo-Joekes, et al., "All patients were offered a comprehensive range of psychosocial and primary care services in keeping with Health Canada best practices." (p. 778) NAOMI has directly informed the recommendations that follow and many characteristics of optimized MMT used in that study should be considered to be essential components for all MMT models developed in the province.

"People with addictions require multiple kinds of interventions, not just medical, prescribing is not enough".

The need to make counselling and other psychosocial supports a fundamental part of the MMT package was one thing that most participants agreed upon as a strategy for positive systems change. Participants also agreed that such services were very few and far between, particularly in northern and rural areas of the province, and therefore not an option for many of those on MMT. Participants wanted to see more services to address the "upstream" issues that impact people with addictions, rather than only "firefighting" once problems have become entrenched. Services that address the contextual features of people's lives are essential such as services to address violence and abuse and resultant trauma, mental health problems, housing, employment, parenting, transportation, community integration and the need for advocacy and information. As one client stated in a focus group:

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Research shows that providing a minimum level of counselling to MMT clients pays dividends in terms of better outcomes in relation to drug use, crime and health (Kraft, Rothbard, Hadley, et al., 1999). Research also shows that

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counselling services, and how they are delivered, can have as critical a role in client outcomes as methadone dosage (Blaney & Craig, 1999). According to the UK's National Treatment Agency for Substance Misuse (2004), drug treatment services should make links with external agencies providing training, education, housing and employment so that clients who need these additional supports can gain benefits from them. One US study found that three quarters of the methadone clients in the study wanted further training and education for a professional or technical position (French, et al., 1992 cited in National Treatment Agency for Substance Misuse, 2004). Services that attempt to meet these needs through case management achieve better outcomes (National Treatment Agency for Substance Misuse).

Providing MMT through other social or welfare services can be another model to increase access and comprehensive, wraparound care. One example is the setting up of MMT services in homeless hostels as Dunn, et al. (2006) and Robertson (2005) describe in their work with hard-to-reach, chaotic, homeless poly-drug users. A survey of residents of one central London hostel indicated a variety of reasons why previous treatment episodes had failed including long waiting times for treatment, difficulties in keeping fixed appointments, and sanctions given for continued heroin use. A satellite MMT clinic was provided in the hostel to try to address these issues and make MMT as accessible as possible for those that wanted it. While long term outcomes were not reported, at 16 weeks 87% of residents were still in treatment, a significant finding given the population group accessing service.

Another potential model for achieving effective partnership working, and improving the patient experience of health care, is the use of managed clinical networks. These are "linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and health board boundaries, to ensure equitable provision of high quality clinically effective services." (Scottish Executive, 1999) Managed clinical networks can be a way of coordinating seamless patient care pathways, are dynamic and fluid and operate through trust and strong relationships rather than hierarchy and bureaucracy (Lugon, 2003). Tayside region in Scotland is currently using managed clinical networks to facilitate enhancing multi-disciplinary working and quality of care in substance use services, including methadone services.

Bringing pharmacies into a multi-disciplinary context was another very popular idea amongst review participants, most specifically to create more opportunities for engagement for clients with other staff members and to better regulate the dispensing aspect of MMT. Some MMT clients were viewed as needing more comprehensive support than a community pharmacy can provide. As this report has described, current dispensing practice through community pharmacies, while improving access, is creating serious fragmentations of care, particularly for those people with complex health issues such as HIV, as well as opioid dependence. According to research conducted by Palepu, et al., (2006) at the University of British Columbia, integrating opioid addiction care and HIV care may provide improved health outcomes for this vulnerable population and should therefore be expanded. Multi-specialty clinics, dual skilled primary care physicians and enhanced links between treatment dispensing services, may all help to integrate care.

The problematic practices described in Chapter 8 were also considered to be having such a negative impact on care that other models are clearly needed. A recent recommendation from Australia comes from a study by Lea, Sheridan & Winstock (2008) that explored consumer satisfaction with, and experiences of, a range of issues associated with the delivery of opioid substitution treatment at community pharmacies in New South Wales. The authors suggest argue that the assessment of consumer satisfaction can facilitate the improvement of opioid treatment services at community pharmacies and, therefore, treatment providers should determine the most effective ways to incorporate consumer feedback to improve treatment services (p. 940). Client feedback is commonly used to address quality concerns in other health care services and there is no reason why it should not be used in MMT services. Indeed, given what this report has indicated as the serious and intersecting vulnerabilities and health challenges of this population, it could be argued that this group is in need of such approaches most urgently.

