

British Columbia
Methadone Maintenance Treatment Program
A Qualitative Systems Review – Summary Report

Tessa Parkes
and
Dan Reist

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**University
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Centre for Addictions
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Acknowledgements

This report is a summary of a comprehensive qualitative review of 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. It was made possible through the generous involvement of more than 300 people who gave of their time and expertise to guide the process and provide the material.

The qualitative review produced hundreds of pages of transcriptions and other materials. The thematic analysis carried out by the principal investigator first led to the preparation of a report of considerable length. The present report is a summary of this longer report and represents the collaborative efforts of the principal investigator and a policy analyst both associated with the Centre for Addictions Research of BC.

The review was commissioned by the British Columbia Ministry of Healthy Living and Sport. The authors acknowledge the support and help of ministry staff in facilitating the review and in commenting on various drafts of the reports. Responsibility for the representation of the views of participants and for the picture of the methadone maintenance system contained in this report, however, rests with the authors.

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The authors:

Tessa Parkes is a research fellow with the Centre for Addictions Research of BC, adjunct assistant professor in the Faculty of Human and Social Development, University of Victoria and a senior lecturer in the Department of Nursing & Midwifery, University of Stirling, Scotland, and was the principal investigator for the qualitative systems review.

Dan Reist, Assistant Director (Knowledge Exchange) and a senior policy analyst with the Centre for Addictions Research of BC, University of Victoria.

Introduction

This report summarizes the findings of a qualitative systems review of methadone maintenance treatment (MMT) in British Columbia, which was commissioned by the British Columbia Ministry of Healthy Living and Sport in 2008. 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

MMT is recognized internationally as among the most efficacious treatments for illegal opioid dependence. Its effectiveness is optimized by a comprehensive approach to health service delivery. British Columbia has significantly increased the number of MMT patients since the 1990s, so it was appropriate to undertake a review to determine where improvements can be made and to ensure treatment successes and client satisfaction.

This systems review used a multi-phase, qualitative research method, engaging stakeholders from across the province to offer perspectives on BC's approach to MMT that included MMT clients, family members, advocacy organizations, physicians, pharmacists, other service providers in both the public and private sectors, those working within relevant ministries, and health system managers. Over 300 individuals took part in the systems review, including representatives from Aboriginal populations, women, and street-involved people on methadone (see Table 1). Sampling also ensured that clients using services across the continuum of models, and in different geographic locations, were included.

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	

Data were collected and coded for thematic analysis, and then analyzed for the content that forms the basis of this summary report. Ethical clearance for all data collection was given by the University of Victoria Human Research Ethics Committee. A team of expert advisers helped to steer the research process and the main findings and recommendations of the review were presented to a range of stakeholder groups for feedback and comment. Other background research informing the review included a literature review on MMT and a scan of service models from other jurisdictions in Canada and internationally.

In addition to the qualitative systems review discussed in this report, a quantitative analysis of the BC PharmaNet and other linked databases by the Centre for Health Evaluation and Outcome Sciences (CHEOS), University of British Columbia was commissioned as a complementary research project. Together, both the qualitative systems review and the quantitative health database analysis have informed an analysis prepared by the Centre for Addictions Research of BC, University of Victoria.

Who are the clients?

The population of clients accessing methadone maintenance treatment is complex and diverse. Some clients experience concurrent health and social needs requiring a range of services and supports. Mental illness, physical injury and disability, diabetes, and neurocognitive disorders were described as common among clients.

While service providers in the Downtown Eastside of Vancouver described many or most of their clients as receiving income assistance, in other areas of BC, including Vancouver Island, the North and the Interior, service providers reported that a majority of their methadone clients were employed.

The original goals for the rapid expansion of BC's MMT program in the 1990s were public health goals, particularly the mitigation of the HIV epidemic in Vancouver's Downtown Eastside. While MMT may have contributed to preventing many more HIV infections in BC over the past decade (Anderson, 2000), many former or current injection drug users in the province are currently living with HIV or hepatitis C. There are systemic problems with ensuring consistent linkage between MMT and HIV treatment.

Some health professionals reported that the majority of people they see with opioid dependency have a history of violence and complex trauma. Many informants connected childhood and adult trauma to client experiences of chronic pain. Indeed, some health professionals suggested that chronic pain should be considered a "*comorbid condition*" for people with substance use problems, similar to the co-occurrence of mental or physical health problems. People on MMT, particularly in the Downtown Eastside, report that their pain medication needs are not addressed, due to a growing concern on the part of physicians that opioid medications are being over-prescribed, over used, and diverted into a black market. 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.

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 experienced by MMT clients. 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 and to improve treatment outcomes and quality of life for their clients.

Conclusions

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

- 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 multiplicity of needs of many clients
- A wide range of psychosocial supports are necessary to address the health and social needs of MMT clients

- 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
- The professionals providing MMT services need to be supported with access to specialized advice (e.g., pain management)
- 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

Professional Roles and Models

The system of methadone-related services in BC, as in many other jurisdictions and countries, is multifaceted and reaches 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.

