Report of the

Methadone Maintenance Treatment Practices Task Force

W. Anton Hart
Chair

MARCH 2007
ONTARIO, CANADA

"Methadone was a miracle for my family, saves a lot of lives and gave me back hope for a good life."

– One of many submissions made to members of the Methadone Maintenance Treatment Practices Task Force using its web response page.

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Methadone Maintenance Treatment Practices Task Force

An external task force established by the Ontario Ministry of Health and Long-Term Care to provide advice on how to improve methadone maintenance treatment in Ontario

W. Anton Hart
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MARCH 2007
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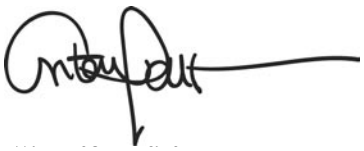
Mr. Ron Sapsford
Deputy Minister of Health and Long-Term Care
Government of Ontario
Toronto, Ontario

Dear Mr. Sapsford,

On behalf of the Methadone Maintenance Treatment Practices Task Force, I am pleased to submit this report as advice and guidance to the Ministry of Health and Long-Term Care on improving methadone maintenance treatment in Ontario. I believe that implementing the task force's recommendations will result in improved access and a safer, more efficient and effective methadone maintenance treatment system for the citizens of this province.

Yours truly,



Chair
Methadone Maintenance Treatment Practices Task Force

cc:
The Honourable George Smitherman, Minister of Health and Long-Term Care

John McKinley, Assistant Deputy Minister (Acting), Community Health Division,
Ministry of Health and Long-Term Care

Methadone Maintenance Treatment Practices Task Force

An external task force established by the Ontario Ministry of Health and Long-Term Care to provide advice on how to improve methadone maintenance treatment in Ontario

W. Anton Hart, Chair
Publisher
Longwoods Publishing Corp.

Larry Boggio, RPh, BSc Phm
Owner/manager of Boggio Pharmacy Ltd
Methadone Dispensing Pharmacist

Carole Bouchard, BPharm, MAP
Director, Office of Controlled Substances
Drug Strategy and Controlled Substances Programme,
Health Canada

Anne Bowlby
Manager, Addiction Program
Mental Health and Addiction Branch
Ministry of Health and Long-Term Care

Heather M. Campbell, RN, BN, MS (alternate)
Director, Practice & Policy
College of Nurses of Ontario

Anne Coghlan, RN, MScN
Executive Director, College of Nurses of Ontario

Rob Cushman, MD
CEO, Champlain Local Health Integration Network

Gail Czukar, MA, JD (LLB)
Executive VP, Policy, Education and Health Promotion
& General Counsel
Centre for Addiction and Mental Health

Chantal Desgranges, BScH
Community Member

Donnie Edwards, RPh, BSc Phm.
Chair, Ontario Pharmacists' Association

Frank Evans, MD
Addictions Specialist, Humber River Regional Hospital

Morris Field
Patient/Advisor

Kumar Gupta, MD, CCFP
Council Member, College of Physicians and Surgeons of
Ontario

Wade Hillier
Manager Government Programs (Methadone/IHF)
College of Physicians and Surgeons of Ontario

Sarah Hutchison, MHSc
Director, Professional Services
Ontario Medical Association

Elizabeth Larocque
Program Director; Algoma Public Health
Community Alcohol/Drug Assessment Program

Dennis Long, MSW
Executive Director, Breakaway and
Past President, Addictions Ontario

Elaine Medline (alternate)
Special Projects and Communications Coordinator
Champlain Local Health Integration Network

Beth McCracken, RPN, CAE (c)
Deputy Executive Director
Registered Practical Nurses Association of Ontario

Barry McLellan, MD, FRCPC
Chief Coroner for Ontario

Anne Resnick, RPh, BScPhm
Director, Professional Practice
Ontario College of Pharmacists

Christopher Sankey, MD
Satellite Clinic

Sue Starling, RN, BScN, MSc
Registered Nurses Association of Ontario,
Community Health Nursing Initiative Group

Jean Trimnell, MScN, CHE
CEO, North Simcoe Muskoka LHIN

Deanna L. Williams, RPh, BScPhm. CAE
Registrar, Ontario College of Pharmacists

Katherine Vesterfelt, RPh, BScPhm (alternate)
Office of Controlled Substances, Health Canada

SUPPORT OF THE TASK FORCE

Joann Trypuc, PhD
Independent Healthcare Consultant

Donna Kline, BA, MPA
Emerge Communications

Kathleen Foisey
Administrative Assistant

NOTE

The members of the Methadone Maintenance Treatment Practices Task Force volunteered their time and expertise, attended numerous task force and subcommittee meetings, read significant amounts of background material, participated in community consultation sessions, reviewed and considered submissions entered on the task force's website and debated the issues. The commitment of these individuals is gratefully acknowledged.

This report is the product of the task force's deliberations and is presented for the benefit of the Government of Ontario's Deputy Minister of Health and Long-Term Care. This report does not necessarily represent the views of the affiliated organizations of the task force members. The opinions of the task force members expressed in this report have not necessarily been approved or disapproved by their affiliated organizations.

ACKNOWLEDGMENTS

The task force wishes to thank:

- the many individuals who responded to our requests for information, interviews and consultations, and who are listed in the report
- Dr. Douglas Gourlay from Mount Sinai Hospital and the Centre for Addiction and Mental Health for his expert input on urine drug screening, Dr. Peter Selby from the Centre for Addiction and Mental Health for his expert input on access to treatment, and Christopher Smith, a PhD candidate at York University, for his expert input on integrating MMT into communities
- Dr. Pat O'Campo and Charoula Tsamis of the Centre for Research on Inner City Health, St. Michael's Hospital for developing a situational analysis for the task force
- these Local Health Integration Networks for responding to our request to help organize and host community consultation sessions: Champlain LHIN, South East LHIN, North West LHIN, Toronto Central LHIN, North East LHIN and Erie St. Clair LHIN
- the Corktown Residents and Business Association for hosting a local community consultation
- The University of Toronto for providing a home for the task force in the Health Sciences Building
- Joann Trypuc and Donna Kline for their outstanding contributions, wise counsel and great good humour; Kathleen Foisey for providing administrative support; and Francine Geraci for editing the whole lot
- all those who assisted the task force in achieving its goals in a timely and concerted fashion.

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EXECUTIVE SUMMARY

> The provision of methadone services in the province is not an easy issue. The patients are not all easy, the work is not easy and it is not easy for communities, but methadone is an essential service.
>
> – George Smitherman, Minister of Health and Long-Term Care, January 24, 2007

Methadone maintenance treatment (MMT) is used by people who need help managing their addiction to opioid drugs, which include opiates (that come from the opium poppy) and other drugs that have morphine-like effects.[1] MMT – a small but vital piece within the broad area of addictions and mental health – can be understood as a chronic disease management treatment that helps people manage their opiate addiction and stabilize their lives. When MMT is used appropriately, it can be a life-saving treatment. As one person on MMT noted, "Methadone changed my life. I can't stress the need enough for services like methadone to save lives."

MMT has many benefits:

- it is a very effective treatment used in Canada for heroin dependence
- it helps prevent the transmission of the HIV/AIDS and hepatitis C viruses by reducing the frequency of addicts injecting opioids and sharing needles
- it reduces criminal activity because people buy and use fewer illegal drugs and commit fewer crimes to feed their habit
- it helps reduce deaths due to overdose
- it improves economic productivity by helping stabilize people's lives so they can work
- it improves physical and mental health, social functioning, quality of life, and outcomes of pregnancy for women addicted to heroin.

In February 2007, 258 physicians in Ontario were prescribing MMT to about 16,400 people as a treatment for opioid addiction. Of the 3,059 pharmacies in the province, 533 or 17.4% were dispensing methadone for either MMT or pain. Although the number of people receiving MMT in Ontario is relatively small, the benefits of MMT far outweigh its costs. It has been estimated that the cost of providing comprehensive MMT to 15,000 people who are opioid dependent is $90 million a year. The personal and social costs to society of these individuals is seven times this amount: $660 million.

In April 2006, The Honourable George Smitherman, Minister of Health and Long-Term Care, created the Methadone Maintenance Treatment Practices Task Force to advise the Deputy Minister in five specific areas:

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1. Examples of drugs with morphine-like effects include heroin, morphine, opium and codeine, and brand name drugs such as Dilaudid, Percodan, Demerol, OxyContin, Percocet and others.

- access to methadone and appropriate regulatory regime
- best practices and training
- fair payment models
- quality assurance and assessment
- community engagement

The task force was chaired by Anton Hart – Publisher and CEO of Longwoods Publishing – and was made up of members reflecting a broad range of experience and expertise in methadone maintenance treatment, administration and regulation. The task force reviewed literature, research studies and background documents, analyzed data and created subgroups that focused on particular issues. Deliberations were enriched by widespread input from over 240 individuals across Ontario who came to public and small group meetings, were interviewed or sent in written submissions.

Although methadone is one part of recovery, it is the most highly regulated and controlled area in addiction treatment, and one of the most highly regulated in all of medicine. In the eyes of the public, policy makers, as well as health and social service providers, there is an unfortunate stigma associated with methadone and people who receive MMT. Although many organizations and committed individuals do an admirable job of administering and providing MMT in Ontario, there are opportunities for improvement. Many of the problems facing MMT are similar to the challenges facing all of healthcare: equitable access to appropriate and high-quality care in a timely manner.

The Methadone Maintenance Treatment Practices Task Force offers 26 recommendations to the Deputy Minister of Health and Long-Term Care for his consideration.[2]

Access to a Comprehensive Range of Integrated Services

The task force believes that the increasing emphasis by the Ministry of Health and Long-Term Care ("the Ministry") on stewardship of the system, promoting local decision-making through Local Health Integration Networks (LHINs) and strengthening primary healthcare presents an ideal opportunity to improve access to comprehensive, integrated MMT services in the province.

The task force recommends that:

- the Ministry develop a provincial strategy and policies to ensure that Ontarians have equitable access to a comprehensive range of integrated MMT services that include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone dispensing (R1)

2. The numbers in brackets refer to the report's recommendations.

- LHINs develop plans to ensure that people living within the LHIN have access to the full range of MMT services (R1)
- the Ministry build on its Primary Care Reform priorities by strongly encouraging and supporting Family Health Teams to provide comprehensive MMT where access to care close to home is an issue (R2)
- LHINs strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies to work together to provide MMT where access is an issue. This responsibility should be linked to new and ongoing funding in accountability agreements (R2)
- the Ministry develop a communication strategy that includes standardized information and education targeted at Ontarians who are considering MMT. (R4)

To improve access, it is further recommended that:

- the Ontario Telemedicine Network submit a plan to the Ministry for telemedicine technology to improve access to comprehensive MMT in underserviced, rural and remote areas of the province (R3)
- the Ontario Pharmacy Council submit a plan to the Ministry to enhance the role of pharmacists in MMT (R5)
- the Ministry support provincial regulatory changes to enable primary healthcare nurse practitioners to prescribe and administer methadone for opioid dependence where access to MMT is limited (subject to appropriate changes to the federal legislation) (R6)
- LHINs strongly encourage and support public acute care hospitals with pharmacies to dispense methadone to meet the needs of the local community where access to MMT is limited. This recommendation will help address the lack of access in areas where pharmacies do not dispense methadone. (R7)

Elements That Support Access

Federal and Provincial Laws and Policies to Govern Methadone Use

At the federal level, methadone is a controlled substance regulated under the Controlled Drugs and Substances Act (CDSA) and regulated under the Narcotic Control Regulations as a narcotic. Physicians must be exempted under Section 56 of the Act by Health Canada to prescribe methadone. The task force supports the continued granting by Health Canada of exemptions for methadone.

In March 2006, a non-traditional model was developed for dispensing methadone to patients for opioid dependency in methadone clinics in Ontario. This interim exemption – issued by Health Canada on a pilot basis – allows physicians and qualified persons to administer methadone and pharmacists to transfer custody of individually prepared doses of methadone.

There is a need to balance the goal of improving access to MMT with the goal of minimizing risk (including the risk of diverting methadone) and ensuring public safety and

quality of care. The task force believes that current federal requirements for prescribing and administering methadone need to be more enabling, and so it supports the recent interim exemption enabling physicians to delegate the authority to administer methadone in medical offices and clinics, and allowing pharmacists to transfer methadone doses to a physician or his or her delegate. Although there is some anecdotal evidence from the consultations to suggest that the exemption has improved access to MMT, the task force could not make a firm recommendation on this issue because the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists and the Ministry are still evaluating the impact of this exemption.

Standards and Guidelines to Support Best Practices

A wide range of standards and guidelines are used to support MMT best practices. The report addresses areas to be added to the guidelines published by the College of Physicians and Surgeons of Ontario (CPSO), and notes that there is a need for more interdisciplinary best practice standards. The task force recommends that:

- standards and guidelines be developed for nurses who provide MMT services (especially to support the recommended role of primary healthcare nurse practitioners to prescribe and administer MMT), and that standards and guidelines be developed for addiction counsellors with a particular emphasis on MMT (R8, R9)

Urine drug screening was one of the most controversial issues raised during the task force's community consultations. Although the CPSO's guidelines include best practices for urine drug screening, there is wide variation in how physicians interpret these guidelines. This situation has resulted in significant variations in practice that are costly and detrimental to the care of people receiving MMT. The task force believes urine drug screening – using both laboratory and point-of-care testing[3] – is an important part of MMT as long as it is centred on the patient, is clinically relevant to the goals of treatment and adds value to the ongoing care of the individual. The task force recommends that:

- the Ministry use the CPSO's current guidelines for urine drug screening as the standard for reimbursing point-of-care testing for physicians who provide MMT in Ontario (R10)
- the Ministry phase in caps on the maximum number of point-of-care urine drug tests in the Ontario Health Insurance Program fee schedule that will be compensated per patient on MMT within a defined period of time. Urine drug testing performed in a laboratory would not be subject to the recommended cap. (R10) To ensure that access is maintained, caps should be phased in along with appropriate improvements in comprehensive MMT and physician services.