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A promising local interdisciplinary example is the new women-only pharmacy in Vancouver's Downtown Eastside, Canada's first pharmacy exclusively for women. This pharmacy is operated by Vancouver Women's Health Collective as a social enterprise (profits fund the non-profit organization's social programs) designed to provide a safe and respectful environment for women in the Downtown Eastside. Women are able to have their prescriptions filled and get advice from a pharmacist, access primary care from a nurse practitioner, buy over the counter products, access health information and workshops and use the space to meet. A second phase is also planned for the project where other health services will be provided including those of a naturopath (Waugh, 2008). Other such models, designed to ensure continuity of care and an effective multi-disciplinary approach to MMT, exist internationally (Bennett, n.d.).

Inter-disciplinary working, shared care and nurse-driven models of MMT

Reports of well-functioning partnership arrangements in substance use services and MMT were rare in this review. *"Turf wars"* between different players in the system were more commonly described. However, practitioners generally believed that all MMT clients needed a *"group of professionals supporting them."* As other sections of this report have indicated, many participants did not believe that MMT should be led by physicians exclusively. The MMT system should become much more interdisciplinary in order to build the capacity required to meet current and future demand for services. Many stakeholders believed that for MMT to be successful in addressing access, retention and quality, active engagement by a full range of health professionals was essential. While there is a clear need to *"take the load off the physicians,"* there is also a tremendous variety of skills and resources offered by other professionals that can be utilized more effectively.

Shared care models of MMT exist in other countries, commonly between GPs and specialist addiction workers (Dey, et al., 2002). Sometimes physicians take on the role of assessing and initiating clients and helping them to reach stabilization and once clients are stabilized they get transferred to another physician, or a nurse with expertize and prescribing authority. There was, in fact, widespread agreement among stakeholders that a nurse-driven or nurse-facilitated model for MMT would go a long way towards addressing some of the many access problems in BC, particularly in Northern, rural and remote areas, and on reserve communities (Self and Peters, 2004). Nurses can be an ideal resource to have centrally involved in the use of telehealth models of MMT provision, for example. Hepatitis Service pilot sites were noted to be potential models for development of MMT nurses. Here Registered Nurses deal with day-to-day client needs and have an extended role within a multi-disciplinary team.

Nurse Practitioners are increasingly called on to provide high-quality health care in BC, particularly for people who face significant barriers to accessing services. They are typically educated to Masters level and have a scope of practice that incorporates activities that were traditionally undertaken by physicians, including diagnosing and prescribing medications (Browne & Tarlier, 2008). Nurse Practitioners work well as part of multidisciplinary frameworks, and according to Browne and Tarlier, *"With their feet planted firmly in both the medical and nursing worlds, NPs have the potential to become an essential component of health care systems in diverse health care environments"* (p. 84).

The current Health Canada licensing restrictions would need to change to allow opportunities for non-medical prescribing to help meet access demands for opioid dependency treatments. Currently, Nurse Practitioners can prescribe every drug except for narcotics. Many participants did not see this as insurmountable, however. In the UK, nurse prescribing of methadone and buprenorphine has been facilitated since reforms to legislation in 2005 in order to improve patient access to medicines, develop workforce capacity, utilize skills more effectively, and ensure the provision of more effective and accessible patient care (National Treatment Agency for Substance Misuse, 2005b). With Nurse Practitioners increasingly proposed as essential components of primary health care in Canada, they are an ideal group to drive MMT forward.

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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:

> *"We all in the end have to hammer out whatever framework works for each of us and what works for me might not work for you or the next person. Some people just have horrors at the thought of their methadone patient in their family practice clinics. I have a lot of patients who are working. They don't use a methadone clinic, it's not the right place for them. There is no one size fits all."*

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

> *"We need to look at rights based kind of care and care that is driven by the moral imperative. The moral imperative being what we all know in health care: that we have a social mandate in practice and that we always engage in ethical practice and that includes excellence in relational practice."*

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:

> *"Different programs, because not everything that works for one person is going to work for the next. It's got to be more on an individual basis defined by the individual needs, not as a mass."*

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"We need to rethink the program. It isn't going to look the exact same for everyone. But that we still need to continue to offer them all of the pieces of the continuum. That we do that. And so even though we are a small team, and limited resources, there are opportunities for people to access different pieces that they need."