A variety of professional groups play important roles in the delivery of the MMT system in BC, including physicians, pharmacists, nurses, counsellors, case managers and administrative supports. Physicians, the only professional group in Canada permitted to prescribe methadone for maintenance, require a special exemption under the *Controlled Drugs and Substances Act* to do so. In addition to prescribing methadone, physicians are responsible for initiating, stabilizing and maintaining clients on MMT, and tapering them off when the client is ready. The College of Physicians and Surgeons of BC (CPSBC) provides detailed guidelines regarding the various aspects of a physician’s role in their revised handbook (CPSBC, 2009).

Most methadone prescribed for maintenance is dispensed through community pharmacies, making pharmacists an integral part of the MMT process. The pharmacist’s role includes client engagement, ongoing communication with the client, liaising with physicians, reviewing PharmaNet profiles and updating the database, and reviewing and evaluating prescriptions (CPBC, 2007). 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.

In some MMT care models, nurses do much of the administrative work associated with MMT, alongside medical office assistants. Nurses may also help physicians with physical examinations, substance use screening and counselling, chronic disease management, support and outreach. In rural areas, nurses may also help care for clients who are not connected to (or in some cases banned from) local family physicians.

The use of counsellors in the delivery of the MMT program varies depending on the care model. Trained counsellors may play an important role in taking a client’s social history, conducting intake assessments and screening, providing crisis counselling and longer-term counselling, witnessing urine tests, liaising with other providers such as pharmacists, and arranging for clients to see the physician. Differing views were expressed regarding the relevance of counselling for MMT clients. Whether counselling should be a client choice or a requirement to be on MMT was frequently raised in discussions on counselling.

Case management is used in some MMT models, but this term refers to different roles and activities in different locations and services and is performed by a variety of professional roles rather than specific “case managers.” Case management was seen to have the most potential benefit for clients who frequently moved between settings (e.g., corrections, hospital and community settings) or for Aboriginal people moving between reserve and off-reserve communities. These transitions give rise to greater likelihood of gaps in continuity of care and associated problems.

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.

Medical office assistants play an important role in many MMT services, 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.

There are three primary models of MMT in BC: the general practitioner/family physician model, integrated models, and private sector models. Private sector models are described in detail in the next section.

MMT provision through family physicians or general practitioners (GPs) is an important service model across BC. This model is regarded by some participants as ideal for MMT because it allows for inclusion and integration of clients within mainstream services and offers MMT clients the benefits of comprehensive care. The GP model may be particularly good for certain client groups, such as those who are more stable, or people living in northern, rural or remote areas of BC. It is also preferable for those who want to avoid the "congregation" dynamics of some MMT clinics and have the benefits of the greater anonymity that comes from being integrated into a general practice context.

Integrated models of MMT take at least three distinct approaches to service delivery: Community Health Centres, non-profit models, and mental health and addiction services provided by the regional health authorities. Community Health Centres provide a comprehensive care approach and include health care provision by physicians, nurses, social workers, mental health and addictions counsellors and psychologists. Public health services such as immunizations and perinatal care are also available in these settings. In terms of MMT, some Community Health Centres are able to offer case management services and some have in-house pharmacies. Some not-for-profit organizations also run comprehensive health clinics, where physician services are integrated with other supports such as nursing, case management and counselling. Health authority-based mental health and addiction services vary in the level of integration between MMT and other health services such as primary care or public health, addictions and harm reduction services.

Conclusions

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 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.

- 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
- Integrated models appear to have the greatest potential to meet the needs of clients and communities

Private Methadone Clinics

The definition of a private clinic in this report is a clinic that provides methadone treatment exclusively (or almost exclusively) 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 comprehensive primary care services.

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 MMT clients would be disruptive in their regular 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 who objected to adding methadone prescribing to existing health services. Many physicians were prepared to prescribe in a separate clinic setting, with the accompanying systems and staff support. Having this additional support in place alleviates many of the more demanding aspects of methadone provision for these physicians.

All private methadone clinics provide methadone prescription by a physician, and most provide some access to counselling or other support services. Some clinics support clients in accessing primary care services 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. 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.

A number of clients talked about the support given at private clinics very positively. One aspect of this is important to raise here. A good number 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 staff members that can be invaluable on a person's recovery journey.

Five main criticisms were raised concerning private clinics by those working in and outside of them. While many of the criticisms are not unique to private clinics, they were most repeatedly raised in that context. Participants expressed concern about:

1. The lack of standards, regulations or quality controls in place for the private clinics (views differed widely on who and what this should involve)
2. MMT being provided separately from comprehensive primary and public health interventions
3. There being 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 are even receiving any counselling
4. Continuity of care, citing examples of private clinics sometimes closing overnight with no notice to clients
5. The reported financial links between some private methadone clinics, pharmacies and recovery houses that may involve directing clients to use a particular service in return for a financial kick-back to the referring service

Conclusions

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 sometimes 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 concern about quality and ethics within private clinics needs particular attention.

- 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

Fiscal Systems

Funding for MMT in BC is multi-faceted and complex. The system is supported by significant expenditures through the Medical Services Plan (e.g., payments to physicians and urine drug screens), BC PharmaCare (e.g.,

dispensing and drug costs), health authorities (e.g., counselling services), the Ministry of Health Services contract with CPSBC, the Ministry of Housing and Social Development alcohol and drug treatment supplement, and the Health Canada non-insured health benefits program. On top of this, some clients are required to pay up to \$80 per month in user fees.