A number of the report's recommendations will help provide the necessary supports to people who want to taper their methadone safely. To help address the needs of people receiving MMT who are undergoing transitions (e.g., going to a hospital emergency department, being admitted into a hospital, entering or leaving a correctional institution),

3. Point-of-care testing is done by the physician is his or her office on the physician's own patient.

it is recommended that:

- educational sessions be developed on the emergency and hospital care of persons on MMT (R11)
- standard provincial admission and discharge policies and procedures be followed for persons receiving MMT who are serving time in correctional facilities. (R12)

Education to Support Appropriate Treatment

There are opportunities to improve education on MMT and addictions. It is recommended that:

- education courses in addictions continue to be developed and offered with the schools of medicine, nursing, pharmacy, psychology and social work in Ontario, and be linked to continuing education or continuing professional development credits, where possible (R13)
- the College of Physicians and Surgeons of Ontario be supported to develop educational initiatives such as a second-level MMT course for prescribing physicians, a provincial mentorship program for new MMT prescribers and addiction medicine education sessions. (R14)

Appropriate Payment and Support

The task force recommends that the Ministry:

- phase in blended physician payment models to support MMT services that build on the Ministry's priorities in Primary Care Reform. These models should be evaluated for their impact on access, quality, efficiency and effectiveness (R15)
- allocate funding to Family Health Teams for addiction and MMT counselling and case management services (LHINs should allocate funding for addiction and MMT counselling and case management services in Community Health Centres, hospitals, Community Care Access Centres and mental health and addiction agencies) (R17)
- identify ways to improve access to MMT for people who live in underserviced areas and have difficulties obtaining treatment. (R18)

It is also recommended that the Ontario Pharmacy Council determine, and advise the Ministry on, the most appropriate funding model to encourage pharmacists to dispense MMT. (R16)

Best Approaches to Integrate Methadone Maintenance Treatment into Society and Communities

To help better integrate MMT into society, the task force believes that MMT needs to be viewed as any other medical service and recommends that:

- A public education campaign be developed that addresses the stigma associated with addictions and MMT. (R19)

Over the course of the consultations, it became clear that integrating MMT practices into communities is generally not well done. Organizations funded by the Ministry or LHINs should be required to engage the community when planning to provide MMT services. Furthermore, it is recommended that:

- The Centre for Addiction and Mental Health (CAMH) update its guide for introducing MMT services into communities to include supporting the principle of openness, identifying clear steps on engaging the community, and, requiring clinics to establish community advisory/liaison groups and peer support models (R20)
- CAMH provide consultative support to help guide the integration of MMT services into communities. (R20)

To help providers establish communities of practice for the benefit of patients, it is recommended that:

- LHINs – in consultation with ConnexOntario, Health Services Information – develop comprehensive lists of services relevant to users and providers of MMT and addiction services. (R21)

Public Accountability for Quality Assurance

Although the professional regulatory colleges do a good job of providing public accountability by overseeing professionals who deliver MMT, some opportunities for improvement are addressed. To respond to the fact that public accountability for groups that provide MMT varies, the task force recommends that:

- the Ministry support the College of Physicians and Surgeons of Ontario to develop and implement a plan to assess physician group practices that provide MMT. These assessments should review the group's practices, policies, procedures and organization of services, and include clear accountabilities for standards, guidelines and best practices. As part of ongoing public accountability, the Ministry and LHINs should continue to oversee the services provided by government-funded organizations. (R22)

Critical Success Factors

The task force identified five critical success factors. It recommends that:

- the Ministry provide appropriate funds to expand and support comprehensive MMT services, especially when caps are phased in on the maximum number of point-of-care urine drug tests. It is critical that the phasing in of caps not destabilize the system and reduce access to needed MMT services (R23)

- the Ministry develop a computerized, Web-based information system to track prescribing and dispensing activity for all prescriptions in Ontario, with the goal of promoting public safety (R24)
- the Ministry address the critical issue of the abuse and diversion of oxycodone in the province. This should build on the work being done in Ontario, Canada and other countries, and serve as the first step towards the development of a comprehensive long-term drug strategy for the province. (R25) The task force heard heartfelt stories about the significant impact of addictions on human lives from a wide range of people. Although the stories varied and many issues were raised, the common theme was that addictions are a widespread problem that needs to be addressed immediately. Oxycodone was of particular concern.
- the Ministry identify a single point of authority and accountability for MMT within the Ministry to coordinate MMT efforts and maximize the use of resources for the benefit of Ontarians using MMT. An advisory panel should be established to provide ongoing strategic advice on MMT issues. (R26)

A commitment to implementation is the final success factor. A commitment to implementation represents a willingness to follow through with recommended changes. The task force includes a work plan to guide decision-makers as they work towards strengthening the MMT system in Ontario.

PART A:

Introduction

1. Background

> The provision of methadone services in the province is not an easy issue. The patients are not all easy, the work is not easy and it is not easy for communities, but methadone is an essential service.
>
> – George Smitherman, Minister of Health and Long-Term Care, January 24, 2007

Methadone maintenance treatment (MMT) is used by people who need help managing their addiction to opioid drugs.[1] These drugs are the most effective painkillers and include opiates (which come from the opium poppy) and other drugs that have morphine-like effects.[2] Oddly enough, methadone is also an opioid drug. It was first discovered in Germany before the Second World War, where it was used to control pain. In the late 1940s, methadone was used to help treat the withdrawal symptoms of people who were addicted to heroin. Methadone treatment for opioid dependence was first experimentally practised in the late 1950s by the Canadian researcher, Robert Halliday, and his addiction-treatment team in Vancouver.[3] Halliday set up what may have been the first MMT program in the world in 1963 in British Columbia. In the early 1960s, two American researchers, Marie Nyswander and Vincent Dole, discovered that when their subjects received methadone to help them gradually withdraw from morphine, they lost the desire to take drugs and resumed their pre-addiction interests and activities.[4]

It is estimated that about 30,000 people between the ages of 15 and 49 in Ontario regularly used illegal opioids in 2003.[5] The dramatic increase in opioid prescribing over the last 10 years in Canada has led to an increase in opioid misuse. For example, a national study found that the majority of injection opioid users in Canada are now injecting prescription opioids rather than street-derived heroin.[6] About 16,400 people in Ontario currently receive MMT as a treatment for opioid addiction.[7] MMT does not cure opioid dependence; rather, it is a medical treatment that can help people manage their opiate addiction and stabilize their lives. It is not appropriate for everyone who is opioid dependent, and is only one of a number of treatment options that should be considered. When MMT is used appropriately, however, it can be a life-saving treatment. As one person receiving MMT noted, "methadone changed my life. I can't stress the need enough for services like methadone to save lives." Two providers of MMT services described MMT as "health promotion and disease prevention in action."

The benefits of MMT are far reaching. Currently, it is a very effective treatment used in Canada for heroin addiction; it helps prevent the transmission of the HIV/AIDS and hepatitis C viruses by reducing how often addicts inject opioids and share needles; it reduces criminal activity, since people are buying and using fewer illegal drugs and committing fewer crimes to feed their habit; it helps reduce deaths due to overdose; it improves economic productivity by helping stabilize people's lives so that they can work; and it improves physical and mental health, social functioning, quality of life and outcomes of pregnancy for women dependent on heroin.[8] There is great stigma

associated with methadone and people who use it, on the part of the public, policy makers and health and social services providers. Ontario's Minister of Health and Long-Term Care recognized the challenges of MMT but rightly noted that it is "an essential service" to which all Ontarians should have access.

The benefits of MMT far outweigh its costs. Indeed, this treatment provides excellent returns on investment. It has been estimated that the cost of providing comprehensive MMT to 15,000 people who are opioid dependent is $90 million a year. The personal and social costs to society of these individuals is seven times this amount: $660 million a year.[9]

In April 2006, Minister George Smitherman created the Methadone Maintenance Treatment Practices Task Force to provide advice in five specific areas:

1. access to methadone and appropriate regulatory regime
2. best practices and training
3. fair payment models
4. quality assurance and assessment
5. community engagement

The Minister recognized that it had been 10 years since Health Canada made changes to the provision of MMT to increase access to treatment. Since that time, there has been a significant growth in the use and supply of MMT services in the province. This growth has led to challenges: providing access to services in an equitable and timely manner; ensuring that MMT services are safe and effective, and meet high quality standards; and responding to concerns of local communities where MMT services are provided. Various media reports and a recent coroner's inquest into methadone-related deaths[10] further highlighted the complexity of Ontario's MMT system and the timeliness of reviewing the service.

Although methadone is one part of recovery, it is the most highly regulated and controlled area in addiction treatment, and one of the most highly regulated in all of medicine. Many of the problems facing MMT are similar to the challenges facing all of healthcare. The task force focused its deliberations and recommended solutions on improving equitable access to appropriate, high-quality MMT services that are supported with best practices, clear accountabilities, appropriate payment, integrated communities and effective and efficient use of resources.

2. The Methadone Maintenance Treatment Practices Task Force

In April 2006, Minister Smitherman created the Methadone Maintenance Treatment Practices Task Force to advise the Deputy Minister of Health and Long-Term Care on

the best approaches to providing MMT in Ontario. The task force was chaired by Anton Hart – Publisher and CEO of Longwoods Publishing – and was made up of members reflecting a broad range of experience and expertise in methadone maintenance treatment, administration and regulation. Members of the task force came from regulatory colleges (College of Physicians and Surgeons of Ontario, Ontario College of Pharmacists, College of Nurses of Ontario), associations (Ontario Medical Association, Ontario Pharmacists' Association, Registered Nurses' Association of Ontario, Registered Practical Nurses Association of Ontario), the Centre for Addiction and Mental Health, Local Health Integration Networks, the Office of the Chief Coroner, Health Canada's Office of Controlled Substances, providers, community representatives and the Ministry.

The task force was asked to provide advice and guidance to the Ministry in five areas (see Appendix A for the complete terms of reference):

- access to methadone and appropriate regulatory regime
- best practices and training
- fair payment models
- quality assurance and assessment
- community engagement

2.1 Access to Methadone and Appropriate Regulatory Regime

The task force will examine issues associated with meeting the needs of people requiring methadone maintenance treatment, and specifically the following:

- recommendations regarding the exemption process under section 56 of the Controlled Drugs and Substances Act (CDSA) and associated methadone regulations
- advice on evaluation of the interim exemption project
- recommendations on changes to provincial statutes or regulations regarding audit of clinics providing methadone maintenance treatment
- the development of model(s) for community methadone maintenance treatment

2.2 Best Practices and Training

Guidelines have been established for Ontario physician and pharmacist practice. The task force will advise on the need to update these guidelines and training, specifically:

- recommendations on changes to the training for physicians, pharmacists and counsellors, as well as specific training for nurses
- recommendations for practice guidelines for physicians, pharmacists, counsellors and "delegated persons," as well as the carry (take-home doses) policy
- recommendations for delegation process and requirements
- recommendations on updating of physician internship and possible internship for other professionals.

2.3 Fair Payment Models

Payment for methadone maintenance services includes physician services, laboratory testing and the dispensing and administration of methadone. It is important to ensure that providers are appropriately compensated for this key service. It is also important that costs associated with these services are manageable and predictable. The task force will advise on:

- appropriate payment models for physicians prescribing methadone and pharmacists/physicians for dispensing/administering methadone, including models related to physician services, laboratory testing and dispensing and administration of methadone.

2.4 Quality Assurance and Assessment

Quality assurance programs for professionals and assessment of methadone maintenance treatment practices are essential in ensuring safety for people receiving methadone, as well as others in the community. The task force will provide advice on quality assurance models, content and enforceability.

2.5 Community Engagement

The majority of methadone treatment is provided within community-based practices. The task force will provide advice on the development and implementation of effective community engagement processes for the establishment or relocation of clinics or practices.

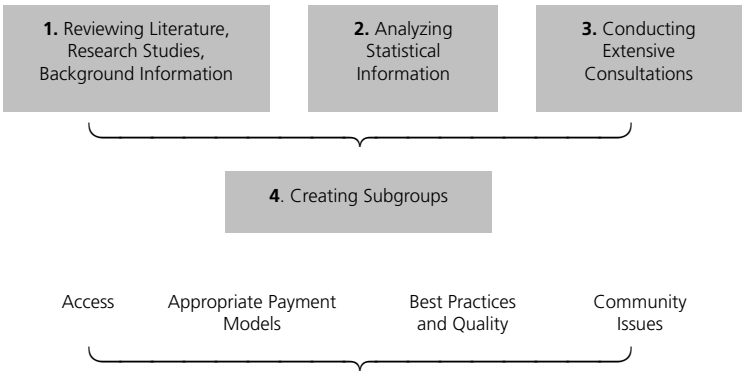
3. Strategies to Support the Work of the Task Force

Four strategies were used to support the work of the task force (See Figure 1 on next page). These included reviewing literature, research studies and background documents; analyzing statistical information; conducting extensive consultations; and creating subgroups to focus on certain issues.

3.1 Literature, Research Studies and Background Documents

The task force reviewed published literature, research studies and many background documents developed by the regulatory colleges (e.g., College of Physicians and Surgeons of Ontario, Ontario College of Pharmacists, College of Nurses of Ontario), Health Canada, the Centre for Addiction and Mental Health and committees struck by the government of Ontario and the Ministry of Health and Long-Term Care. In addition, researchers at the Centre for Research on Inner City Health (St. Michael's Hospital) developed a situation analysis for the task force. This analysis was based on a review of the literature between 2001 and 2006 on MMT in Canada and Ontario, with a focus on the specific areas in the task force's terms of reference. International literature was also reviewed, where necessary.

Figure 1: Strategies to Support the Task Force



3.2 Statistical Information

Statistical information was obtained from a number of sources.

- The College of Physicians and Surgeons provided data on numbers of patients on MMT and physicians who prescribe MMT.
- The Ontario College of Pharmacists provided data on pharmacies and pharmacists in Ontario.
- The Drug and Alcohol Registry of Treatment (DART) – a provincial information and referral service funded by the Ministry of Health and Long-Term Care – provided information on callers interested in MMT services.
- The Drug and Alcohol Treatment Information System (DATIS), managed by the Centre for Addiction and Mental Health on behalf of the Ministry, provided information on people using MMT services from about 160 Ministry-funded agencies in Ontario.
- MMT prescribers provided opinions on questions asked at the annual Methadone Prescribers' Conference organized by the College of Physicians and Surgeons of Ontario (November 27, 2006).
- The Ontario Telemedicine Network provided information on the methadone consultations conducted with the aid of telemedicine technology.

3.3 Consultations

Consultations were conducted with a wide range of stakeholders (Appendix B). These consultations included:

- public meetings hosted by the task force in partnership with Local Health Integration Networks. Meetings were held in Ottawa (Champlain Local Health Integration Network), Belleville (South East Local Health Integration Network), Thunder Bay (North West Local Health Integration Network), Toronto (Toronto Central Local Health Integration Network), Sudbury (North East Local Health Integration Network) and Chatham (Erie St. Clair Local Health Integration Network). In addition, task force members attended a public meeting hosted by the Corktown Residents and Business Association, Toronto. Over 100 people provided input at these sessions.
- meetings and interviews held with a wide range of stakeholders, including people on MMT, prescribers, healthcare providers, regulatory colleges, service organizations and others. In total, meetings and interviews were held with over 100 people.
- written submissions received from the public and providers (33 submissions were received from 42 people).