As one manager notes, positive attitudes in staff lie at the heart of service provision for people with opioid dependency: *"My staff are great … warm, friendly, non-judgmental."* Many stakeholders wanted a reorientation towards the relationship of care. Relationships were viewed as the ideal model to help facilitate helpful changes in people's lives. Throughout the review process, people spoke about the need for compassionate and relationship-centred care in MMT. Listening to clients, respecting their journey, and working with them on their own self-identified goals, was highlighted in participant meetings time and again. A non-judgmental approach was considered by many to be the foundation for work in the substance use field: *"We never say sorry you can't try again."* Research evidence supports the importance of experienced and helpful treatment staff and positive staff characteristics (Magura, et al., 1999). Relationship-centred care is actually a new philosophy or framework for delivering care in general medicine and is essentially about recognizing that the nature and quality of relationships are central to health care (Beach, Inui & the Relationship-centred Research Network, 2005). This philosophy could be a helpful paradigm for MMT in BC.

Chronic Disease Management, Long Term Conditions and Self-Care

"We have to be putting forward this as a chronic illness and have this inform practices accordingly."

Long-term care or chronic disease management models can be helpful models in the facilitation of relational models of care (BC Medical Association, 2009). Concepts of self-care and self-management are increasing as approaches to working with people with long-term conditions and chronic illnesses. As well as offering better models for fiscal arrangements, as explored in Chapter 4, these concepts should be actively explored in MMT because of their potential to address the power imbalances that can dominate in care relationships that rely heavily on medical models of understanding illness and disease. Imbalances of power, most specifically between providers and clients, lie at the heart of many of the problems described in this report. The recommendations outline a variety of mechanisms that deliberately attempt to equalize power relationships and empower those least powerful in MMT services: people taking methadone and their families and supporters. Information given to clients, their families and supporters is one important way that participation can be enhanced and power shared. Patient information guides are produced by the Guidelines and Protocols Advisory Committee to provide doctors and patients with information and recommendations about medical and health care.[67] There is currently no opioid dependence information guide. Creating an information guide for people with opioid dependence, their families, supporters and physicians, could be an important step in normalising this health problem. This should of course be done with the central involvement of these stakeholders.

Peer models, service user involvement, support and advocacy

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A number of participants drew attention to the potential of peer and self-advocacy groups in developing the effectiveness and quality of MMT. One person commented:

[67] For GPAC patient information guides see http://www.bcguidelines.ca/gpac/patient_guides.html

"self-advocating organizations are important. We've seen a real decline in that in the last 5 years in this province. And there's a resurgence of them again. We are kind of trying to rebuild those things ... I feel that there is definitely a key role for those organizations because they have the ability to speak about what's real for the population."

A health authority participant noted similarly:

"You need an advocacy group. Some pressure. Take the plunge. You know, stick your neck out. Stay with it. Be tenacious. That's the only way it is going to happen."

Consulting peer or self-advocacy groups can generate new solutions for ongoing problems in service systems. Discussions as part of this review generated one particular suggestion for an MMT client identity card that contained information about a person's methadone treatment, as this focus group quote illustrates:

"I think it would be great to have an identity card for methadone, and you know, so they can just punch up Pharma to see if you've had your dose today, no matter where you are. And if you haven't had your dose ... For any other disease, you'd be given the required medication right away without a question ... With all the data on a metallic strip. Like a bank card so they know you've had your drink. How much, where, when ... Automatically like a debit card. You've had it, just go anywhere, doesn't matter, any pharmacy and proof that you're that person."

Government and health authorities need to reach out to client, patient, advocacy and peer groups to invite them to come to the table to create significant and lasting change in the MMT system. Building capacity amongst peers, through networks and information exchange, for example, can pay many dividends. Wood, et al. (2003) found that drug user organizations can play a major role in reducing harm among their peers by reaching the highest risk drug users with harm reduction.