There are a wide range of views on the subject of whether physician compensation is adequate or not. Generally, review participants agreed that community physicians who are doing the comprehensive care, as well as the MMT work, are not reimbursed well enough. For example, 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. Physicians, and other stakeholders, believe that MMT physicians should be adequately compensated for MMT, whatever their caseload and circumstances.

Some physicians in rural parts of the province suggest that the clinical practice guidelines stipulated as part of the fee item—especially the clause that requires a minimum of two patient visits per month—are onerous for physicians and MMT clients in non-urban settings and directly interfere with clinical decision making and individualized treatment planning. For example, many clients are stable and, given the distance that they live away from their physicians and the limited travel options that people on MMT tend to have, these guidelines are viewed as negatively impacting client access and retention. In addition, in rural areas there may only be one prescribing physician for a large geographic area so twice monthly visits are not viewed as feasible given the large caseloads some physicians are carrying.

On the other hand, many participants reported that MMT in urban regions has become a “cash cow” for some physicians who seek to profit from the current compensation system by taking large numbers of MMT patients but without necessarily providing optimal care. Many drew attention to a wide variety of problems felt to be due to the perverse incentives or disincentives that the current funding system encouraged.

More generally, others criticized the MSP payment system for MMT as not being conducive to a chronic disease management model of care, which may be more appropriate for treating opioid or other drug dependence. Certainly, a lack of clarity and clear protocol around physician billing was evident. The fee-for-service system was described by participants as very problematic for MMT and good alternatives are much needed. Many emphasized 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. Finally, MMT funding mechanisms need to recognize and support the important roles of nurses, counsellors, social workers, outreach workers and other professionals.

Urine drug screens detect the presence of illegal drugs in MMT patients and may be used by physicians as part of an initial assessment for a patient seeking MMT, or as part of ongoing supervision after stabilization. Urine drug screens are billed through MSP and are recommended at a frequency of at least every two months. Physicians are split on the usefulness of urine drug screens, with some seeing them as an important clinical practice tool and others as a method of control and punishment with limited clinical utility. Some physicians suggest that the cost of urine drug screens could be significantly reduced by allowing office-based point-of-care testing.

The pharmaceutical costs of methadone and its dispensing to patients are paid for by the BC PharmaCare program, which assists BC residents in paying for eligible prescription drugs. The fees for the pharmacy component of MMT include the drug cost of methadone, a dispensing fee, and a monitoring and interaction fee paid to pharmacists when they have patients who require daily witnessed ingestion. These pharmacy reimbursements, which were instituted or increased in 2001, may have helped double the number of dispensing pharmacies in the province (particularly in northern and rural areas) since the 1990s. Many participants believed that levels of reimbursement had been raised too high and, in some urban areas, were distorting MMT in significant ways. Cash or other incentives to clients being offered by some pharmacies and pressure by pharmacies to have clients request daily witnessed ingestion are examples of such distortions. Some participants feel the

current compensation mechanism for methadone dispensing leaves clients vulnerable to exploitation by unscrupulous pharmacists.

Several participants noted that the current funding system does not easily allow for the integration of service provision. Different components of the system are funded independently, and some components are funded using different formulas depending on the client and the funder. This fragmentation, according to participants, contributes to the lack of accountability and consistency in the system. Some go so far as to suggest there is no “system” for MMT in BC.

Some commentators were particularly 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 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.

Conclusions

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 deliver 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. 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.

- 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 or 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

Accountability and Regulation

The accountability, regulation and oversight of methadone maintenance treatment in British Columbia were hot topics for many participants. In 1996, the federal government devolved responsibility for MMT to some provinces, including British Columbia. At the time, the public health imperative of increasing capacity for MMT to reduce illegal opioid use – and thereby overdoses, unsterile injections and blood-borne pathogen transmission – prompted the BC government to establish incentives to increase the number of prescribers and dispensers. But many participants believed that a lack of coordinated government oversight during this period of widespread up-scaling has contributed to creating substantial problems within the current program. Provincial government policy was described as “*toothless*”, “*indifferent*” to the program, and “*unresponsive*” to complaints, leading to despondency, apathy, exasperation and a feeling that “*there is nothing that anyone can do.*”

The College of Physicians and Surgeons of BC (CPSBC) has responsibility for the training and licensing of physicians and some administrative aspects of the MMT program (under contract to Pharmaceutical Services Division, Ministry of Health Services). The CPSBC makes recommendations to the Federal Minister of Health on behalf of physicians in BC who want a federal exemption to prescribe methadone for either pain or opioid dependency. In order to receive authorization to prescribe methadone for maintenance, a physician must complete a one-day workshop and two half-days of preceptorship. CPSBC also audits clinical practices of its members who are authorized MMT prescribers, maintains a register of patients receiving methadone for the treatment of opioid dependency, chairs an Advisory Committee on Opioid Dependency, and publishes an annual report on aspects of the program that the College oversees. The CPSBC does not monitor counselling or other support services included in MMT or any other aspect related to clinic functioning or financing. The fact that these fall outside the College's mandate, suggested to a number of participants that leadership of the MMT system needs to be broader than CPSBC. Participants who are members of the CPSBC had mixed opinions about its role in MMT in BC. Some reported a collegial and fair organization that does its best to balance the various interests of patients, physicians and drug control authorities. Others felt that the College's approach to MMT was overly concerned with preventing overdoses and diversion at the expense of fostering a low-threshold, patient-focused approach to MMT. Some suggested that the College's administrative processes lacked transparency and that its Advisory Committee on Opioid Dependence was too conservative and not fully supportive of harm reduction approaches to addiction treatment.