Extensive efforts were made to encourage people to attend public meetings, to make submissions and, if they wished, to meet with the task force chair. A task force website was set up providing information on activities and where to make submissions. The website was publicized at all community consultations, through the newsletter of the College of Physicians and Surgeons of Ontario, the annual Methadone Prescribers' Conference and through the 14 Local Health Integration Networks.

3.4 Subgroups

The task force established four subgroups in the following areas:

- Best Practices and Quality Subgroup
- Appropriate Payment Models Subgroup
- Community Issues Subgroup
- Access Subgroup

The deliberations of these subgroups were presented to the task force for its consideration.

4. Overview of the Report

Part B of this report presents an overview of methadone maintenance treatment in Ontario. Chapter 5 briefly summarizes who does what in MMT.

Chapter 6 presents MMT activity using a wide range of data sources to answer eight questions:

1. Who uses opioids?
2. Who uses methadone maintenance therapy?
3. Who prescribes MMT in their office and through the Ontario Telemedicine Network?
4. Who dispenses MMT?
5. Who looks for services through the Drug and Alcohol Registry of Treatment (DART)?
6. Who uses MMT from Ministry-funded agencies that participate in the Drug and Alcohol Treatment Information System (DATIS)?
7. What are the results of questions asked at the annual Methadone Prescribers' Conference?
8. What were the main themes in the task force's consultations?

These questions are answered in Chapters 6.1 to 6.8, respectively.

Part C of this report presents the task force's deliberations and recommendations. Chapter 7 sets the stage with a brief introduction.

Chapter 8 explores access to a comprehensive range of integrated services. The chapter addresses four main areas, and begins by identifying the range of MMT services, highlighting the importance of an initial comprehensive assessment and standard information on treatment options, exploring the importance of interdisciplinary treatment and examining methadone dispensing.

Chapter 9 analyzes the elements that support access. The chapter begins with federal and provincial laws and policies to govern methadone use (Chapter 9.1). Standards and guidelines to support best practices are presented in Chapter 9.2 and include best practices for physicians, pharmacy, nursing, counselling, interdisciplinary care, urine drug screening, tapering and transitions. Chapter 9.3 examines education to ensure appropriate treatment, followed by appropriate payment and support (Chapter 9.4). Best approaches to integrate methadone maintenance treatment into society and communities are analyzed in Chapter 9.5, followed by public accountability for quality assurance (Chapter 9.6).

Part D of this report presents the task force's conclusions as five critical factors for success (Chapter 10), followed by a consolidated list of recommendations (Chapter 11). A work plan is presented in Chapter 12, followed by supporting appendices and a bibliography.

Notes

1. Persons taking MMT can be called patients, clients, consumers or people. As there is no agreement on which term is the most appropriate, all are used in this report.
2. Examples of drugs with morphine-like effects include heroin, morphine, opium and codeine, and brand-name drugs such as Dilaudid, Percodan, Demerol, OxyContin, Percocet and others.
3. As documented in Fischer, B. and J. Rehm. 2006. "Illicit Opioid Use and Treatment for Opioid Dependence: Challenges for Canada and Beyond." *The Canadian Journal of Psychiatry* 51: 621-623.
4. Centre for Addiction and Mental Health. 2003. *Methadone Maintenance Treatment: A Client Handbook* (2nd ed.). Toronto: Author.
5. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
6. Centre for Addiction and Mental Health. 2007. "Education Is Key in Safe Opioid Prescribing, Dispensing and Managing." *Insite*. Internal staff newsletter, as provided by Barney Savage, Director of Public Policy, Centre for Addiction and Mental Health.
7. Personal communication, Wade Hillier, College of Physicians and Surgeons of Ontario, February 22, 2007.
8. Health Canada (Office of Canada's Drug Strategy). 2002. Best Practices: Methadone Maintenance Treatment. Ottawa: Minister of Public Works and Government Services Canada; Erdelyan, M. 2000. Methadone Maintenance Treatment: A Community Planning Guide. Toronto: Centre for Addiction and Mental Health; Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
9. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care. It is noted that: "Comprehensive methadone treatment programs in Ontario (i.e., programs that provide counselling and support services as well as medical care) report that it costs about $6,000 a year to treat someone who is opioid dependent in a stand alone methadone treatment clinic. About half of that goes for medication and urine testing, the other half to cover the cost of physician services, nursing services and counselling staff."
10. Lucas, W.J., Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).

PART B:

Methadone Maintenance Treatment in Ontario

5. Who Does What in Methadone Maintenance Treatment?

Methadone is highly regulated and controlled at the national and provincial levels through the use of legislation, standards and guidelines. (For detailed information, see Chapter 9.1, Federal and Provincial Laws and Policies to Govern Methadone Use, and Chapter 9.2, Standards and Guidelines to Support Best Practices). The major roles and responsibilities of the key players in MMT at the federal, provincial, regional, local and patient levels are summarized briefly below.

At the *federal level:*

- Health Canada – specifically, the Office of Controlled Substances – administers the *Controlled Drugs and Substances Act* (CDSA) and its regulations. With regard to methadone, the Office of Controlled Substances manages the process for issuing methadone exemptions to physicians to allow them to prescribe methadone for opioid dependence and/or pain.
- Methadone services are provided in federal correctional facilities, which begin, as well as continue, methadone treatment for inmates.

At the *provincial level:*

- The College of Physicians and Surgeons of Ontario determines the requirements that physicians must meet to prescribe methadone, oversees methadone maintenance education programs, develops guidelines for best practices and carries out peer assessments of physicians who prescribe methadone.
- The Ontario College of Pharmacists determines the education requirements of, and develops best practice guidelines for, pharmacists who dispense methadone.
- The College of Nurses of Ontario determines the standard of practice for nurses administering medications. These medication standards reflect best practices for nurses who administer methadone.
- The Ministry of Health and Long-Term Care supports methadone maintenance treatment through the following program branches:
  - The Mental Health and Addiction Branch funds the College of Physicians and Surgeons of Ontario's methadone program, case management services across the province and an interdisciplinary methadone treatment clinic in Toronto. (Another interdisciplinary methadone treatment clinic is funded through the global budget of a public hospital.) In addition to methadone-specific services, the Branch also funds substance abuse treatment programs, including residential and community withdrawal management, community counselling and residential treatment and support.
  - The Provider Services Branch is responsible for the Fee-for-Service Payment Program under the *Health Insurance Act*. The majority of methadone-prescribing physicians bill the Ontario Health Insurance Plan as fee-for-service.

  - The Drug Programs Branch develops and manages drug programs, and manages a reimbursement system for prescription drugs, including methadone.
  - The Health Professionals Regulatory Policy and Programs Branch develops policy guidelines for regulated health professions and administers the *Regulated Health Professions Act*, 1991. This Act, along with 22 Acts specific to individual health professions, sets out a common framework for regulating health professions in Ontario. Each health regulatory college – such as the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists and the College of Nurses of Ontario – is responsible for establishing standards of practice for its profession and monitoring the profession to ensure that these standards are maintained.
- The Ontario Health Insurance Plan, funded by the Ontario government, pays physicians fee-for-service for prescribing methadone according to a set schedule of benefits.
- The Ontario Drug Benefit Program, funded by the Ontario government, covers the cost of methadone syrup for people who qualify for the drug program (e.g., lower income, over the age of 65).
- The Ontario Telemedicine Network (OTN) uses the latest electronic technology to support the delivery of clinical care, professional education and health-related administrative services at more than 360 urban, rural and remote sites across the province. OTN is an independent, not-for-profit organization funded by the Ontario Ministry of Health and Long-Term Care.
- The Drug and Alcohol Registry of Treatment (DART), funded by the Ministry of Health and Long-Term Care, is a provincial information and referral service that uses a computerized database, website and toll-free line to provide comprehensive, up-to-date information on a wide range of drug and alcohol treatment services in Ontario.[11]
- The Drug and Alcohol Treatment Information System (DATIS), funded by the Ministry of Health and Long-Term Care, provides information on clients who use Ministry-funded addiction treatment services. The Centre for Addiction and Mental Health operates DATIS.
- Methadone services are provided in provincial correctional facilities. These do not start inmates on MMT (exceptions are pregnant offenders and certain medical circumstances), but provincial facilities do continue treatment for people who are already receiving methadone maintenance treatment.

At the *regional level:*

- The 14 Local Health Integration Networks (LHINs) are responsible for funding, planning and integrating healthcare services at the regional and local levels. On April 1, 2007, the LHINs will assume full responsibility for these actions. LHINs will oversee a number of organizations that provide methadone maintenance treatment services, including hospitals, community health centres, community support services and mental health and addictions agencies.

At the *local level,* methadone maintenance treatment in Ontario is provided in a number of settings using a variety of approaches.

- The Centre for Addiction and Mental Health provides a comprehensive methadone treatment program for Toronto, as well as some clinical consultation services to others in Ontario who treat clients with methadone.
- There are comprehensive, community-based MMT programs that include health and social supports. In addition, mental health and addiction services and withdrawal and detoxification services are available for people who want help with their addiction. Methadone case managers (funded by the Ministry of Health and Long-Term Care) focus specifically on MMT clients.
- Physicians in private practice, who are paid fee-for-service and work either on their own or in groups, provide methadone services.
- Pharmacies dispense methadone when a person presents a prescription for the medication.

At the level of the *patient*, a person who receives MMT must either obtain a dose of methadone each day at the pharmacy (the drug is mixed with juice) or, if the person is stable, he or she can get "carries," doses of methadone to take at home. The maximum number of carries is usually six days' worth of medication.

6. Methadone Maintenance Treatment Activity

A wide range of statistical information was gathered on MMT from a variety of sources. Although it was not possible to create a comprehensive overview of MMT patients and prescribers, this chapter presents data in the following areas:

1. Who uses opioids?
2. Who uses methadone maintenance therapy?
3. Who prescribes MMT in their office and through the Ontario Telemedicine Network?
4. Who dispenses MMT?
5. Who looks for services through the Drug and Alcohol Registry of Treatment (DART)?
6. Who uses MMT from Ministry-funded agencies that participate in DATIS (Drug and Alcohol Treatment Information System)?
7. What are the results of questions asked at the annual Methadone Prescribers' conference?
8. What were the main themes in the task force's consultations?

6.1 Who Uses Opioids?

It is estimated that there were more than 80,000 regular illegal opioid users in Canada in 2003 between the ages of 15 and 49; Ontario accounted for 30,000 of these individuals.[12] It is further estimated that in 2002, there were 958 illegal drug-related overdose deaths in Canada; 384 of these were in Ontario (illegal drugs combined with alcohol).[13] The deaths

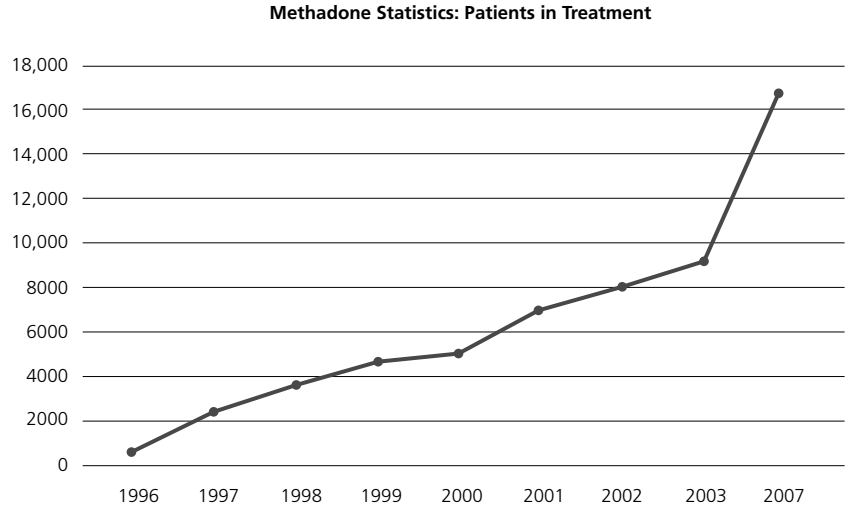
in Ontario due to illegal drugs only were 301.[14] These deaths do not include deaths that are indirectly related to opioid use, such as infection[15,16,17] and suicide.[18]

6.2 Who Uses Methadone Maintenance Therapy?

The College of Physicians and Surgeons of Ontario maintains an up-to-date roster of patients receiving methadone maintenance treatment (MMT). It is the responsibility of physicians to register and de-register their MMT patients in a timely manner.

Figure 2 shows the number of people receiving MMT in Ontario from 1996 to 2007. In 1996, there were about 700 people using MMT. By February 21, 2007, this number had increased to 16,406 people.[19]

Figure 2: Number of Persons Enrolled in Methadone Maintenance Treatment in Ontario, 1996 to 2007



Source: College of Physicians and Surgeons of Ontario

In Ontario on February 21, 2007, there were 11,029 men (67.2%) and 5,161 women (31.5%) receiving MMT. (The gender of 1% of patients was unknown.) Almost 60% of women receiving MMT were under the age of 40, whereas about half of the men (51%) were less than 40 years of age. The median age of women receiving MMT was 36.5 years of age compared to 38.5 for men. (See Table 1.)

Attempts were made to estimate how many people received MMT in the treatment city where they live and how many had to travel to a treatment city (Table 2). This information must be viewed with caution, since the exact distances that people had to travel could

Table 1: Current Patients in Methadone Maintenance Treatment in Ontario, 16 Years of Age or Older by Sex, February 21, 2007

	Female		Male		Sex Unknown	Total	
Age Group	Number	Percent	Number	Percent	Number	Number	Percent
16-19	85	1.7	78	.7	2	165	1.0
20-24	506	9.8	741	6.7	24	1,271	7.8
25-29	830	16.1	1,522	13.8	42	2,394	14.6
30-34	778	15.1	1,600	14.5	36	2,414	14.7
35-39	837	16.2	1,715	15.6	30	2,582	15.7
40-44	822	15.9	1,932	17.5	29	2,783	17.0
45-49	702	13.6	1,722	15.6	21	2,445	14.9
50-54	388	7.5	1,078	9.8	12	1,478	9.0
55-59	123	2.4	387	3.5	9	519	3.2
60-64	39	.8	105	1.0	0	144	.8
65-69	6	.1	35	.3	2	43	.3
70-74	8	.1	19	.2	0	27	.2
75+	3	.0	5	.0	1	9	.05
Age Not Known	34	.7	90	.8	8	132	.8
Total	5,161	100%	11,029	100%	216	16,406	100%

Source: Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.

Table 2: Number of Patients Receiving Methadone Maintenance Treatment Who Live in Their Treatment City, and the Number of Patients Travelling to the Treatment City for MMT, for Selected Cities on March 14, 2007

Treatment City	Total Patients	Number of Patients Receiving MMT Who Live in the Treatment City	Number of Patients Travelling to the Treatment City for MMT
Kenora	61	31	30 (49%)
Kingston	463	332	131 (28%)
Ottawa	370	294	76 (21%)
Sudbury	423	282	141 (33%)
Toronto	3,302	2,578	724 (22%)
Windsor	243	203	40 (17%)

Source: Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.

not be determined. The information suggests that high proportions of people travel for their MMT. For example, 49% of patients receiving MMT in Kenora do not live in the city; 33% of patients receiving MMT in Sudbury do not live there.