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). International examples: the National Alliance of Methadone Advocates in the USA, and the Alliance in the UK, provide models for this work. A grass-roots patient organization is already established in the province however, the BC Association of People on Methadone,[68] and this group would be a valuable resource for such an initiative. Support groups are also important for people who are socially isolated and online groups could be an interesting model to explore given the geographic diversity of BC.

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

"There's no one really to champion the treatment. The College of Physicians do their best, I know. I've seen some of the speeches that they make and presentations that people like X make, who was very involved in this. She would go around B.C. during very good presentations about the importance of drug treatment and methadone. ... It's not like we don't have any individual champions. But we don't have a champion in government or in the health authority that demands that this problem of untreated addiction be taken with the seriousness that it should have - that there be almost a Manhattan Project effort to fix it. There needs to be someone out there who has entry to the very highest levels of government to be able to say our methadone programs badly need an overhaul; they need to be looked at again in the light of the needs of the 21st Century."

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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[68] For more information on the BC Association of People on Methadone see http://www.vandu.org/groups.html#bcapom

action on improving the MMT system for the future. This multi-agency dialogue was thought to be needed after the review process specifically but also to be built into the ongoing leadership of the program:

> *"get a task force together to look at certain elements and approach it reasonably so that you don't take on the world because you won't solve the problem but perhaps focus on three … but almost put a strategic plan together on what you've identified the issues are, now put a strategic plan around how are you going to focus and get something done and really what's the goal."*

> *"I would like to see, once your study is done, all of the health authority decision makers that know something about addictions, and of course physician groups and everything else but addictions frequently is not at both tables, mental health might be, addictions rarely. Bring them together and say "Ok, here's what we found. Here's the consensus, here's five key things. Is there a way for us to have some uniformity around what we think we need to be providing clients?"*

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.

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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.*

- Membership on the Committee should ensure representation from all agencies, regulatory bodies and stakeholder groups that have an interest and involvement with MMT (the involvement of clients, families and advocates is imperative)
- Members should be chosen based on their ability to effectively represent their respective constituencies and to reflect the gender, age, ethnic diversity and geographic regions of BC
- The Committee should be mandated to support the health authorities in the development of strong policy tools to support best practice in MMT (e.g., evidence-based provincial practice guidelines, ethical and conflict of interest guidelines, etc.) and make recommendations on appropriate accountability and regulation machinery
- Health authorities should each develop a regional Methadone Maintenance Committee that provides advice to the health authority regarding regional implementation of MMT and has stakeholder representation as per above, tailored to needs of each region and involving local communities

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.*

- Northern, rural and remote access, including Aboriginal and First Nations reserve communities, should be prioritized for service development with particular attention to the application of telehealth in these settings
- Local communities should play a central role in the implementation of new MMT services

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.*

- MMT should be provided, wherever possible, through the development of locally based, multi-agency, integrated and shared care models
- The contribution of private methadone clinics should be respected and encouraged but their work must be fully aligned with all policies of the provincial system and be available to clients without user fees
- All MMT services should be provided in a non-judgmental and supportive manner that protects the dignity of all clients (e.g., pharmacies should be required, wherever possible, to have confidential spaces for supervised consumption of methadone)
- Case management should ensure coordination of care for people on MMT who are involved with other systems (e.g., acute care, HIV, mental health or corrections) or who are particularly vulnerable (e.g., homeless)
- Nurse Practitioners should become an integral part of MMT care delivery
- Care should be planned and regularly reviewed with clients (and their supporters if desired)

- Flexibility in service delivery should be maximized to ensure that services are available to people at times and in locations that make accessing them compatible with employment, parenting and other activities of daily living
- MMT provision should include a range of optional, complimentary psychosocial supports for all clients (including counselling and supports related to housing, employment and parenting)

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.*

- Factors influencing inequities in service access or provision between population groups (e.g., discrepancy between PharmaCare and NIHB reimbursement models) should be addressed
- Opioid dependency should be considered to be a long-term condition and appropriate fiscal arrangements should be developed that fit this model, including coverage for a range of evidence-based non-medical psychosocial supports
- Fiscal arrangements that currently appear to be distorting practice and interfering with good client care (e.g., the financial incentive for daily witnessed ingestion) should be reviewed and replaced as appropriate
- Fiscal arrangements must be flexible and fit for purpose to adequately deal with the complexity and variability of MMT provision across the province, including northern, rural and remote areas and services designed for particular sub-populations such as Aboriginal and First Nations people
- A "whole systems" approach should be taken to ensure that policy or fiscal arrangements in one part of the system do not negatively impact on other areas