The College of Pharmacists of BC (CPBC) has a regulatory function for MMT that includes the licensing, training, directing, and assisting of pharmacists who dispense methadone. The CPBC is also responsible for developing guidelines for pharmacy practice. Pharmacists who dispense methadone are not required to complete formal training, although the CPBC does offer on its website workshops and information about MMT and the pharmacist's role in providing effective treatment. The CPBC tries to ensure its members comply with pharmacy regulations by doing checks on pharmacies that include site visits and financial or practice reviews. The College also has the power to take away a pharmacist's license, although high standards of evidence and a rigorous formal investigative process are required before this happens. If criminal activities are suspected or alleged, the CPBC works with police and the Ministry of Health Services to conduct appropriate investigations. While many pharmacies that dispense methadone uphold professional standards, some well-publicized exceptions in the Lower Mainland regarding payments or other incentives to MMT clients have challenged the reputation of the profession. Many participants expressed frustration at the inability or unwillingness of the College to address these issues or respond to complaints.

Health authorities in British Columbia have responsibility for delivering health services in their geographic jurisdictions, including delivery of addiction treatment services. Provincial health policies on problematic substance use are set by the Ministry of Health Services and the Ministry of Healthy Living and Sport, while health authorities manage resource allocation and program delivery. With respect to MMT, all participants who worked with Health authorities felt they could and should play a more important role in its provision within their regions. Some participants noted that links between primary care, public health, mental health and addiction services, and community agencies in health authorities were in many cases weak and not reflective of a collaborative or innovative approach to MMT. Regulation of support recovery houses was cited as an issue of concern, as it was reported that some have potentially unscrupulous links to particular pharmacies or physicians while others refuse to accept patients with methadone prescriptions.

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 concerns about MMT in their regions, some participants suggested that they should have been more proactive in acknowledging service gaps and responding to them. A lack of trust and respect between some physicians and health authorities was noted. Some participants were concerned about the "lack of connection between mental health and addictions

counselling services and prescribing physicians.” According to some, health authorities 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.” A stumbling block to development is having “no regional leadership for methadone,” and the 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.

Conclusions

Some of the problems with MMT accountability have been exposed by the press and other media. This, and the perceived lack of timely responsiveness from authorities, has eroded confidence in current administrative structures and led to diminished faith in BC’s methadone program among many stakeholders. Current structures do not provide a cohesive base for administering a comprehensive, multi-disciplinary methadone system 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.

- A clear set of provincial policies to guide a comprehensive and integrated methadone program is 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, communities, and community-based organizations, is essential to addressing current concerns and maintaining transparency
- 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 or accreditation as needed

Strengths

Clients described the many ways that methadone had positively affected their lives. These include prevention of overdose or HIV transmission, building confidence and feeling valued as a “normal” person, and changing their values and reducing involvement in criminal activities. The stability and routine of MMT helped some clients reconnect with family and friends or begin employment. For some, MMT helped create more safety in their lives, by reducing the risk of harm from injection drug use or involvement in the sex trade. A reduction in anxiety associated with opioid withdrawal and a decrease in other kinds of substance use were also seen as positive impacts of methadone.

Clients described what they value in their relationships with their prescribing physicians: being treated as an individual; kindness, compassion and respect; open-mindedness and non-judgmental care. In their relationship with dispensing pharmacists, clients value being treated with care and respect “like a normal human being.”

Professionals described a number of perceived strengths of the MMT program, including contributing to the betterment of society, saving lives and helping clients turn their lives around, providing access to better health care, breaking the cycle of substance dependence, and reducing preventable harms such as overdoses, HIV, and

hepatitis C. Some professionals compared the program favourably to others, both in Canada and the rest of the world.

Conclusions

MMT was viewed by clients and professionals 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 program has achieved many important successes that should be examined and built upon for future improvements.

- 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 building a more effective, accessible and responsive system of care, support and treatment
- Current champions and practice leaders should be utilized and supported in better informing the public and other professionals about MMT in BC

What Clients Do Not Like

Client dislikes regarding MMT include lack of psychosocial supports and information, poor pain management, the physical effects of methadone, controlling and punitive practices, and constraints on their daily lives imposed by the rules and practices of methadone treatment. Clients also commonly report experiences of stigma and discrimination.

The provision of psychosocial supports is uneven, and no guidelines exist for provision of this service. The provision of methadone treatment without health and social supports is seen as an ineffective service. Further, clients report they do not receive the information they need for informed decision-making about methadone and their treatment.

Many clients experienced inadequate management of their chronic pain. Some clients were convinced that physicians perceived them as drug seeking, so would not properly assess, investigate or treat their pain.

The physical health impacts of methadone was a common theme in the review. In addition to physical and emotional side effects, the process of reducing and eventually completely withdrawing from methadone use was reported to be very difficult. Clients also reported concerns with both under-dosing and dosing increases.