Finally, in the spring of 2006, the College of Physicians and Surgeons of Ontario (CPSO) conducted a methadone patient satisfaction survey.[20] Of the 1,950 surveys that physicians gave to their patients to fill out, 859 completed surveys were returned to the CPSO (44% response). Of the 859 respondents:

- Sixty percent were male and 36% were female (4% transgendered or unknown).
- The most common age groups were 25 to 35 years of age (32% of respondents), 36 to 45 years of age (31% of respondents), and 46 to 55 years of age (22%). Eight percent of respondents were under the age of 25.
- Almost half of respondents (46%) had been going to their MMT clinic one to five years, 23% of patients were going less than one year and 22% were going more than five years (the remainder were unknown).

Table 3 presents the percentage of respondents who replied "excellent or okay" when asked to rank seven questions about their treatment. The results indicate high levels of patient satisfaction with many aspects of their MMT care.

Table 3: Ontario Methadone Patient Survey Preliminary Results, 859 Respondents, May 2006

Question	Percentage "Excellent or Okay"
1. I feel my safety and comfort at my methadone office or clinic is:	94
2. The hours of operation are:	90
3. The respect I receive from my doctor is:	98
4. The respect I receive from my doctor's staff is:	98
5. The amount of time my doctor spends talking with me about my ongoing treatment is:	96
6. If I needed other things to help in my recovery, e.g. counselling, housing, employment, my doctor's help was:	91
7. The response of staff to my questions/complaints is:	93

Source: Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.

When asked to name one thing that they would change about their treatment, the most common answers were:

- dosage
- length of carries
- number of appointments

- hours of clinic and/or pharmacy
- location of clinic and/or pharmacy.

When asked whether they would recommend their clinic to someone needing treatment for their addiction, 97% of patients responded "yes."

6.3 Who Prescribes MMT in Their Office and Through the Ontario Telemedicine Network?

The College of Physicians and Surgeons of Ontario maintains an up-to-date roster of physicians who are exempted to prescribe MMT.

The number of physicians in Ontario who held exemptions to prescribe methadone for opioid dependency increased from 36 in 1993 to 258 on February 21, 2007.[21] Of these 258 physicians, 228 held three-year exemptions and 30 held one-year exemptions. The majority of prescribing physicians – 210, or 81.4% – were male, with the remaining 48 physicians being female (18.6%). The average age of all the prescribing physicians was 49 years old (with a median age of 48 years).[22] The age of prescribing physicians ranged from 27 to 78 years of age.

From April 1, 2006 through to March 13, 2007, 19 physicians conducted 4,664 MMT consultations using the Ontario Telemedicine Network.[23] One physician accounted for 29% of all the methadone consultations. The MMT consultations made up 15.7% of the Network's total clinical activity of 29,700 consultations from April 1, 2006 to March 13, 2007.

The Ontario Telemedicine Network funded MMT consultations that ranged in cost from an average of $29.80 to $52.45, depending on the type. For example, follow-up appointments are less costly than more general assessments ($30.95 compared to $61.00). The 4,664 MMT consultations cost $172,958, or almost 13% of the Network's total physician payments in fiscal 2006/07 (up to March 13, 2007). The Network has capped the number of MMT consultations so that it can continue to support the other 200 specialties and specialists.

6.4 Who Dispenses MMT?[24]

There were about 10,000 pharmacists and 3,059 pharmacies in Ontario on February 27, 2007. Of the total number of pharmacies, 533, or 17.4%, were dispensing methadone for either MMT or pain. Only 358 reported that they were accepting new patients for MMT.

6.5 Who Looks for Services through the Drug and Alcohol Registry of Treatment (DART)?[25]

The Drug and Alcohol Registry of Treatment (DART) is a provincial information and referral service funded by the Ministry of Health and Long-Term Care. (See Chapter 5, Who Does What in Methadone Maintenance Treatment.)

From January 1, 2006 to December 31, 2006, 300 people called DART on its toll-free help line for information on accessing methadone. An additional 412 people called who were receiving MMT or were calling about someone receiving MMT. These callers wanted information on addiction treatment services, such as initial assessment/treatment planning, case management, community treatment, community day/evening treatment, community medical/psychiatric treatment, community withdrawal management, residential withdrawal management, residential treatment, residential medical/psychiatric treatment and/or residential supportive treatment.[26] (See Appendix C.)

Of the 412 callers, 41% were women (170 calls) and 59% were men (242 calls). About 18% of the callers were from people 24 years of age or younger. Callers were asked to identify the addictive substances for which they were seeking help (multiple drugs were identified). The most commonly noted substances and the number of times they were mentioned were cocaine (179), narcotic pain reliever (90), crack (69), alcohol (66), heroin (44) and prescription opioids (37).

From January 1, 2006 to December 31, 2006, DART made 1,320 referrals to organizations for methadone-related services such as case management, community day/evening treatment, community treatment, initial assessment/treatment planning, residential withdrawal management (levels 1, 2, 3), residential treatment and residential supportive treatment (level 1). The breakdown by Local Health Integration Network (LHIN) is noted in Table 4.

The policies used by organizations for MMT clients varied.[27]

Table 4: Referrals from DART to Organizations for Methadone-Related Services, by Local Health Integration Network (January 1, 2006 to December 31, 2006)

1. Erie St. Clair	33
2. South West	77
3. Waterloo Wellington	151
4. Hamilton, Niagara, Haldimand, Brant	268
5. Central West	0
6. Mississauga Halton	20
7. Toronto Central	244
8. Central	11
9. Central East	70
10. South East	9
11. Champlain	76
12. North Simcoe Muskoka	8
13. North East	248
14. North West	105
Total	**1,320**

Source: DART, February 8, 2007

- *Residential treatment, residential medical/psychiatric treatment and/or residential supportive treatment services that accept methadone clients*. There is no standard policy for accepting methadone clients in these services. The policies set by individual organizations vary.

  For example:
  - Some programs require methadone clients to be stable. Other organizations will arrange MMT by referring clients to a prescribing physician/methadone clinic, with the counsellors consulting with the physician or clinic.
  - Some programs require that the methadone client be under the care of a physician, have a weekly blood test for opiates, have urine screening, actively work to withdraw from methadone use, be on low dosages, be taking under 85 milligrams of methadone and/or be taking methadone six to nine months with a willingness to abstain from all substances while in the program.
  - Some programs provide locked storage for carries, whereas others will not store methadone. Some programs allow the pharmacy to deliver methadone, whereas other programs require clients to go daily to a local pharmacy. Some programs will pay for transportation, whereas others require clients either to walk or to pay their own transportation to and from the pharmacy daily.
- Some programs limit the number of methadone clients at any one time.
- Some residential addiction treatment facilities will not accept MMT clients since they are not considered to be abstinent from drugs.
- *Residential withdrawal management services that accept methadone clients*. There is no standard policy for accepting methadone clients in these programs. The policies set by individual organizations vary. Programs that indicate that their methadone policies will "detoxify" clients help people withdraw from methadone. Programs that "accept" and "maintain" methadone clients allow them to take methadone while withdrawing from other substances (e.g., cocaine).
- *Community treatment services* that do not *accept methadone clients*. A number of callers to DART who are receiving MMT have indicated that they are not receiving counselling and support from their methadone clinics. In some areas, it is a challenge to find other community treatment services that will accept these methadone clients. It may be that some agencies assume that other groups are receiving funding for counselling and that it is not their job to do this. Some community treatment facilities will not accept MMT clients since they are not considered to be abstinent from drugs.

The staff of DART's 1-800 phone line provided anecdotal feedback on the issues raised by callers involved with methadone.[28] The overwhelming frustration came from individuals who were looking for help to taper their methadone use. In these situations, the only providers who could help these clients were their methadone physicians who, in many cases, were refusing to help them. (The reasons for refusing were not known). Although many level 2 residential withdrawal management centres will accept clients taking methadone who want to withdraw from other substances, the centres will taper clients' dosage only if they are already on fairly low doses. It is difficult for people on high doses of

methadone who want to taper to find a medical facility or another physician to help them taper methadone safely. A secondary concern expressed by some callers to DART was the lack of choice in MMT services in their communities. In some areas, callers wanted an alternative service provider to the only one in their community.

6.6 Who Uses MMT from Ministry-Funded Agencies That Participate in DATIS (Drug and Alcohol Treatment Information System)?[29]

Addiction and problem gambling treatment agencies in Ontario funded by the Ministry of Health and Long-Term Care are required to submit information to the Drug and Alcohol Treatment Information System (DATIS). Developed and managed by the Centre for Addiction and Mental Health – on behalf of the Ministry of Health and Long-Term Care, Mental Health and Addictions Program – DATIS collects and reports standard client demographic and service utilization data from about 160 agencies.

Information for three fiscal years (2003/04 to 2005/06) was obtained on people who were prescribed methadone at the time of being admitted to an agency participating in DATIS.[30] It is important to note that DATIS reflects only about 15% of people who are receiving MMT in Ontario.

Table 5 indicates that in DATIS agencies in 2005/06, there were 3,089 open admissions (cases)[31] and 2,278 open (unique) individuals.[32] Over three years, open admissions increased 57%, and the number of unique individuals increased 47%.

Table 5: Number of Open Admissions and Open Individuals of Methadone Clients with a Substance Abuse Program Registration in DATIS Agencies, Fiscal Years 2003/04-2005/06*

	2003/04	2004/05	2005/06
Open Admissions	1,974	2,648	3,089
Open Individuals	1,548	1,935	2,278

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database.
*DATIS reflects only about 15% of people receiving MMT services in Ontario.

Table 6 indicates that slightly less than two-thirds of open admissions in DATIS agencies were male methadone clients, with slightly more than one-third being females. This proportion stayed the same from 2003/04 to 2005/06. About 2% of the female methadone clients in 2005/06 – 62 women – were pregnant, compared to about 1.6% in the two earlier years.

Table 6: Open Admissions in DATIS Agencies of Methadone Clients by Gender, Fiscal Years 2003/04-2005/06*

Gender	2003/04		2004/05		2005/06	
	N	%	N	%	N	%
Male	1,248	63.2	1,659	62.7	1,925	62.3
Female	726	36.8	989	37.3	1,164	37.7
Total	**1,974**	**100.0**	**2,648**	**100.0**	**3,089**	**100.0**

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database
*DATIS reflects only about 15% of people receiving MMT services in Ontario.

About 15% of methadone clients (open admissions) from 2003/04 to 2005/06 were people 24 years of age or younger (Table 7). About half these clients were between the ages of 35 and 54 years, with a small proportion – about 2% – 55 years of age or over.

Table 7: Open Admissions in DATIS Agencies of Methadone Clients by Age Group, Fiscal Years 2003/04-2005/06*+

Age Group	2003/04		2004/05		2005/06	
	N	%	N	%	N	%
Under 16	20	1.0	25	0.9	19	0.6
16 – 24	300	15.2	386	14.6	438	14.2
25 – 34	623	31.6	843	31.8	1,077	34.9
35 – 54	984	49.8	1,344	50.8	1,483	48.0
55 – 64	41	2.1	41	1.5	62	2.0
65+	6	0.3	9	0.3	10	0.3
Total	**1,974**	**100.0**	**2,648**	**100.0**	**3,089**	**100.0**

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database
*DATIS reflects only about 15% of people receiving MMT services in Ontario.
+The age calculation is based on the date of birth of the client and the latest date of registration in a program.

Only about a quarter of methadone clients in DATIS agencies were married, partnered or in common-law relationships from 2003/04 to 2005/06. Half of clients were single (never married), and about 20% were separated or divorced.

About 25% of methadone clients (open admissions) in DATIS agencies from 2003/04 to 2005/06 either had some or had completed community college, technical college, CEGEP or university.[33] About 62% of clients had some or had completed secondary or high school. Less than 25% of methadone clients in DATIS agencies from 2003/04 to 2005/06

were either employed full- or part-time. Over half were either unemployed (looking for work) or not working because of a disability. The remaining clients were students, not in the labour force (e.g., homemakers) or retired.

The major sources of income for MMT clients in 2005/06 were Ontario Works (27%), employment income (19%), Ontario Disability Support Program (17%) and disability insurance (5%). About 11% of clients had no source of income, and 5% received family support.

The vast majority of methadone clients in DATIS agencies had no conditions surrounding their agency contact (Table 8). On average, 7% of clients had contacted their agency as a condition of their probation/parole from 2003/04 to 2005/06. Over this time, contact as a condition of the child welfare authority grew from 3.7% to 5.2%.

Table 8: Open Admissions in DATIS Agencies of Methadone Clients by Conditions Surrounding Contact, Fiscal Years 2003/04-2005/06*

Conditions Surrounding Contact	2003/04		2004/05		2005/06	
	N	%	N	%	N	%
None	1,552	78.6	2,061	77.8	2,374	76.9
Choice between treatment or jail	33	1.7	43	1.6	43	1.4
Condition of probation/parole	125	6.3	181	6.8	207	6.7
Child welfare authority	73	3.7	111	4.2	162	5.2
Condition of employment	22	1.1	31	1.2	37	1.2
Condition of school	4	0.2	6	0.2	10	0.3
Condition of family	21	1.1	32	1.2	42	1.4
Other	55	2.8	83	3.1	133	4.3
Unknown	87	4.4	97	3.7	79	2.6
Not specified	2	0.1	3	0.1	2	0.1
Total	**1,974**	**100.0**	**2,648**	**100.0**	**3,089**	**100.0**

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database
*DATIS reflects only about 15% of people receiving MMT services in Ontario.

Table 9 indicates that the proportion of methadone clients in DATIS agencies with mental health problems increased from 2003/04 to 2005/06. For example, the percentage of methadone clients who were diagnosed with a mental health problem by a qualified mental health professional within the last 12 months or lifetime increased from 35% to 43%. Similarly, the percentage of methadone clients who were prescribed medication for a mental health problem within the last 12 months, lifetime or currently increased from 39% to 45%.