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.*

- All *new* physicians should be required to provide opioid substitution treatment as part of their work and licensing requirements should be built into undergraduate medical training
- Developing regulations and mechanisms for prescribing by Nurse Practitioners should be considered a priority to address the access problems in BC

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.*

- MMT clients should be represented on all bodies that provide advice and oversee professional practice related to MMT in BC
- Client groups should be resourced specifically to become meaningfully involved in professional training on MMT, to produce training materials for health care providers and the public on a range of issues important to clients, and to develop informational materials to assist MMT clients
- Peer networks in northern, rural and remote areas should be resourced, including a virtual provincial network for MMT clients

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

- A short information leaflet for clients and family members should be produced
- A booklet or DVD on MMT should be provided for the general public and local communities

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- Best practices in the province should be regularly profiled by holding an annual conference to showcase innovative practice and service development in MMT
- The press should be kept updated of these innovations and developments

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

- The provincial government should actively involve all stakeholder groups in decision making related to widening access to evidence-based pharmacological medications for the treatment of people with opioid dependency, where alternatives are indicated as being of benefit
- A system for monitoring the provision of different substitution therapies and associated client outcomes including cost-effectiveness and client satisfaction should be implemented
- Decision making about MMT effectiveness should actively include clients and their supporters

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.*

- Existing undergraduate physician education and training should be adapted to ensure that all newly qualifying physicians have had sufficient education and training in the management of people with problematic substance use to enable licenses to prescribe opioid substitution treatment to be awarded
- All training and continuous professional development for health providers connected with the provision of opioid substitution treatment should be free of charge, and all travel costs paid
- Regular multi-professional opioid substitution treatment training workshops should be held in each health authority to encourage new prescribers and other stakeholders to become involved in MMT
- People who are currently taking methadone should be involved in providing this education and training and should receive the training and support to do so in a meaningful way
- Province-wide and regional virtual Communities of Practice for MMT should be developed to support continuous professional development and knowledge exchange on clinical decision making and promising practices
- Pharmacists should be required to undertake training and continuous professional development with other health professionals

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Appendices

Appendix 1: Coding Framework

Note: This was first created in September 2008 and revised throughout the coding and analysis stages to best fit emerging data.

1. Background and Context
2. Models of methadone provision
3. Methadone Clients
4. Alternatives to methadone
5. Financial systems and who pays for what?
6. Accountability/Regulation Systems
7. Methadone in private clinics
8. Prescribing physicians
9. Pharmacists
10. Need for other professional support
11. Health Authority Involvement
12. Strengths of Methadone Program
13. Access issues and barriers to methadone
14. Factors that impact client retention on methadone program
15. Stigma and discrimination of people on methadone
16. Client views of methadone program
17. Aboriginal
18. Gender issues
19. Physical health impact of methadone
20. Practice issues
21. Interface with Police/RCMP, Corrections/Prisons
22. Problematic practices
23. Suggestions for change

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Appendix 2: Data Collection Schedules

Interview Schedule for Key Informants - Phase 1 of study – an Issues Scan

Note: This is a semi-structured interview format and will be used to guide the interview process. Due to time limitations there may not be time for all questions depending on how much the interviewee wishes to lead the discussion. Some of the questions may also be addressed in earlier questions. This schedule is designed for face to face interviews but can also be used for telephone interviews.

Introduction

Introduce researcher and provide contact details – leave business card.

Ensuring Consent

Give participant copy of the participant consent form.

Talk through each point.

Ask if there are any questions

Remind the participant that they can verify the ethical approval of the study (read out from consent form).

If consent confirmed then ask the participant to sign both copies of the consent form and give one to them to keep and retain the other copy for the project files.

Thank the participant for their involvement and check how much time the participant has to conduct the interview.

Questions

Informant's Role, Position, Location etc

1. What is your role and how are you/have you been involved in the BC MMTP?
2. How long have you been involved with/connected to the MMTP?