Clients expressing concerns about controlling and punitive practices, specifically addressed restrictive carry policies as one example. 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.

In their feedback about problematic rules and practices, respondents primarily discussed the constraints imposed by the rules for carrying methadone. Many clients viewed the daily trips to the pharmacist as a major burden on their lives. Some spoke about the challenges they had encountered finding pharmacies that dispense methadone in areas where they lived or wanted to travel to, and that this had inhibited their ability to travel or move. Clients

reported being unable to avail themselves of employment opportunities—for example, 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.¹

Stigma and discrimination was a frequently recurring theme and is discussed in more detail below.

Conclusions

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 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.

- Clients views about what does not work for them should influence the services and supports which would positively impact client satisfaction, 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

Problematic Practices

Many participants reported issues related to BC's MMT system that they described as unethical, abusive, or problematic in some way. Most, but not all, of the problematic practices identified were reported to have occurred in the Lower Mainland.

Problematic pharmacy practices alleged by participants included providing financial or material incentives including other drugs for clients to use a particular pharmacy; unauthorized carries; unauthorized deliveries/pick-ups; not witnessing the ingestion of the methadone, or having non-health care professionals witnessing the ingestion; interpretive prescribing or dispensing (for example, methadone being given without a prescription, or patients being weaned off methadone without their physician's knowledge); and irregular or inconsistent dose strength interpreted as perhaps indicating dilution or 'watering down' methadone at the point of dispensation.

Problematic physician practices were also alleged: methadone-prescribing physicians having ownership of, or shares in, particular pharmacies, or having ownership of, or shares in, recovery houses where clients are being sent; restricting clients to particular pharmacies; clients being pressured into MMT by their physician; and clients being prescribed methadone inappropriately (e.g., to treat cocaine dependency).

Participants also discussed problems created by financial links between some non-licensed recovery or rooming houses, other housing, treatment programs and pharmacies. Landlords were reported to have threatened or evicted tenants when they did not use the landlord's pharmacy and some recovery houses were reported to be denying access to clients unless their physician agreed to daily dispensing of methadone. Particular attention was given to

¹ 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).

the systemic problems with ensuring consistent linkage between MMT and HIV treatment in light of these problematic practices.

Conclusions

Alleged problems in 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 Methadone Maintenance Program. The people taking methadone in the Downtown Eastside that attended the focus groups and interviews believed that the services they received were being held to a “lesser standard of care” than health services targeted at other groups of patients or clients.

- 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

Access to MMT

Many participants felt that access to MMT in BC is overall much better than it was in the 1990s. This is reflected in increases in the number of prescribing physicians, dispensing pharmacies and program clients over the past decade in many parts of the province. Some outstanding barriers remain, however, particularly for some populations in some places. The Lower Mainland (i.e. most of Vancouver Coastal Health and Fraser Health) has the largest number of physicians licensed to prescribe methadone, and the establishment of community health clinics has improved access and helped integrate methadone into primary care services. Fraser Health has less capacity, much of which is available only through private methadone clinics that charge clients user fees. In the North, Interior, some parts of Vancouver Island, and other rural or remote parts of the province, MMT is less accessible than in the Lower Mainland, largely due to fewer prescribing physicians, but in some places because of broader community resistance to substitution treatments for addiction. Physicians identified workload and caseload as among the reasons for not wanting to take on MMT patients, especially in rural areas. While dispensing pharmacies are more commonplace than they used to be, there are still some communities where methadone is not readily available and clients must travel long distances to get their medication. Both the College of Physicians and Surgeons and the College of Pharmacists are aware of and have been working to address these ongoing barriers to access.

Other systemic barriers limiting access to methadone that were identified by participants included paperwork for physicians, the costs and travel required for training to be licensed to prescribe, and transfer of methadone clients from systems such as acute care or correctional institutions to a family physician or other community care option. Stigma and discrimination against people with addictions among health professionals was also cited by some participants as an issue. MMT clients are perceived by some physicians or pharmacists as undesirable individuals with complex needs, who might be threatening or off-putting for other patients. Some physicians in underserved communities reported not wanting their methadone license status widely publicized out of concern that this would attract more MMT patients and overwhelm their family practices.

Conclusions

Significant improvements in access to MMT were reported, particularly since 1996 when CPSBC was given administrative responsibility for the program, and the number of clients has correspondingly increased. However, many ongoing challenges were also identified. The most significant among these revolve around attracting and retaining prescribing physicians. There is 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.

- Attention to physician recruitment and retention is critical for increasing access to, and improving effectiveness of, MMT
- Mechanisms to normalize MMT as part of regular medical practice while recognizing and enhancing the multi-disciplinary nature of the program should be pursued
- Training for physicians should address the stigma and discrimination related to substance use and MMT and that affects the 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 should be reviewed and adjusted to balance the need for improved access with the need for quality service
- The MMT system needs to enhance its regional responsiveness and explore mechanisms for getting local stakeholders more involved in planning and implementation

Retention in MMT

Retention in MMT is recognized as among the most important factors in attaining positive treatment outcomes for people with opioid dependence. Issues that negatively affect retention in MMT include inadequate dosage or insufficient duration, lack of supports, services and information, problems with continuity of treatment, care issues with physicians, and financial issues.