Table 9: Open Admissions in DATIS Agencies of Methadone Clients With Historical or Current Mental Health Problems, Fiscal Years 2003/04-2005/06*

Historical or Current Mental Health Problems	2003/04 (N=1,974)		2004/05 (N=2,648)		2005/06 (N=3,089)	
	N	%+	N	%+	N	%+
Diagnosed with a mental health problem by a qualified mental health professional within the last 12 months or lifetime	695	35.2	1,071	40.4	1,332	43.1
Hospitalized for a mental health problem within the last 12 months or lifetime	368	18.6	591	22.3	704	22.8
Received treatment for a mental health, emotional, behavioural or psychological problem from a community mental health program or professional within the last 12 months or lifetime or currently	730	37.0	1,085	41.0	1,251	40.5
Prescribed medication for a mental health problem within the last 12 months or lifetime or currently	764	38.7	1,131	42.7	1,387	44.9

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database
*DATIS reflects only about 15% of people receiving MMT services in Ontario.
+Percentages are taken from the total number of open admissions for the fiscal year

The problem substances used by methadone clients in DATIS agencies changed over the three-year period (Table 10). In 2005/06, 46.5% of clients presented with problems related to over-the-counter codeine preparations or prescription opioids, compared to 40% of clients in 2003/04. The percentage of methadone clients who presented with heroin/opium problems decreased from 24.4% in 2003/04 to 15.7% in 2005/06.

Table 10: Open Admissions in DATIS Agencies of Methadone Clients by Presenting Problem Substances, Fiscal Years 2003/04–2005/06*+

Presenting Problem Substances	2003/04 (N=1,974)		2004/05 (N=2,648)		2005/06 (N=3,089)	
	N	% ~	N	%~	N	%~
Heroin/Opium	481	24.4	526	19.9	484	15.7
Over-the-counter Codeine Preparations or Prescription Opioids	790	40.0	1,132	42.7	1,436	46.5
Alcohol PLUS at least one of Heroin/Opium, Over-the-counter Codeine Preparations or Prescription Opioids	266	13.5	413	15.6	502	16.3
Cocaine or Crack PLUS at least one of Heroin/Opium, Over-the-counter Codeine Preparations or Prescription Opioids	474	24.0	703	26.5	900	29.1
Alcohol PLUS Cocaine or Crack PLUS at least one of Heroin/Opium, Over-the-counter Codeine Preparations, or Prescription Opioids	154	7.8	206	7.8	273	8.8

Source: Drug and Alcohol Treatment Information System (DATIS) Central Database
*DATIS reflects only about 15% of people receiving MMT services in Ontario.
+Up to five substances may be reported per admission. Therefore, column totals may not add up to the total number of open admissions and percentages may not add up to 100.
~Percentages are taken from the total number of open admissions for the fiscal year.

Three years of data indicate that methadone clients increasingly referred themselves to agencies for services.[34] In 2003/04, 42.6% of clients self-referred, compared to 48.9% of clients in 2005/06. The next most common referral source was physicians or private practitioners, who referred 8.3% of methadone clients in 2003/04 and 7.3% in 2005/06. Family and friends were the referral source for about 6% of methadone clients over the three years, followed by the legal system (excluding police) at about 5.5%.

6.7 What Are the Results of Questions Asked at the Annual Methadone Prescribers' Conference?

On November 27, 2006, the College of Physicians and Surgeons of Ontario held its annual Methadone Prescribers' Conference. Of the 200 people who attended the day-long conference, 131 were methadone prescribers who were asked to answer eight questions developed by the task force. Prescribers used touch pads to respond automatically to the questions.

When prescribers were asked how often over the past year they wished they had had more training to treat methadone patients, the majority of respondents – 62% – answered "sometimes" (Figure 3). About 18% answered "often" or "always."

Although the majority of prescribers (61%) wished sometime in the past year that they had more opportunity to consult with an addiction specialist when treating methadone patients, 24% wished this often and 1% always (Figure 4). Only 14% never wished more opportunity to consult with an addiction specialist.

Figure 3: In the past year, how often have you wished that you had more training to treat methadone patients (102 prescribers)?

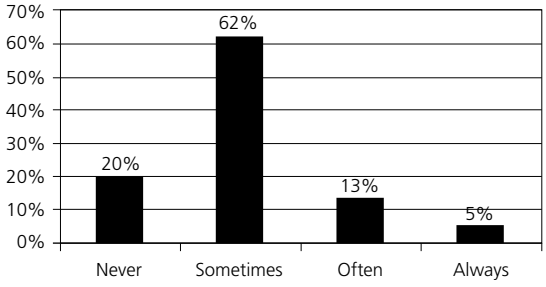


Figure 4: In the past year, how often have you wished that you had more opportunity to consult with an addiction specialist when treating methadone patients (93 prescribers)?

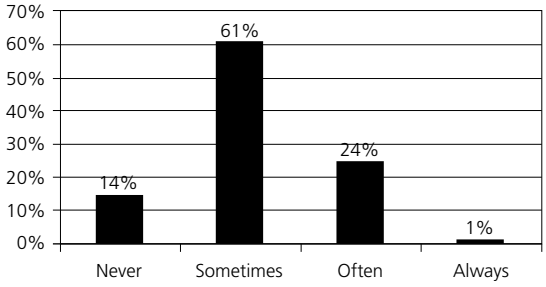
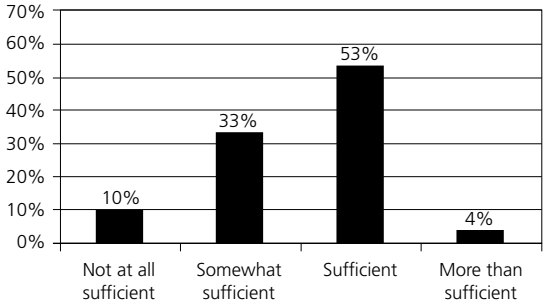
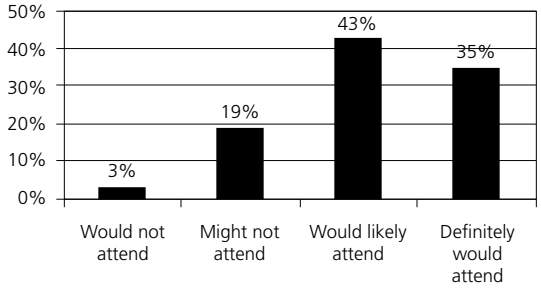


Figure 5: To what extent do you feel that the current education requirements for methadone prescribing are sufficient (104 prescribers)?



Slightly over half (53%) of prescribers felt that the current education requirements for methadone prescribing were sufficient, whereas only 4% felt they were more than sufficient (Figure 5). About 43% of prescribers felt the requirements were somewhat or not at all sufficient.

Figure 6: Beyond what is offered by the Centre for Addiction and Mental Health or at the annual MMT Conference, how willing would you be to attend addictions medicine–specific Continuing Medical Education (96 prescribers)?

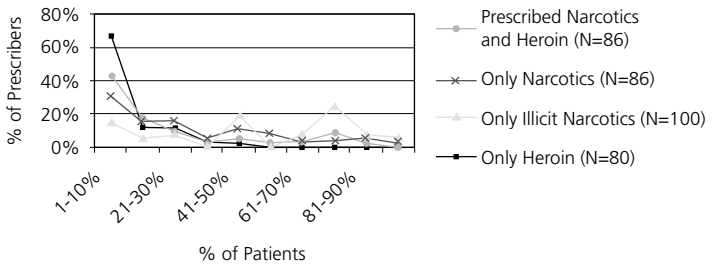


When prescribers were asked how willing they would be to attend addictions medicine–specific Continuing Medical Education beyond what is offered by the Centre for Addiction and/or the annual MMT conference, 78% of prescribers reported that they would likely (43%) or definitely (35%) attend (Figure 6).

Prescribers were asked what percentage of their patients presented for treatment using (Figure 7):

- both prescribed narcotics and heroin
- only narcotics prescribed for them
- only illicit narcotics
- only heroin.

Figure 7: Percentage of Patients Presenting for Treatment Using Various Drugs



6.8 What Were the Main Themes in the Task Force's Consultations?

Consultations were conducted with a wide range of stakeholders. Over 100 people provided input in public meetings; over 100 people were interviewed or attended meetings; and 33 written submissions were received from 42 members of the public and providers. The following is a summary of the main themes in the consultations.

Access/Appropriateness

- *Barriers to access* include: having to see a physician or pharmacist every day, a requirement that can be disruptive; the lack and cost of transportation (especially an issue in northern, rural and remote communities); the lack of access to prescribers and pharmacies; the lack of comprehensive care and supporting resources; problems being in residential care while receiving MMT; methadone being an undesirable area of medicine for physicians.
- *Principles of access* include: treatment should be there when an addict is "ready"; Ontarians who need MMT should have equitable access to treatment; MMT should take a holistic and comprehensive approach to addictions; one size does not fit all.
- *Appropriateness* of using methadone (i.e., sometimes it's too easy to get), the need for alternative treatment options, and the significant positive benefits of MMT on many individuals and communities.
- *Wait lists* for MMT in certain communities mean that people do not have access to the service.
- *Access to other services/full range of services* should include case management, residential programs for methadone, counselling and pharmacies that are connected, medical detox, weaning programs and other therapies.
- *Health Canada* interim exemption allowing a non-traditional model of providing methadone to be piloted in Ontario was seen as increasing access to MMT.
- *The aging methadone population* is a growing problem.

Best Practices/Guidelines

- *College of Physicians and Surgeons of Ontario Guidelines* are seen as too flexible by some and not flexible enough by others; many wanted clarity about the guidelines, especially in certain areas (e.g., urine drug testing).
- *The best practice model* is multidisciplinary MMT clinics that are integrated with other services; consider locating addiction treatment facilities and supporting services in hospital settings or clinics affiliated with a hospital; need for better accountability, better controls, more education and community cooperation; link with primary healthcare reform initiatives (Family Health Teams, Community Health Centres); use telemedicine, educate staff on best practices, integrate MMT with care for HIV/AIDS and hepatitis C.
- *The frequency of urine drug screening* used by physicians to test for recent use of prescription medications and illegal substances varies widely according to opinions on best practices and philosophies of care.
- *MD–client relationship* should be built on trust and honesty, and scheduled appointments help give structure.
- *Create centres of excellence for MMT.*

Training/Education/Information

- *Access to information* on prescribers and pharmacies in the community.
- *Need better training* for healthcare providers of hard-to-serve patients; setting limits; refusing to give prescriptions; handling behavioural issues; chronic pain; how metha-

done works; anti-stigma; frequently asked questions book; Continuing Medical Education credits; collaborative training for physicians, pharmacists, nurses, social workers and counsellors; give continuing education credits.
- *Train providers who do not usually work with MMT users*, such as hospital staff.
- *Train medical students* about managing addictive diseases and MMT.
- *Use innovative ways to train and mentor prescribers*, especially in smaller communities.
- *Educate the public, service providers and parents* on the new reality of taking drugs.

Payment/Funding

- *Fee-for-service payment* does not easily support comprehensive care; consider other models such as capitation, sessional, salary or an alternative funding plan especially to care for more complex patients.
- *Need adequate financial incentives* to attract and keep physicians in MMT.
- *Need to compensate pharmacists appropriately and other providers* such as counsellors.
- *Patients' costs* should be covered, especially if people cannot afford to continue with MMT.
- *Large impact on hospital costs of newborns* receiving methadone.

Quality Assurance And Accountability

- *Evaluate programs and clinics* using quality standards; consider accrediting methadone clinics; clinics need to connect with their communities and have a sense of social responsibility; make clinics accountable for their operations.

Community

- *Clinics need to consult* with communities before setting up a program; clinics should address community concerns about safety and engage the community; clinics need to be designed well and add value to their neighbourhoods.

Larger Drug Issues

- *Use of other drugs* – such as Oxycontin – is alarming, especially the increasing use of prescription drugs in First Nations communities.
- *It is too easy to access drugs* on the Internet, in schoolyards and in physicians' offices.
- *Common knowledge that some physicians overprescribe.*
- *Need for a provincial drug strategy.*

Transitions (Prisons, Correctional Facilities, Hospitals)

- *Need to take MMT more seriously* through staff training, guidelines, etc.
- *Concerns that MMT stops* when a person goes to prison or is released from prison.

Information Technology/Management

- *Electronic patient record* supported.
- *Support for a centralized electronic system to track prescriptions.*

Notes

11. DART is a program of ConnexOntario Health Services Information, which is governed by a community-based board of directors. ConnexOntario also operates the Ontario Program Gambling Helpline (OPGH) and Mental Health Service Information Ontario (MHSIO).
12. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
13. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
14. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
15. Hser, Y., V. Hoffman, C. Grella and M. Anglin. 2001. "A 33-Year Follow-up of Narcotics Addicts." *Archives of General Psychiatry* 58: 503–8.
16. World Health Organization. 2002. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva: Author.
17. Joint United Nations Programme on AIDS (UNAIDS). 2002. *Report on the Global HIV/AIDS Epidemic 2002*. Geneva: Author.
18. Darke, S. and J. Ross. 2002. "Suicide among Heroin Users: Rates, Risk Factors and Methods." *Addiction* 97: 1383–94.
19. Personal communication, Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.
20. Personal communication, Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.
21. Personal communication, Wade Hillier, Manager Government Programs, Methadone/Independent Health Facilities, College of Physicians and Surgeons of Ontario, February 22, 2007.
22. The median is the "half-way" point, where half the population is above this point and half are below it.
23. Thanks are extended to Dr. Ed Brown (CEO, Ontario Telemedicine Network) and Lisa Sarsfield (Regional Vice President and Corporate Services, Ontario Telemedicine Network) for providing this information.
24. Personal communication, Anne Resnick, Director, Professional Practice, Ontario College of Pharmacists, February 27, 2007.
25. Thanks are extended to Brad Davey, Executive Director, ConnexOntario – Health Services in Information, and Karna Trentman, Operational Supervisor, Information and Referral Services, DART, OPGH for providing this information.
26. For definitions, please see <http://www.dart.on.ca/DART/owalive/dart_dir_multi_v2.service_categories>.
27. Personal communication, Karna Trentman, Operational Supervisor, Information and Referral Services, DART, OPGH, February 8, 2007.
28. Personal communication, Karna Trentman, Operational Supervisor, Information and Referral Services, DART, OPGH, February 8, 2007.
29. Thanks are extended to Larry Corea, Director, DATIS, Centre for Addiction and Mental Health for providing this information. Data from the Drug and Alcohol Treatment Information System (DATIS) Central Database were extracted on February 15, 2007.
30. A fiscal year begins April 1 of one year and ends March 31 of the following year.
31. An open admission is an admission to an agency where clients were registered in a substance abuse program that was open for at least one day during the fiscal year. If a client is admitted to an agency twice during the reporting period, this counts as two admissions.
32. Open individuals are the number of distinct (unique) individuals with open admissions. If a client is admitted to an agency twice during the reporting period, this counts as one individual.
33. CEGEP is a post-secondary educational institution in Quebec that offers two-year programs for preparation for university and three-year training programs in professions and trades.
34. Clients could identify up to two referral sources per admission.

PART C:

Deliberations and Recommendations

7. Introduction

Methadone maintenance treatment (MMT) is a small but vital piece within the broad area of addictions and mental health. MMT can be understood as a chronic disease management treatment that enables a person who is addicted to opioids to quickly achieve a better level of functioning in life.