Open Questions to set the scene

3. What are your views of the MMTP in BC in general?
4. Are there any historical issues that still adversely affect the program?
5. Are these improving?
6. What strengths do you think the program has or specific areas of good practice, if any?
7. Do you have any concerns about the MMTP? If so, can you describe these? Do these concerns have any direct negative implications for any individuals or communities? (is there evidence that can be produced for this?)
8. What have you done about your concerns thus far, if anything? What response have you received?
9. How does the BC MMTP compare with other MMTP in your opinion?

More specific questioning, if not covered in above, on access, retention, quality, effectiveness, inequalities...

10. Are there issues related to treatment access you would like to raise?
11. Are there any barriers to accessing the BC MMTP in your opinion? Is this the case for some groups of clients more than others?
12. Are there any groups that you feel are receiving poor/poorer access to the program? If so can you talk about the impact of this on these clients or groups of clients/communities?
13. Are there issues related to retention of clients in treatment that you would like to raise?
14. Are there issues related to quality of treatment that you would like to raise?
15. Are there issues related to effectiveness of the program that you would like to raise?
16. Are there issues related to capacity to provide the service that you would like to raise?

17. Are there issues related to inequalities across the program that you would like to raise? (after their response specifically probe on Aboriginal/First Nations communities and individuals on and off reserve,

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those in corrections facilities, on women, pregnant women, younger clients, older clients, clients with mental health problems, clients in particular neighbourhoods, rural and northern versus urban etc).

Client/Consumer Satisfaction

18. In general would you say that the majority of people who receive the MMTP in BC are satisfied with their treatment and experiences with treatment?
19. If not, what would be the main complaints?
20. What could be done to address these complaints, in your opinion?

Fiscal issues

21. Do you have any comments to make concerning fiscal or financial issues within the program?
22. Have you any comments to make regarding how fees are charged or administered in the MMTP program? (probe separately on physician fees, clinic fees, pharmacy fees)
23. Are there areas of poor value for money in any areas of the program?
24. What are your views on urinalysis tests? Are these tests a useful aspect of the program?
25. If so, are there ways that these could be addressed?
26. Are there issues concerning the accountability/responsibility of different organizations that you would like to mention?
27. Could accountability be tightened up in any areas and if so where? How would you suggest doing this?
28. Should there be any changes, in your opinion, to how the MMTP is overseen/administered to improve services to clients? If so, how would you suggest this is changed? Would this change be controversial to other stakeholders?

Possible solutions to problems or concerns with the MMTP

29. What solutions do you have (if any) to these issues you have raised?
30. What organization/agency/individual is best placed to take action to create improvement in these areas you have raised?

Closing comments

Is there anything further you would like to add that we have not covered already?

Would you be interested and available to give a further interview, if required, in the next phase of the evaluation?

Other informants

Are there other people you know who I should talk to in this evaluation?

Thank you

Thank you for your participation in this study. I will keep you informed of the evaluation's progress over the coming months via email.

Please contact me if you have any questions arising from our conversation together. Please also let me know if you would like to add to or amend anything that you have said today and I shall be happy to do this.

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Phase 2 – Focus Group Schedule for Clients/Consumers

Note: This is a semi-structured format and will be used to flexibly guide the focus group process.

Introduction

Introduce research and provide contact details – leave business card of lead researcher.

Ensuring Consent

Give participants a copy of the participant information and consent form. Talk through each point and ask if there are any questions. Remind the participants that they can verify the ethical approval of the study (read out from consent form). If consent confirmed then ask the participants to sign both copies of the consent form and give one to them to keep and retain the other copy for the project files.

Stress confidentiality and anonymity

Stress to the participants that their involvement with the review and answers they give will be completely confidential and will not be viewed by or discussed with any service providers. They will not be identifiable in the research documents that are produced nor in any presentations.

Thank the participants for their involvement and stress how helpful their involvement is in the research.