Adequate dosage is one of the most important predictors of retention in MMT, as clients who do not receive enough medication may seek out illegal opioids on the black market to alleviate cravings or withdrawal symptoms. Furthermore, if tapering to reduce the prescribed dose begins too early in the stabilization phase of MMT, clients may be at higher risk of relapse to illegal opioid use.

Adjunct services and supports for MMT patients—including psychosocial counselling, affordable housing, income assistance, and employment training—can all improve treatment retention. Gaps in continuity of treatment, which may be due to geographic issues or transition between systems, were also identified as factors in decreased retention. In particular, patient experiences in acute care settings such as hospitals, where staff sometimes display callous or stigmatizing attitudes towards MMT patients, were noted as contributing to discontinuity of MMT. Some patients reported not receiving enough information about MMT and its benefits and challenges to have made the best decision about treatment. Examples of this kind of information included the pharmacological effects of methadone and the logistical challenges of ongoing maintenance therapy.

Care issues between patients and physicians were also cited by some participants as reasons for suboptimal retention. Examples of these included a lack of time with their doctor, long wait times, how urine drug screens are administered, and how carry privileges or dose adjustments are used as control mechanisms. Reducing a patient's dose or terminating MMT treatment altogether because of a relapse into illegal drug use were cited by both patients and some physicians as punitive and working against the goal of improving retention. This may be particularly problematic in regions where there are few alternative options for MMT prescription.

Financial issues were also reported to be a factor in retention, especially for clients with limited means or on income assistance. The charging of fees by some methadone clinics was reported by some patients as contributing to their termination of treatment. For example, after using up the \$500 annual allowance from MHSD to cover counselling fees for MMT, some clients drop out of the program if they are unable to cover the fees themselves. Physicians in some rural areas have also reported that the fee schedule for MMT, which requires them to see

clients at least once every two weeks unless they live “a significant distance” away, could have a considerable impact on retaining patients.

Increased retention in MMT was attributed to a variety of factors, including having a positive relationship with one’s physician, being in close proximity to a dispensing pharmacy, and having supports and involvement in one’s community. Flexibility on the part of health care professionals was identified as important, recognizing that patients are people whose needs may change over time and that a punitive approach to MMT is not going to improve retention.

Conclusions

The issue of client retention in 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 work and interest in working with clients, their families and client-representative organizations. Review stakeholders emphasized that client retention in 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.

- A “systems approach” is necessary in order to manage the complex and interconnected issues in a comprehensive way
- The interests and concerns of clients should 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

Gender and Age

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 2). 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 women who are dependent on opioids.

Some participants reported differences between men and women in terms of their need for adjunct services, with men preferring support for employment, and women preferring counselling support.

Many participants stressed the importance of a biopsychosocial assessment that asked people clearly what they want in terms of services and supports.

Table 2: 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

Respondents were supportive of gender-specific substance use treatment settings including those in primary care services. Addiction services were viewed as more successful than mental health services in terms of providing gender-specific programs; however, participants felt there is generally a lack of trauma-informed, woman-centred day programming.

The stigma associated with substance dependence was viewed by client and professional responders as much worse for mothers and pregnant women with substance use problems. At the same time, some responders pointed out that pregnancy can be a gateway to MMT and associated stabilization. Differing levels of knowledge concerning pregnant women were evident among service providers. The current dominant best practice guidance in this area indicates that women dependent on opioids need to stay on opioids until their child is born (Health Canada, 2002). Participants expressed a desire for best practice guidelines, and CPSBC has addressed this within their revised handbook (CPSBC, 2009).

Participants reported concerns among women about the Ministry of Children and Family Development apprehending their children if it is discovered that the women are using methadone. For many other women, however, involvement in MMT was seen as a way to get their children back from the care of the Province. For men, being in methadone treatment often means getting a job and providing stability for their family, while for women, family stability can be threatened by being in treatment. For women who live separately from their children, visits can be important to stability and recovery. However, it can be difficult for women to get sufficient carries in order to visit their children.

CPSBC sets out specific guidelines for youth and MMT, including meeting criteria for late-stage dependence, experiencing significant adverse consequences, having inadequate support systems, and having been unsuccessful at previous treatment attempts (CPSBC, 2009). Participants agreed that if youth are going to have access to MMT it is essential that case management, outreach and psychosocial supports are available. The need for regular review with opportunities to taper off methadone, if and when clients choose, was also emphasized.

As can be seen in Table 2, the population of seniors (over age 60) accessing MMT is only 1.8% of the total number of current clients. However, demographics may shift considerably as the largest group of MMT clients (age 40-59) grow older. Planning for this shift is recommended, particularly given the intersecting health issues that will emerge as MMT participants age.

Conclusions

The importance of a gendered-approach was felt to be an important component of 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.

- MMT services should be planned, implemented and reviewed to ensure they are responsive to diverse needs related to gender and age

Aboriginal and First Nations Peoples

In 2002, the Provincial Health Officer found that Aboriginal and First Nations peoples in BC are overrepresented in mortality and morbidity rates connected to problematic substance use. Many participants linked health issues to experiences of colonization, stressing the importance of taking historical factors into account in the provision of harm reduction and treatment services for Aboriginal people in BC. Participants noted that mental health and problematic substance use services are inadequate to meet the needs of Aboriginal and First Nations peoples, partly due to insufficient resources but also because services are not viewed as culturally appropriate. In particular, long waitlists, underfunding, and a lack of services for Aboriginal women were identified.