Ontarians face problems accessing methadone services. Many communities – especially those in northern, rural and remote areas of Ontario – do not have adequate access to methadone services or are served by physicians who come for brief periods of time to provide treatment and then leave (e.g., physicians may fly into a community for a day). Even communities that have methadone services have long wait lists, not enough services to meet the needs of the population and services that are not optimal. The most recent published data (2003) indicate that 30.3% of people 15 to 49 years of age who are illegal opioid users in Ontario are in MMT programs, compared to 62.2% in Saskatchewan and 40% in British Columbia.[35] The Canadian average is 26.4%.

A person who wants help with addiction may not be able to wait for months. As one stakeholder noted, "When an addict is 'ready,' the treatment needs to be there." A number of barriers can affect equitable access to MMT.[36]

- Regulations and requirements that appear to be too restrictive may discourage physicians from becoming methadone prescribers.
- Such attitudes as stigma, fear and misinformation about the benefits and use of methadone may discourage people using opioids from seeking treatment with methadone and physicians from becoming prescribers.
- Healthcare providers who support abstinence (i.e., cessation of opiate use) may view people who use methadone as still being "on drugs." In fact, abstinence and harm reduction are part of the continuum of care in which abstinence is the highest level of harm reduction.
- The lack of support for innovative ways to provide MMT, especially in rural and remote areas, may mean that communities go without treatment.
- There are not enough prescribers, pharmacists, nurses and counsellors providing MMT across the province.

The task force believes that Ontarians should have equitable access to a comprehensive range of integrated MMT services (see Chapter 8). Access to these services needs to be supported by the following elements:

- federal and provincial laws and policies to govern methadone use (Chapter 9.1)
- standards and guidelines to support best practices (Chapter 9.2)
- education to ensure appropriate treatment (Chapter 9.3)
- appropriate payment and support (Chapter 9.4)

- best approaches to integrate methadone treatment into society and communities (Chapter 9.5)
- public accountability for quality assurance (Chapter 9.6)

8. Access to a Comprehensive Range of Integrated Services

This chapter examines:

- the range of MMT services that are necessary to achieve the goal of access to comprehensive integrated services and accountability for this goal. The role of telemedicine is also examined.
- the importance of an initial comprehensive assessment and standard information on treatment options
- the importance of interdisciplinary treatment
- methadone dispensing.

8.1 The Range of Methadone Maintenance Treatment Services

The task force believes that Ontarians should have equitable access to a comprehensive range of integrated MMT services that are centred on the person. The focus should be on the person's needs rather than the organizations or providers. People should be treated as partners in their care and encouraged to participate in decisions that affect their health and healthcare.

Comprehensive MMT services are associated with improved treatment outcomes.[37] No single treatment is appropriate for all individuals.[38] Indeed, providing a broad range of services recognizes that people who use methadone have a wide range of treatment needs. These can range from a simple desire for information or medication to more complex needs, such as health problems (e.g., tuberculosis, HIV/AIDS, hepatitis C) that complicate their care,[39] legal problems, employment/vocational difficulties, dysfunctional social relations, mental health issues and housing problems.[40] Even if someone's needs appear to be simple, the task force believes that comprehensive services should be available. As a nurse noted:

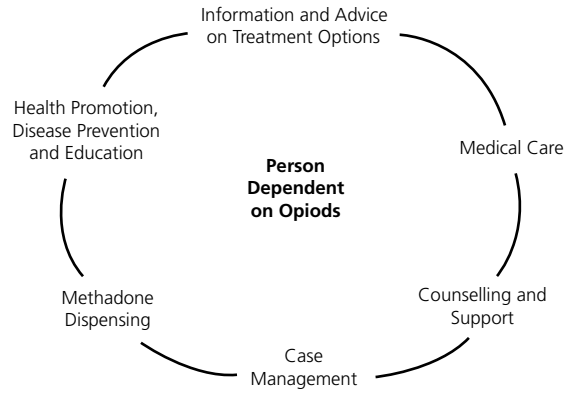
> Methadone should not just be about "picking up a script" and routine urine testing. Methadone service provision should be in a non-judgmental motivational setting that includes counselling, interventions around additional substance use like crack, alcohol, crystal meth, etc., and provides interventions that are relevant and practical to the client's current needs and situation.

Treatment needs vary depending on the group and also within each group (e.g., women, youth, older adults, First Nations, people with multiple drug dependencies, people in contact with the justice system and so on). Methadone programs need to be flexible and provide a continuum of program options.[41] For example, many MMT programs in Ontario are "high threshold."[42] The goal of these is to stop using all other substances. People who want help with their use of opioids but who are not yet ready to give up other substances are not eligible for these programs. "Low-threshold" methadone programs have minimal entry criteria; they tend to be more flexible and provide methadone treatment to people who use other drugs. These programs also tend to have fewer mandatory requirements for regular urine testing and counselling.[43] The primary goal of low-threshold programs is to reduce the risk of harm from drug use and illnesses such as HIV and hepatitis C. The expectation is not that clients will stop using all drugs, but that the severity of their drug-related problems and their risks will be reduced. Low-threshold programs may serve as a "bridge" to programs with more comprehensive services.

Addressing the wide range of needs – and recognizing that these needs change over time – increases the chance that people will continue with MMT. The longer someone stays in treatment, the greater the chance that the treatment will be effective.[44] As one counsellor noted, "The best practice model is MMT case management and comprehensive care. When we did a study of our methadone clients who got six months of case management care, their level of functioning increased significantly."

There is no universal definition of what a methadone maintenance treatment program should include.[45] However, the task force has identified the following components of a comprehensive approach to MMT that can be delivered in a variety of ways and at varying levels of intensity (Figure 8):

Figure 8: A Comprehensive Range of Methadone Maintenance Treatment Services



- information and advice on all treatment options, enabling an informed decision about whether methadone is the right treatment
- medical care that includes evaluating, prescribing, monitoring, treating and providing support for a wide range of co-morbid medical conditions as well as other substance use
- counselling and support that includes crisis intervention, one-to-one counselling, brief and long-term mental health support, group therapy, family and couples therapy, child and family services and psychological assessments
- case management that includes outreach, advocacy and links with community-based supports and services (e.g., social services; child, youth and family services; legal/justice services; education; employment, etc.)
- health promotion, disease prevention and education
- methadone dispensing

The task force believes that planners, funders and providers of health services should make every effort to ensure that Ontarians have access to a comprehensive range of integrated MMT services. This goal needs to be achievable, and "someone" needs to be accountable for achieving it. Achieving this goal and being accountable are addressed below.

Achieving the Goal of Access to Comprehensive Integrated Services

Currently, the Ontario government's Transformation Agenda includes a number of initiatives that support access to comprehensive, integrated services. Specifically, the Ministry's Primary Care Reform has encouraged many family physicians to work in established group practices that include Family Health Teams, Family Health Groups, Family Health Networks, Community Health Centres and Primary Care Networks. These group practices serve an identified number of patients who "sign up" to receive their services from the group. Many of these group practices include other health professionals, such as nurse practitioners, nurses, counsellors and others. Family physicians who work in these group practices get additional incentives to provide certain services (e.g., influenza vaccine, Pap smears, diabetes screening).

Over the past few years, the Ministry of Health and Long-Term Care ("the Ministry") has increased the number of primary healthcare group practices in Ontario. In November 2005, the Ministry announced the creation of 22 new Community Health Centres (CHCs) and 17 new satellite CHCs. In addition, 150 Family Health Teams have been established since September 2004. These group practices provide primary healthcare, manage chronic diseases and offer tools that anyone can use to improve their health and prevent disease. The Family Health Teams, in particular, have been provided with the Ministry's *Guide to Chronic Disease Management and Prevention* to plan chronic disease management and prevention programs for their patients.[46]

In addition to Community Health Centres and Family Health Teams, hospitals provide a range of integrated services to their local communities in partnership with Community Care Access Centres. This is especially true in smaller and more rural and remote areas of the province, where residents may use the hospital for their urgent and primary care needs.

The task force believes that comprehensive MMT should be provided in settings that have the capacity to provide the full range of services, such as Family Health Teams and Community Health Centres. These organizations are interdisciplinary; offer primary care, counselling and case management; and have the skills and expertise to provide services to patients with complex needs. Concerns that users of methadone may disrupt general primary care practices may be unfounded. In the consultations, a number of family physicians noted that when their practices consisted exclusively of MMT patients, these clients tended to be more violent, difficult and threatening and were more likely to be dealing drugs in the community. When MMT patients were included in the general patient population, this behaviour disappeared, and retention and compliance improved. The satisfaction of MMT clients who get served through general practices may also increase. As one person noted in the consultations:

> I'm a methadone user. I get stigmatized. I go to the clinic and get called a junkie. If you could go to your family doctor, who the hell would know? When everyone is locked into one place between 10 a.m. and 12 p.m., you stand out like a sore thumb. It's pretty embarrassing.

The task force also believes that comprehensive MMT should be provided in local hospitals – in partnership with Community Care Access Centres – where access to care is an issue and there are no Family Health Teams or Community Health Centres to provide this service. As public institutions, hospitals have a social responsibility to ensure that local residents who need MMT can access this essential service, either on site or in partnership with local healthcare providers.

Being Accountable for the Goal of Access to Comprehensive Integrated Services

The Ministry of Health and Long-Term Care is accountable for developing provincial strategy and policy. In addition, the Ministry funds and oversees the administration of Family Health Teams. Over the past two years, the Ministry has been increasing its role as a steward of the system and transferring responsibilities to regional bodies.

In June 2005, the Ministry established 14 Local Health Integration Networks (LHINs) to plan, integrate and fund healthcare services in their areas. On April 1, 2007, the LHINs will assume full responsibilities for funding, planning and integrating healthcare services at the local level. These services are delivered by hospitals, long-term care homes, Community Care Access Centres, Community Health Centres, community support services and mental health and addictions agencies. Increasingly, LHINs have been focusing attention on access to services within their regions. For example, each LHIN has designated experts who are responsible for ensuring access to cancer and critical care services. In the fall of 2006, the 14 LHINs completed their Integrated Health Service Plans, all of which highlighted the importance of mental health and addiction services. The task force believes that the increasing emphasis on provincial stewardship, local planning and primary healthcare presents an ideal opportunity to improve access to

comprehensive integrated MMT services in Ontario.

At the provincial level, the Ministry – as the steward of the system – needs to develop a provincial strategy and policies to ensure that Ontarians have equitable access to a comprehensive range of integrated MMT services. As noted above, these should include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone dispensing.

At the local level, each LHIN should develop plans to ensure that people living within the LHIN have access to the full range of MMT services. Potential strategies that LHINs might consider include:

- identifying a LHIN methadone maintenance treatment lead to advise on access to MMT services in the LHIN
- hiring of regional nurse practitioners and pharmacists to facilitate the establishment of community methadone programs. These professionals could promote interest in MMT among local healthcare providers, help negotiate with hospitals and local health facilities to build the infrastructure necessary for methadone treatment and work with the College of Physicians and Surgeons of Ontario, the College of Nurses of Ontario, the Ontario College of Pharmacists and the Centre for Addiction and Mental Health to organize training. As one physician said in the consultations:

  I'm a family doctor in an inner-city practice where there is trouble accessing services. I have a methadone licence and if I were to start prescribing, I would want to be part of a team of nurses, pharmacists and counsellors that are vocational, addiction and social workers. I do not want to set this up myself.

Both the Ministry and LHINs should identify accountabilities for ensuring access to high-quality services, link these to new and ongoing funding for services and include these responsibilities in accountability agreements. The Ministry should strongly encourage and support Family Health Teams to provide comprehensive MMT where access to care close to home is an issue. LHINs should strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies to work together to provide comprehensive MMT where access to care close to home is an issue.

The task force recommends that:

R1 the Ministry of Health and Long-Term Care develop a provincial strategy and policies to ensure that Ontarians have equitable access to a comprehensive range of integrated methadone maintenance treatment (MMT) services that include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone

dispensing. Local Health Integration Networks (LHINs) should develop plans to ensure that people living within the LHIN have access to the full range of MMT services (e.g., designate an MMT expert lead to advise on access to comprehensive services within the LHIN).

The task force further recommends that:

R2 the Ministry of Health and Long-Term Care build on its Primary Care Reform priorities by strongly encouraging and supporting Family Health Teams to provide comprehensive methadone maintenance treatment where access to care close to home is an issue. Local Health Integration Networks should strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies to work together to provide comprehensive MMT where access to care close to home is an issue. LHINs should link this responsibility to new and ongoing funding in their accountability agreements with these organizations.

The Role of Telemedicine

The broad provincial strategy and the LHIN strategies need to include telemedicine as an enabler of equitable access to a comprehensive range of integrated MMT services. Telemedicine is used to connect physicians, other healthcare providers and patients over long distances. Telemedicine is also used to transmit health information over long distances. This is especially important in rural and remote areas that do not have local medical expertise, or where quick and easy access to services is not possible. As one physician noted:

> Access and transportation is a real issue in the North. Many clients are driving three or more hours to get to us. The travel expenses and the stress of losing work or not being able to keep a job is hard.

A nurse further noted:

> We face a lot of physical barriers in the North, let alone the emotional and mental issues that people on methadone have. Plus, the lack of local service creates problems with transportation, coordination, service integration and after-care follow-up.

The more difficult it is to access MMT, the greater the chance that people will stop trying to get the treatment.

Currently, the Ontario Telemedicine Network plays a valuable role by providing some telemedicine support for MMT in northern Ontario. One physician noted, "A lot of work is being done through telemedicine, which is useful due to distances, geography and weather." As noted earlier (Chapter 6.3), from April 1, 2006 through to March 13, 2007, 19 physicians conducted 4,664 MMT consultations using the Ontario Telemedicine

Network. Although follow-up appointments were less costly than more general assessments, the consultations cost $172,958, or almost 13% of the Network's total physician payments in fiscal 2006/07 (up to March 13, 2007).

A number of issues related to telemedicine need to be addressed.

- It is unclear whether all MMT services being provided via telemedicine are meeting the regulatory requirements found in federal and provincial legislation.
- There is a need to develop guidelines to support safe MMT services provided through telemedicine. The College of Physicians and Surgeons of Ontario has been working to address the need for guidelines for the use of telemedicine in MMT. As one physician noted:

  We could easily double the number of people being seen through telemedicine. Give us counsellors. We need to be more selective with telemedicine patients. Some aren't suitable for telemedicine because they're too complex or they don't show up.