Groundrules for ensuring a good focus group

- Can we all agree to be respectful of each other's points and to listen to what we all have to say? We are likely to have different opinions but need to be polite and sensitive to each other's views. Agree?
- Can we try as hard as possible not to talk over each other? It is very helpful if everyone can raise their hand if they have a point to add into the discussion so that the facilitators can ensure that everyone gets a chance to get hear and we don't feel that people are talking over us. Shall we do this?
- It is important not to talk to others outside of this group about what someone else has said. This needs to be a safe space for discussion because people may say things that they do not want services providers to know, for example. Please can we have a commitment from everyone that everything discussed today will be confidential to this group? The researchers cannot guarantee this so please make your own decisions about what you are comfortable sharing in a group setting and if you would prefer to have an individual interview with the researchers please let us know (be prepared that people may choose to leave at this point).
- I want to get through all the questions so may move us on occasionally into new discussion areas. OK?
- Let's try to stay focused on the topic area – I can help us stay focused. OK?
- Does anyone else have any ground rules to add?

Note: Check how much time the participants have to conduct the focus group and check recording device.

Questions

1. GENERAL VIEWS: Can you tell me your views of the methadone 'program'? (Follow up on all avenues of response fully using the following probes…
    - Strengths of the program: What works well in how the program/system operates for you, if anything?
    - Weaknesses of the program: What does not work well in how the program/system operates for you, if anything?
    - Concerns: Do you have any other specific concerns about the methadone program? What have you done about your concerns thus far, if anything? What response have you received?
2. BARRIERS: Can you tell me about any barriers you found in trying to get on the methadone program? Do you know of barriers other people are experiencing or have experienced?
3. IMPACT ON LIFE: What distances have to be travelled to get prescriptions and the methadone itself? What is the average amount of time spent on ensuring methadone receipt every week? Does being on methadone limit your choices for how you spend your day? Please elaborate.
4. QUALITY: What about the quality of the treatment you receive? What would improve the quality of your experience?

18. What could be done to address these complaints, in your opinion?

Fiscal issues

19. Do you have any comments to make concerning fiscal or financial issues within the program?
20. Have you any comments to make regarding how fees are charged or administered in the MMTP program? (probe separately on physician fees, clinic fees, pharmacy fees)
21. Are there areas of poor value for money in any areas of the program?
22. What are your views on urinalysis tests? Are these tests a useful aspect of the program?
23. If so, are there ways that these could be addressed?
24. Are there issues concerning the accountability/responsibility of different organizations that you would like to mention?
25. Could accountability be tightened up in any areas and if so where? How would you suggest doing this?
26. Should there be any changes, in your opinion, to how the MMTP is overseen/administered to improve services to clients? If so, how would you suggest this is changed? Would this change be controversial to other stakeholders?

Possible solutions to problems or concerns with the MMTP

27. What solutions do you have (if any) to these issues you have raised?
28. What organization/agency/individual is best placed to take action to create improvement in these areas you have raised?

Closing comments

Is there anything further you would like to add that we have not covered already?

Would you be interested and available to give a further interview, if required, in the next phase of the evaluation?

Other informants

Are there other people you know who I should definitely try to talk to in this evaluation?

Thank you

Thank you for your participation in this study.

Please contact me if you have any questions arising from our conversation together.

Please let me know if you would like to add to or amend anything that you have said today and I shall be happy to do this.

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Appendix 3: Minute of the Medical Services Commission

Further amendment to the Medical Services Commission Payment Schedule Section of General Services, May 2009

Miscellaneous

T00039 Methadone treatment only...$22.23

Notes:

i) The physician does not necessarily have to have direct face-to-face contact with the patient for these fees to be paid.

ii) 00039 is the only fee payable for any visit or medically necessary service associated with methadone maintenance therapy. This includes but is not limited to the following:

a) At least one visit per week with the patient during the induction of methadone/methadone stabilization.

b) At least two visits per month with the patient after induction/stabilization on methadone is complete. Exceptions to this criterion are where the patient resides/works in an isolated locale which is a significant distance from the prescribing physician.

c) Case management/treatment planning with care team.

d) Supervised urine drug screening and interpretation of results.

e) Counselling by a physician.

f) Communication with non-physician counsellor.

g) Communication with dispensing/supervising pharmacist.

h) Communication with primary care physician.

i) Communication with hospital-based physician when patient admitted to hospital.

j) Completion and submission of documentation relating to registration, termination or transfer.

iii) Claims for visit fees are not payable in addition.

iv) This fee is payable once per week per patient regardless of the number of visits per week.

v) This fee is not payable with out of office hours premiums.

vi) Eligibility to submit claims for this fee item is limited to physicians who:

a) have a current valid license to prescribe methadone for addiction.

b) are actively supervising the patient's continuing use of methadone within the provincial methadone program.

vii) This payment stops when the patient stops taking methadone.