Mental health and addiction resources do not appear to be serving off-reserve Aboriginal people very well despite attempts to prioritize this population. MMT is not available on-reserve in BC, and the lack of services for those in rural and reserve communities results in travel over long distances to larger urban areas to obtain methadone. While offering methadone services closer to reserves, or actually on-reserve, was cited as an expense that could pose challenges for the health system, some believed it was essential to make this happen.

The movement of Aboriginal people between their reserve communities and urban areas of BC presents challenges for MMT initiation and continuity. As well, continued stigma exists in Aboriginal communities regarding the use of MMT or other harm reduction–based treatment services. Access issues for First Nations peoples with status also present a challenge due to a difference in payment structures for Health Canada’s Non-Insured Health Benefits Program.

Creating culturally appropriate, safe, and accessible environments was generally seen as best done through non-Aboriginal providers partnering with Aboriginal providers as well as supporting Aboriginal capacity to deliver services independently. One of the most popular ideas for making MMT more accessible to rural and on-reserve populations was to use Telehealth (videoconferencing) technologies.

Conclusions

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 for Aboriginal people
- 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 also provide models for the delivery of MMT in non-Aboriginal communities

MMT in Corrections

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 MMT programs that allow for both initiation and continuation of methadone 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 when they are under their care. The potential to engage people on MMT while in corrections settings seems, therefore, to offer important public health possibilities.

Despite progress, problems for people accessing methadone in correctional settings still exist. Identified issues include: unpredictability in responding to people currently enrolled in MMT; poor access to methadone when the person was already stable on a regular dose; unclear policies and guidelines around methadone access and distribution; challenges in initiating methadone in provincial corrections settings because a person’s stay is often very short; and an anti-methadone sentiment amongst some corrections staff, including some physicians and nurses.

Reports exist of prison staff using methadone as a means of controlling a prisoner’s behaviour: methadone may be withheld, causing the person to go into withdrawal; prison staff may attempt to control or change a person’s stabilized dose; or access to methadone or adjustments to an established dose may be used as an incentive for certain behaviour or as a punishment.

Correctional facilities can be a very difficult place for people on MMT. It is widely acknowledged that illegal drugs are available within the prison system, and so the proximity and accessibility of heroin may be a difficult temptation to resist. Methadone may be used as a currency in corrections settings, being diverted and traded. Methadone patients may be pressured or bullied by other inmates to divert their methadone, yet may be punished by prison staff if they are discovered doing so.

Problems also exist when an incarcerated person on MMT is released back into the community. There may be a lack of continuity of care between the corrections system and the wider community, with a lack of prescribing physicians being among the most problematic. There are still many rural and remote communities, including First Nations reserve communities, where geographic distance makes access to comprehensive health services, including MMT care, an ongoing challenge.

Conclusions

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 challenging task. Based on the progress reported by review participants in this particular area of MMT provision, it is clearly worth continuing to strive towards these goals.

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

Pharmacological Alternatives to Methadone

Almost every stakeholder involved in the review felt that pharmacological alternatives to methadone to treat opioid dependency could address many problems currently being encountered with MMT.

Buprenorphine (or Suboxone™, a buprenorphine/naloxone formulation) has become a front-line treatment option in many countries. Buprenorphine has recently been approved for maintenance treatment use in Canada, and the Ministry of Health Services is considering whether or under what conditions to add it (or Suboxone™) to the provincial formulary. Participants who were prescribing physicians suggested they welcomed having buprenorphine available as a medication they could offer as an alternative to clients who may not be suited to taking methadone. 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 improving client satisfaction which is critical to client retention and treatment effectiveness.

Heroin assisted treatment has been successful in the Netherlands, Switzerland and the UK, with improved retention being one of the strongest arguments for effectiveness. The Vancouver/Montreal North American Opiate Medication Initiative (NAOMI) found that the retention rate for heroin-assisted treatment was higher than that of optimally-delivered MMT, adding to the growing evidence-base for this treatment. While some participants of the review found more success with opioid abstinence after heroin-assisted treatment, it was also noted that for those continuing to use injection drugs, those practices posed a health issue, as well as having to deal with the prevailing stigma of heroin as an alternative to MMT.

Morphine was mentioned by some participants in the review as a viable alternative to MMT, due to the belief that it was easier to get off than methadone, it was potentially less controlling, and it could be used to help people

transition off methadone and other opioids. Physicians and clients agreed that client-centred care called for more flexible and individualized options for opioid dependence treatment.

Conclusions

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.

- 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 methadone program

Stigma and Discrimination

Stigma and discrimination were cited with reference to almost every topic in this review. Substance dependence (or use) is still viewed as a moral issue in the minds of many of the public and some health professionals. There is a lack of understanding about the causes of substance dependence, and a fear of illegal drugs and those who use them.

Similarly, considerable lack of knowledge and negative opinion about methadone exists among both members of the public and some health service providers. The dominant view of methadone is that of a “drug” rather than a medication. Media representations of methadone contribute to stigma by focusing only on system problems.