- The Ontario Telemedicine Network is funded by the Ministry and pays physicians for their telemedicine consultations. The Ontario Health Insurance Plan does not pay physicians for services they provide through telemedicine. The Network has had to cap its payment to MMT physicians because of the significant increase in demand for services and billings.
- Telemedicine must support a comprehensive range of integrated MMT services as recommended by the task force (Recommendation 1). It appears that many telemedicine consultations have involved physicians assessing and prescribing methadone without the support of comprehensive interdisciplinary care. Telemedicine does not pay for healthcare providers other than physicians.

Ideally, the Ontario Telemedicine Network should be used to support a full addiction counselling and case management program in underserviced, rural and remote areas that goes beyond MMT. However, the task force believes that MMT would serve as an excellent pilot for a larger telemedicine addiction service.

The task force recommends that:

R3 the Ontario Telemedicine Network develop and submit to the Ministry of Health and Long-Term Care a telemedicine methadone maintenance treatment plan that includes a work plan, deliverables and resource requirements for using telemedicine technology to improve access to comprehensive MMT in underserviced, rural and remote areas of the province. This plan should support best practices, be consistent with federal legal requirements, conform to MMT guidelines and policies from the provincial regulatory colleges, and serve as a foundation for a full telemedicine addiction counselling and case management program in Ontario in the long term.

8.2 The Importance of an Initial Comprehensive Assessment and Standard Information on Treatment Options

Consistent with the guidelines of the College of Physicians and Surgeons of Ontario, the task force believes that people with an opioid addiction who are considering MMT need to have a comprehensive assessment, information on various treatment options and a discussion about options with a physician or counsellor in order to make an informed decision about whether MMT is the right treatment for them.

The initial assessment is critical. MMT is one of the effective treatments for opioid dependence and can result in significant positive benefits. However, taking methadone can be difficult for some people[47] Methadone has physical side effects such as drowsiness, weight gain and loss of libido or sex drive; the process of going for daily doses is time consuming and can interfere with people's lives and responsibilities. In addition, methadone may not be appropriate if someone has a number of addictive disorders and concurrent mental illnesses. The initial assessment, therefore, is also important for developing an effective treatment plan.

The importance of a medical and psychosocial assessment before beginning treatment is noted in the methadone maintenance guidelines developed by the College of Physicians and Surgeons of Ontario.[48] Although the majority of people are assessed before beginning MMT, a number of concerns were raised in the community consultations about people being prescribed MMT inappropriately. Comments included:

- "It seems it's sometimes too easy to get on methadone. Some people haven't been on drugs long enough or have a cocaine addiction, or may have been helped by something like counselling rather than methadone."
- "Access must include proper assessment. Methadone is sometimes given inappropriately. We're seeing younger kids on methadone because they may have used opiates for three to six months. Instead of being tapered off, methadone is being given as the quick fix."
- "There's an inherent bias. If you see a methadone doctor, you'll get methadone. We need objective, comprehensive, up-front screening."
- "Methadone is becoming too common a program in our community."

There is no clear, simple approach to obtaining information on methadone treatment options. Sources include:

- the Drug and Alcohol Registry of Treatment (DART), which has a 1-800 number, telephone operators who are available 24 hours a day, seven days a week, and a website that provides online information
- Ontario's 1-800 Telehealth line, staffed by registered nurses who provide health advice and general health information

- family physicians, hospital and emergency room staff
- pharmacists
- public health units and community agencies
- family and friends.

Since a single approach does not exist – and would probably be difficult to put in place – the task force supports a "no wrong door" system of access to information on treatment options, in which "all and any doors" that people use will lead them to the information and advice they need. For this approach to be successful, however, anyone who is considering MMT must receive standard information and education on options before consenting to treatment. Other options include withdrawal and detoxification services (inpatient, outpatient and home services), which may be appropriate especially if someone wants to stop a low- or moderate-dosage oral opiate medication; Narcotics Anonymous; alternative addiction self-help; day/evening and residential treatment; abstinence; and other maintenance drugs (examples include buprenorphine and LAAM, which are in development).[49] As one addiction counsellor noted, "Users want access to other treatment options, like withdrawal management rather than the 'liquid handcuffs.' "

A person who is focused on obtaining methadone may not be listening to all the various treatment options. As well, the information may be overwhelming. For these reasons, information should be provided in innovative ways. For example, methadone prescribers should encourage anyone considering MMT to come to the initial consultation with a friend or family member who does not take drugs to provide peer support, witness what was said, become educated about the risks of overdose and how to prevent it, and discuss the situation afterwards. Time for "sober second thought" should also be built into the initial consultation process (although certain high-risk patients may need to be assessed and offered treatment options quickly). Web-based tools and a user-friendly CD in multiple languages could be developed for potential methadone users with respect to what to think about, what to expect with MMT and what questions to ask before consenting to methadone treatment. These components should be part of a communication strategy that supports standard information on treatment options.

The task force recommends that:

R4 the Ministry of Health and Long-Term Care – in consultation with addiction specialists, methadone prescribers, specialists in medical ethics, users and non-users of methadone maintenance treatment (MMT) and pharmacists – develop a communication strategy that includes standardized information and education provided in innovative ways and targeted at Ontarians who are considering MMT. Options that should be considered include Web-based and visual tools (e.g., a CD) in multiple languages on the range of treatment options, what to expect with MMT and questions to ask before consenting to methadone treatment.

8.3 The Importance of Interdisciplinary Treatment

A comprehensive range of integrated services depends on interdisciplinary teams of providers with the right training giving the right advice and appropriate services – when these are needed – in a humane and supportive environment. The task force believes that effective MMT is provided by interdisciplinary teams made up of physicians, pharmacists, nurses and counsellors. The members of the team should offer services to the maximum level of their training and skills. This approach will support improved access to appropriate MMT services.

Currently, the way in which methadone services are delivered in each community depends on several factors, one of the most important being the model used by the physician prescribing methadone.[50] Some family physicians like to see MMT patients in their family practice, while others prefer to see patients off site. Some agencies offer space to prescribing physicians, whereas other physicians come together in a group to provide services. Physicians working in each of these practice models provided input to the task force during public consultations. There was agreement that a comprehensive model using interdisciplinary teams was the ideal way to provide MMT, even though this was not always happening for a number of reasons.

Recent studies show that Ontario has been moving away from independent physicians working in solo practice towards more group MMT practices. In 1996, the majority of MMT patients in Ontario (77.5%) received MMT from independent physicians, while the remaining 25.2% of patients received services in a group practice setting.[51] By 2001, this trend had reversed, with the majority of MMT patients receiving treatment in a group setting (67.8%). The researchers noted that unlike MMT provided in community treatment clinics, physicians in group practices shared resources and expertise in offering clinical MMT services but had few or no primary care services or other health professionals providing counselling or psychosocial support. This finding suggests that MMT in Ontario is not becoming integrated within the larger healthcare system and that MMT patients are increasingly being segregated from other patient populations.[52] Although a recent survey found that physicians perceived counselling for MMT patients to be the most pressing need, only half the physicians polled actually provided these services to their patients themselves.[53]

Physicians who provide MMT in their offices or in physician group practices may find it difficult to meet the task force's recommendation that Ontarians have access to a comprehensive range of integrated MMT services (Recommendation 1). Current physician practices may lack the appropriate training, skills and funds to offer comprehensive services, and may find it hard to access additional services for their patients through community agencies. (The issue of payment is addressed in Chapter 9.4, Appropriate Payment and Support.)

In addition to physicians, the MMT interdisciplinary team should include pharmacists, nurses and counsellors. Each of these roles is examined below.

Pharmacists

Pharmacists are an important part of comprehensive methadone treatment. They have daily contact with clients and can develop a rapport with them, assess how they are managing their treatment and help the physician determine when the client is ready for take-home doses of methadone (carries). Pharmacists can also play a key role in helping clients succeed with methadone treatment.

A recent study looking at the role of community pharmacists found that pharmacists had low levels of participation in interprofessional healthcare teams.[54] Reasons that were suggested included physical isolation from other healthcare professionals, lack of time to carry out team activities, limited access to patient information and inadequate support, to name a few. Although recent literature suggests that pharmacists are moving towards team-based practice, both structural and attitudinal barriers to teamwork need to be addressed before community-based pharmacists can be successfully integrated into a team-based community practice.

As members of well-functioning interdisciplinary teams, pharmacists can play an important role in improving access to MMT (especially in remote areas of the province) if they are to take on enhanced roles, especially in unique clinical situations. The Ministry of Health and Long-Term Care recognized the need to address this issue when it established the Ontario Pharmacy Council on November 7, 2006 (see www.health.gov.on.ca/english/media/news_releases). The Council is included in the *Transparent Drug System for Patients Act* passed by the Ontario Legislature in June 2006. The Council is providing expert advice to the Minister of Health and Long-Term Care and Ministry officials on pharmacists' services, infrastructure and supports (e.g., roles, responsibilities, training, accreditation needs, compensation models, etc.).

The task force recommends that:

R5 the Ontario Pharmacy Council develop and submit to the Ministry of Health and Long-Term Care a plan to enhance the role of pharmacists in methadone maintenance treatment. This plan should include training requirements and practice guidelines, and identify any legislative requirements that may be needed.

Nurses

Some clinics that provide MMT include primary healthcare nurse practitioners on the clinical team. These professionals are responsible for clients' primary healthcare needs and can monitor persons who are receiving MMT. The task force believes that nurses could be more involved in improving access to MMT, either within nurses' current scope of practice or through delegation. For example, the interim Health Canada exemption allows physicians to delegate the administration of MMT to registered nurses. Although

the impact of the interim exemption is being evaluated, anecdotal evidence suggests that access has improved. In addition, current provincial legislation enables primary care nurse practitioners to prescribe certain drugs in Ontario. Narcotics – including methadone – are not included. Changes in federal legislation and provincial regulations enabling primary healthcare nurse practitioners to prescribe and administer MMT in the community would help improve access to MMT, especially in remote communities. These changes would need to be supported with appropriate training, guidelines and standards, practice audits, clear accountabilities and changes in federal legislation.

The task force recommends that:

R6 the Ministry of Health and Long-Term Care support amendments to provincial regulations that would enable primary healthcare nurse practitioners to prescribe and administer methadone for opioid dependence within communities and in situations where access to methadone maintenance treatment is limited. Additional training, standards and guidelines, a system of practice audits and clear accountabilities should be put in place to support these activities. Furthermore, to enable this change, the Ministry should seek support from Health Canada for appropriate amendments to the federal legislation.

Counsellors

Counselling is an important part of the comprehensive range of MMT services. Its value is recognized in the methadone maintenance guidelines developed by the College of Physicians and Surgeons: "Access to counselling should be an integral part of methadone maintenance treatment. … studies have shown that people will have increased success in MMT when they receive appropriate counselling."[55]

All members of the interdisciplinary team provide services that are essential to MMT; these can include case management, crisis intervention, group therapy and psychological assessments. However, counselling in MMT is a specialization within substance-use counselling that involves special skills, knowledge and philosophy.[56] As one physician noted in the consultations: "As a doctor, I don't have good counselling skills. We need more multidisciplinary teams with counselling skills." Another physician, who has two methadone practices that use different models of care, noted: "The ideal model is the one that has the addiction counsellors. This community support is critical."

Properly qualified and trained counsellors have an invaluable role to play in improving access to MMT services, especially in remote sites where physicians are not available to provide ongoing care or do not have the necessary training to counsel patients. This issue is addressed further in Chapter 9.2, Standards and Guidelines to Support Best Practices (Counselling Best Practices).

8.4 Methadone Dispensing

The task force believes that persons receiving MMT need to obtain the right dose, safely dispensed and administered when and where it is needed. A key issue that was raised in the consultations was lack of access to pharmacies that dispense methadone or that do not make methadone services available seven days a week. Although pharmacists who do not want to dispense methadone are obliged to send a patient elsewhere, the community consultations indicated that this does not happen consistently across the province. A family physician who has a methadone exemption and practises in a smaller community noted:

> I recently started a young woman on methadone and was shocked to discover that the closest pharmacies to my practice – I could never get my hometown pharmacy to dispense – were no longer taking any new patients to dispense methadone. They told me the new regulations were too onerous, that two pharmacists had to take the training, and the paperwork was not worthwhile. This young woman has travelled at least two hours daily to get her methadone. … a similar woman with limited resources, no car, no money who would have benefited from methadone could not possibly get to a pharmacy that dispenses and so was not put on methadone. Many pharmacies are not open every day, especially on weekends. The response from the CPSO Guidelines Committee was that there was always an open pharmacy somewhere. There isn't.

Pharmacies, as independent businesses, are free to dispense methadone if they choose and do not have to if they do not want to. In the consultations, a number of people told the task force about pharmacies refusing to dispense methadone because of increased shoplifting and difficulties with clients. One pharmacist noted:

> Pharmacists are scared because of the clientele. The main thing is a good relationship with the doctor and ready access to the doctor if there's a problem. There's never a problem if the prescription comes on time. People get upset and mad if the prescription isn't there and it can be scary.

The majority of people who commented on pharmacies in the consultations felt that all pharmacies should be required to dispense methadone. As two people noted:

> Methadone is a drug prescribed by a doctor. If I have a prescription, why can't I go to any pharmacy in Ontario for the drug? Why is it only in selected sites?

> Pharmacies already exist in most communities throughout the province and therefore are logically in an ideal position to dispense methadone services.

The task force believes that every effort should be made to ensure that users of methadone have reasonable access to the drug and that "reasonable access" needs to be defined. For

example, the Liquor Control Board of Ontario's Agency Store Program – established in 1962 – sets up agency alcohol stores in communities where "beverage alcohol consumers do not have reasonable access to an LCBO store." The agency's definition of "reasonable access" looks at distance criteria when selecting communities for the agency store program. The current distance criteria is "10 kilometres from an existing LCBO or outlet of The Beer Store." [57]

The task force identified a number of ways to help improve access to methadone dispensing:

- University schools of pharmacy should include MMT training as part of the regular curriculum for pharmacy students.
- The Ontario College of Pharmacists should encourage practising pharmacists to take the one-day methadone maintenance treatment training course offered by the Centre for Addiction and Mental Health (CAMH). CAMH should use innovative ways to make it easier for pharmacists to complete the training (e.g., provide the course closer to home or via the Internet).
- The Ontario College of Pharmacists should establish a mentoring program in which pharmacists who dispense methadone are partnered with, and can provide advice and support to, pharmacists who are interested in or starting to dispense methadone.
- Local Health Integration Networks should include access to methadone as one of the essential services when developing their plans to support access to the full range of MMT services in their areas (Recommendation 1).

The task force believes that Ontario's public hospitals have an essential role to play in improving access to methadone for local residents. As recommended earlier (Recommendation 1), Local Health Integration Networks will be required to develop plans to ensure that people living within the LHIN have access to the full range of MMT services. This includes methadone dispensing. Recommendation 2 notes that LHINs should strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres to work together to provide comprehensive MMT services where access is an issue. This should include dispensing methadone in acute care hospitals that have pharmacies. Since pharmacists are permitted to provide methadone to a hospital employee or a practitioner in a hospital under the *Controlled Drugs and Substances Act*, nurses are permitted to administer MMT if they are working in the hospital.[58] As a result, nurses working in hospitals – in partnership with hospital pharmacists – can play an important role in ensuring access to methadone.