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Appendix 4: Methadone Guidelines and Frequency of Clinical Visits

Health Canada. (2002). *Best Practices Methadone Maintenance Treatment.*

- permit methadone prescriptions to be faxed to community pharmacies
- explore alternative approaches to monitoring/urine toxicology screening
- recognize the need for flexibility when local circumstances demand it

College of Physicians and Surgeons of Ontario. (2005). *Methadone Maintenance Guidelines.*

Early Stabilization Phase: Frequency of visits

Twice-weekly visits during the first two weeks of treatment are recommended, particularly if the patient is at increased risk for methadone toxicity or cannot be stabilized at a low dose. If possible, the visits should be scheduled for two to six hours after the methadone dose. The physician should inquire about sedation and other side effects.

The late stabilization phase (2–6 weeks)

Patients should be seen at least weekly to assess and adjust their dose. All dose adjustments require a medical assessment by a physician, and the reason for the dosage adjustment should be documented. Avoid automatic dosage adjustments on the prescription (for example—"increase by 5 mg daily"), phone assessments or assessments through non-medical personnel.

The maintenance phase (6 weeks +)

The patient should continue to meet with the physician every one to two weeks during the first year, depending on the patient's clinical stability.

The frequency of visits may be reduced thereafter depending on the clinical stability and recovery needs of the patient.

College of Physicians and Surgeons of Alberta (2005) *Guidelines for Methadone Maintenance Treatment in Alberta.*

Clinical Visits

1. Patients in the first two weeks of the initiation phase will be seen every day by the prescriber or MMTP clinical staff member that includes the prescriber
2. Thereafter patient will be seen weekly until designated stable
3. With few exceptions, the patients will have contact with the prescribing physician or MMTP clinical staff member at least every three months.
4. Urine toxicology results reported positive for proscribed substances after a period os stability necessitate clinical contact.
5. Indications of new instability necessitate clinical contact.

Guidelines

1. Less frequent physician visits may be appropriate for the stable patient with regular attendance for urine toxicology testing, counselling and pharmacy visits.
2. The frequency of face to face interactions should be guided by the clinical situation. However, typical follow-up plan could be

Length of Time Patient Stable on Methadone	Frequency of Clinic Visits
Less than 3 months	At least every two weeks
Less than 6 months	At least monthly
Less than 12 months	At least every 2 months
Greater than 12 months	At least every 3 months

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Appendix 5: PharmaCare Reimbursement for Pharmacy Dispensing of Methadone

Summary of policies effecting the data

Calendar Year May 1, 2001 - Present (Current Policy)

Ingredient Fees:
The maximum accepted cost of methadone was dropped, and set to $0.02/ml. We see a significant decrease in ingredient costs since this prevented pharmacies charging $0.26/ml for methadone. (In May 2001, roughly 30% of claims where processed with ingredient fees of $0.26/ml).

Professional Fees:
PharmaCare will pay up to one professional fee per day regardless of plan (up to the current maximum).

Interaction Fees:
A $7.70 interaction fee for each dispensation of methadone is paid under the current methadone maintenance program. To qualify for interaction fees, the pharmacist must witness the ingestion of the medication by the patient. Each client dispensed methadone under the Methadone Maintenance Program is subject to a maximum of one interaction fee per day.

Calendar Year 1997 - April 30, 2001 (Old Policy)

Ingredient Fees:
The PharmaCare maximum accepted cost for methadone was set at $0.26/ml during this period. Typically, pharmacies submitted ingredient costs between $0.02/ml and $0.26/ml.

Professional Fees:
Only claims adjudicated under the Non-Seniors Universal Coverage Plan (plan E) were eligible to have their professional fees paid for by PharmaCare. PharmaCare did not cover the professional fees of other plans, approximately 75% of methadone clients were registered on income assistance (plan C).

Interaction Fees:
For patients on plans other than E, PharmaCare paid a monthly per diem of $105/patient to the pharmacy. Most pharmacies were only allowed to have 30 different methadone patients registered at any given time.

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