In some cases, the stigma in wider society regarding substance dependence and methadone is mirrored in health care and addiction services and directly contributes to inferior care and poor treatment outcomes. Clients report not wanting to go to emergency departments of hospitals because of previous discriminatory and disrespectful treatment by staff. Providers engaged in delivering MMT also experience stigma themselves through serving this population.

There is still a stigma from some health professionals towards people taking methadone because of personal beliefs in the importance of abstinence. Some residential treatment providers in BC regard methadone as a “drug,” and so do not admit people involved in MMT. Within the group of treatment centres that do accept people on methadone, the majority have specific admittance criteria such as a maximum dosage level. Some health authorities are actively addressing this. For example, in Fraser Health, funding for treatment centres and recovery houses is contingent on allowing access to people taking methadone, and policy is reinforced with clear service contracts.

Both historically and currently, MMT largely operates as separate from the rest of the health care system in BC. People taking methadone are therefore seen as being outside the system. Participants described many structures in MMT that act as barriers and disincentives to care, and push people back towards illegal drug use. Practices such as having to line up at community clinics for physician appointments or at pharmacies for dispensing create barriers to service and fuels stigma.

Participants shared ideas for dealing with stigma, including situating MMT within the context of human rights. They also recommended information and education for members of the public, and education for health professionals through professional development opportunities.

Conclusions

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 of system problems 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.

- Current policy should be reviewed and amended to ensure practices do not contribute to stigma and discrimination
- Improved education and training for all health professionals is needed
- Public education to reduce stigma related to substance use dependence and MMT should be a priority

Looking to the Future

Ideal models for optimized MMT will maximize integration of clients with their communities. Participants in the review spoke of this from various perspectives and suggested attention to linking MMT with a range of other health and social services. Health authorities were viewed as critical 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 were seen as more desirable. Participants agreed on the need to make counselling and other psychosocial supports a central part of MMT services, as a strategy for positive systems change. The majority of stakeholders wanted a multi-model approach to the development of MMT in BC. Long-term care or chronic disease management models were mentioned as helpful alternatives.

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.

Reports of well-functioning partnership arrangements in substance use services and MMT were rare. However, practitioners generally believed that all MMT clients needed a “group of professionals supporting them.” Many participants wanted the MMT system to become much more interdisciplinary in order to build the capacity required to address access, retention and quality. While there is a clear need to support physicians in their role there is also a tremendous variety of skills and resources offered by other professionals that can be utilized more effectively. One possible way forward is the development of explicit shared care models of MMT such as those that exist in other countries. Nurse Practitioners are increasingly called on to provide high-quality health care in BC, particularly for people who face significant barriers to accessing services and are an ideal group to support the delivery of MMT.² Bringing pharmacies into a multi-disciplinary context was another popular idea amongst review participants, most specifically to create more opportunities for engagement for clients and to improve the dispensing component of MMT.

A stepped care model has been identified as best practice (Health Canada, 2002). In this model, clients whose lives are more stable receive their care from GPs, and those with multiple health and social needs receive their care through clinics where there is a range of specialist addictions and other types of support. Stepped care is consistent

² The greater involvement of nurse practitioners can proceed immediately but would be enhanced by changes in federal prescribing regulations to allow them to prescribe methadone as in the UK.

with the tiered model recommended in the National Treatment Strategy and supported by the federally funded Drug Treatment Funding Program.

The importance of an individualized approach to MMT was a theme participants returned to again and again through the review. Stakeholders want a reorientation of the system towards a relationship of care. This relates to new concepts and models that are organized around the concept of “recovery.” 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 the client. Throughout the review process, people spoke about the need for respect, compassion and relationship-centred care. Listening to clients, respecting their journey, and working with them on their own self-identified goals, was highlighted time and again. A non-judgmental approach was considered by many to be the foundation for work in the substance use field.

A number of participants drew attention to the potential of peer and patient-advocacy groups in improving the effectiveness and quality of MMT care. Meaningful involvement of peer or patient-advocacy groups can result in new solutions for ongoing problems in service systems. Participants suggested that when clients start organizing and working actively with health providers, the standard of services can only rise.

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

Conclusion

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. The full 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, and 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, 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.

- A multi-stakeholder Methadone Maintenance Committee is needed to develop a range of improvements in the MMT system in BC (membership should include representation from all agencies, regulatory bodies and stakeholder groups that have an interest and involvement with MMT including clients, families and advocates)
- The Methadone Maintenance Committee should identify 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
- MMT services should be available and accessible in community and institutional settings across the province, including northern, rural and remote communities
- MMT should be integrated wherever possible into existing health and social services and be provided through inter-disciplinary, and stepped care models and include low threshold care, and a range of optional psychosocial supports
- 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
- Models of prescribing used in other jurisdictions should be examined and reviewed with respect to their impact on access, retention, quality, and effectiveness and dialogue engaged with Health Canada regarding needed changes to present federal licensing arrangements
- Peer-led, advocacy and mutual aid groups must be resourced effectively to build capacity for clients and peers to become partners in care
- The benefits of MMT should be celebrated more widely to proactively address the stigma and discrimination still faced by people taking methadone
- Evidence based alternatives to MMT should be examined and made available where and when appropriate
- Pre-service, and multi-disciplinary in-service, training should provide all health and social service professionals with an understanding of MMT that reduces stigma and discrimination

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