The task force recommends that:

R7 Local Health Integration Networks strongly encourage and support public acute care hospitals that have pharmacies to dispense methadone to meet the needs of local communities where access to methadone maintenance treatment is limited.

9. Elements That Support Access

9.1 Federal and Provincial Laws and Policies to Govern Methadone Use

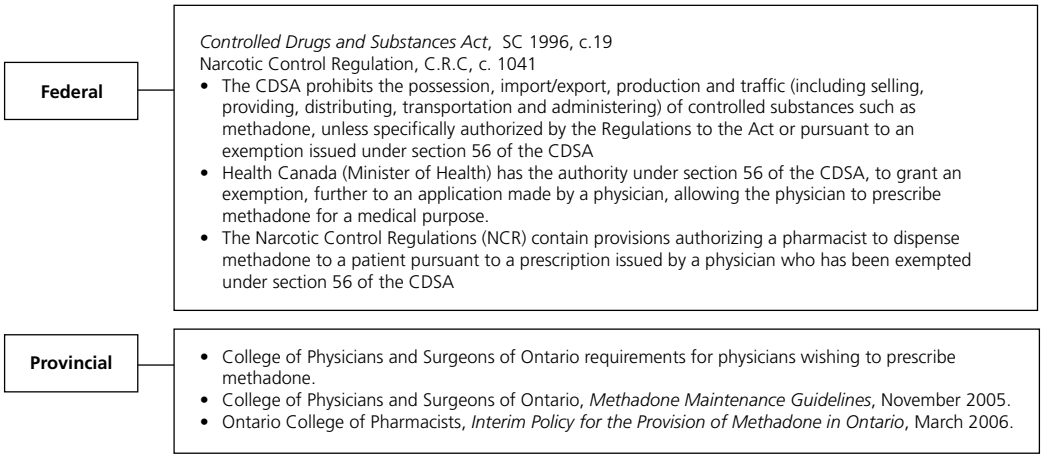
Background

Methadone is highly regulated and controlled at the national and provincial levels through legislation and policies that have changed significantly since the drug was first used to treat opiate addiction in Canada in the 1960s.[59] At that time, methadone began to be recognized and used as an effective treatment for opioid dependence. In the early 1970s, however, concerns raised by the law and health sectors convinced the Canadian government to establish "comprehensive and restrictive federal methadone treatment regulations."[60] Physicians who wanted to prescribe methadone had to be individually approved to do so; they needed to train for 15 days in an MMT practice, and were restricted to a 20-patient caseload (patients also had to be approved).[61] As a result, few physicians in Ontario prescribed MMT. There were long waiting lists to enter treatment, and patients had to travel long distances for services.[62]

Recognizing that MMT had benefits and that concerns were growing about the transmission of HIV and hepatitis C,[63] the federal government changed its policies to increase the availability of methadone treatment in 1996. The federal government kept regulatory authority but gave the provinces administrative responsibility for their MMT systems. The Ontario government gave this responsibility to the College of Physicians and Surgeons of Ontario, which introduced changes in educational requirements, removed limits on the number of patients per physician and developed practice and training guidelines. These changes led to more physicians prescribing MMT and more patients receiving the treatment.[64]

Figure 9 summarizes the major regulation and administration authorities for methadone.

Figure 9: The Regulation and Administration of Methadone: An Overview



At the *federal level*, methadone is a controlled substance that is regulated under the *Controlled Drugs and Substances Act* (CDSA) and is regulated under the Narcotic Control Regulations as a narcotic.

The Act prohibits the possession, import/export, production and traffic (including selling, providing, transporting and administering) of controlled substances such as methadone, unless specifically authorized by the regulations to the Act or pursuant to an exemption issued under section 56 of the Act (see Figure 10). The Narcotic Control Regulations govern the possession, selling or providing, prescribing, dispensing and administration of methadone by pharmacists and practitioners (i.e., physicians, dentists and veterinarians) in Canada.

Figure 10: Federal Legislation

Controlled Drugs and Substances Act 1996, C.19.

Section 5 (1)
No person shall traffic in a substance included in Schedule I, II, III or IV or in any substance represented or held out by that person to be such a substance

Section 56
The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons or any controlled substance or precursor or any class thereof from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest

***Narcotic Control Regulations* C.R.C.C., 1041 (1970)**

Section 31 (3)
A pharmacist may sell or provide methadone to (a) a licensed dealer; (b) another pharmacist; (c) a hospital employee or a practitioner in a hospital; (d) a person exempted under section 56 of the Act with respect to methadone; or (e) a person from whom the pharmacist has received a written order or prescription therefore signed and dated by a practitioner of medicine who is exempted under section 56 of the Act with respect to methadone

Section 35(1)
Subject to subsection (2), a pharmacist may provide a narcotic to an employee of a hospital or a practitioner in a hospital if the pharmacist receives a written order for the narcotic signed and dated by (b) a practitioner who is authorized by the person in charge of the hospital to order the narcotic and who, in the case of methadone, is exempted under section 56 of the Act with respect to methadone. (2) Before providing a narcotic under subsection (1), the pharmacist receiving the order must know the signature on the order or verify it

Section 53 (3)
No practitioner shall administer methadone to a person or animal, or prescribe, sell or provide methadone for a person or animal, unless the practitioner is exempted under section 56 of the Act with respect to methadone.

Health Canada – specifically, the Office of Controlled Substances – administers the CDSA and its regulations. With regard to methadone, the Office of Controlled Substances manages the process for issuing methadone exemptions. When deciding to grant exemptions to physicians to allow them to prescribe methadone for the treatment of opioid dependency, the Office of Controlled Substances takes into account the recommendations by the provincial college of physicians and surgeons (e.g., the College of Physicians and Surgeons of Ontario). Pharmacists do not need to be specially authorized or exempted to dispense methadone.[65]

Examples of methadone exemptions allowed by Health Canada include:

- methadone exemption for the purpose of opioid dependence (also known as methadone maintenance treatment or MMT)
- methadone exemption for the purpose of pain management (also known as analgesia)
- delegation exemption. In March 2006, a non-traditional model was developed for dispensing methadone to patients for opioid dependency in methadone clinics in Ontario. The pharmacist supplies daily-prepared, individually labelled patient doses of

methadone to the clinic for custody of and administration to patients by an exempted physician or exempted qualified persons who are acting under the physician's control and direction. The exemption for physicians and qualified persons allowing them to administer methadone and the exemption for pharmacists to transfer custody of prepared doses of methadone were issued by Health Canada on a pilot basis. The exemption was issued on the understanding that the Ontario College of Pharmacists and the College of Physicians and Surgeons of Ontario would jointly develop a policy to provide methadone in Ontario and to ensure that an adequate accountability framework exists for this non-traditional approach to providing methadone. In addition, the Ministry of Health and Long-Term Care would develop an evaluation framework to assess this approach and conduct an evaluation.

- temporary methadone exemptions. A temporary exemption for a physician to prescribe methadone to a specific patient or inmate may be requested from Health Canada's Office of Controlled Substances. A physician may seek a temporary exemption to prescribe methadone when a patient already stabilized on methadone is admitted to a hospital or institution and there are no exempted physicians available at the hospital or institution who could prescribe methadone to continue the therapy. A temporary exemption may be issued to the physician responsible for the patient's treatment at the hospital or institution. The exemption is granted for the period of the patient's hospitalization and expires on the earlier of the date on which the patient is discharged from the hospital or a maximum of 60 days. The Office of Controlled Substances informs the College of Physicians and Surgeons of Ontario (CPSO) when a temporary exemption has been issued.

At the *provincial level*, physicians who want to prescribe methadone must get the federal Minister of Health to exempt them from the *Controlled Drugs and Substances Act*. The CPSO sets the requirements that physicians must meet to be recommended for an exemption. These include:

1. Be a licensed physician in Ontario in good standing with the CPSO.
2. Complete a methadone application form. This form asks physicians to provide information on their previous experiences and training in opioid dependence and details on the methadone program they want to provide. Physicians must agree to prescribe methadone to patients who are registered and approved by the CPSO's methadone program, agree to comply with the CPSO's *Methadone Maintenance Guidelines* and understand that they are subject to a peer assessment by CPSO within their first year of practice.[66]
3. Complete an approved one-day training workshop, currently conducted by the Centre for Addiction and Mental Health, and two days of clinical training in an office-based methadone practice with a pre-approved preceptor.
4. Agree to practise in accordance with the CPSO's *Expectations in Methadone Prescribing for Opioid Dependence*.[67]

The CPSO does not recommend exemptions to prescribe methadone for pain. A physician can request this exemption by applying directly to Health Canada. Physicians who want to prescribe methadone to treat pain do not need to complete the one-day training workshop or the two days of clinical training.

When a physician meets the above requirements to prescribe methadone for opioid dependence, the CPSO sends a recommendation to Health Canada requesting the Minister of Health to consider issuing an exemption for treating opioid dependence. It takes about one week to process the exemption. Initial exemptions are issued for one year followed by renewable exemptions every three years. An exemption to prescribe methadone allows physicians to administer, prescribe, provide or sell methadone.[68] Physicians do not need to go through this process when they are requesting a temporary exemption for MMT.

When a physician's delegate administers methadone to a patient, the physician is accountable and requires an appropriate exemption from Health Canada. Physicians must ensure that their delegate is properly qualified and informed about the policies and procedures for administering methadone. Physicians must also provide appropriate supervision, and their patients must give informed consent to allow the methadone to be administered by another properly qualified professional.

The CPSO defines a "properly qualified individual" as:

> Those who possess the appropriate knowledge, skill and judgment needed to safely administer methadone to patients. The following are the minimum requirements that individuals should possess:
>
> *A. Nurses*: Individuals must be either:
> - A Registered Nurse, including a Registered Nurse in the Extended Class; or
> - A Registered Practical Nurse who has successfully completed a medication course either during his or her studies or after graduation; and
> - Have demonstrated to the satisfaction of the physician an understanding of methadone maintenance treatment, including the risks associated with methadone treatment.

> *B. Other Health Professionals*: Individuals must:
> - Be another health professional regulated under Ontario's *Regulated Health Professions Act*; *and*
> - Have successfully participated in and completed the Methadone Treatment Workshop at the Centre for Addiction and Mental Health or equivalent training approved by the CPSO in how to safely and appropriately administer methadone; and
> - Have demonstrated to the satisfaction of the physician an understanding of methadone maintenance treatment, including the risks associated with methadone treatment.[69]

Pharmacists are not required to have a special authorization or exemption to dispense methadone. If a pharmacy decides to dispense methadone:

- the owner/manager of the pharmacy must inform the Ontario College of Pharmacists within seven days in writing or by fax that the pharmacy is dispensing methadone, whether it is accepting new patients, the names of pharmacists who are trained to dispense methadone, changes in this status, and the hours of operation and days of the week the pharmacy is open, including holidays
- the pharmacy is required to purchase the latest version of *Methadone Maintenance Treatment: A Pharmacist's Guide to Treatment*.[70]

In March 2006, the Ontario College of Pharmacists released an interim policy noting that the pharmacist must securely transfer the methadone doses to the physician or his or her delegate to give to the patient. The physician or delegate must sign for receipt of the doses of methadone. Unless the drug is directly handed by the pharmacist to the physician or the physician's delegate, the pharmacist must use a method of transfer that involves a means of tracking and safekeeping of the package during transit (e.g., a chain of signatures).[71]

Observations

Although methadone is not as highly regulated as it was from the early 1970s to 1996, a physician who wants to prescribe it still needs to get a federal exemption to prescribe, and undergo additional training and peer reviews. This level of control may contribute to problems of access to methadone. One physician in the community consultations noted, "Methadone can be a difficult and undesirable area of medicine for physicians. One reason is the area has increased public and professional scrutiny, and increased oversight of one's practice by the CPSO through frequent practice audits."

The current regulations and controls on providing methadone may make it hard for some people who are receiving MMT to access the drug. For example, in a number of community consultations, providers commented on how difficult it was for users of MMT who were in residential withdrawal programs to leave the facility to go to a pharmacy to get their methadone. Although some residential programs cover the cost of transportation, other programs refuse to admit persons receiving MMT because of the additional hassle and cost. It is extremely difficult to access methadone in remote communities where there are no physicians or physicians who fly in only for very brief periods of time. In these communities, the vast majority of medical services are provided by primary healthcare nurse practitioners. The *Controlled Drugs and Substances Act* allows only certain practitioners (physicians, dentists, veterinarians) to prescribe drugs included in the Act; a physician needs an additional exemption to prescribe methadone. As a result, an increased role for nursing and pharmacists may be limited. (See Chapter 8, Access to a Comprehensive Range of Integrated Services, for the task force's deliberations on this issue.)

The task force recognizes that there is a need to balance the goal of improving access to MMT with the goal of minimizing risk (including the risk of diverting methadone) and

ensuring public safety and quality of care. It is further recognized that unless legislative changes to improve access are introduced carefully and with appropriate accountabilities and supports, the probability of error increases. For these reasons, the task force supports the continued granting by Health Canada of special exemptions for methadone. However, the task force believes that the current federal requirements for prescribing and administering methadone need to be more enabling.

The task force supports the recent interim exemption enabling physicians to delegate the authority to administer methadone in medical offices and clinics, and allowing pharmacists to transfer methadone doses to a physician or his or her delegate. Although there is some anecdotal evidence from the consultations to suggest that the exemption has improved access to MMT, the task force could not make a firm recommendation on this issue, since the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists and the Ontario Ministry of Health and Long-Term Care are still in the process of evaluating the impact of this exemption.

The task force supports legislative changes that can be introduced responsibly and improve access to MMT at the same time. It has recommended that appropriate regulatory changes be made at the provincial and federal levels to enable nurse practitioners to prescribe and administer methadone for opioid dependence in communities and in situations where access to methadone maintenance treatment is limited (Recommendation 6). Any changes in provincial legislation will need to be supported with appropriate changes in federal legislation.

9.2 Standards and Guidelines to Support Best Practices

In the consultations, a physician noted that "the practice of providing methadone must be governed by a comprehensive set of regulations that are uniformly enforced and based on best practices." This chapter examines standards and guidelines that support:

- physician best practices
- pharmacy best practices
- nursing best practices
- counselling best practices
- interdisciplinary best practices
- urine drug screening best practices
- tapering best practices
- best practices during transitions.

Physician Best Practices

The College of Physicians and Surgeons of Ontario has guidelines on methadone for opioid dependence (methadone maintenance treatment, or MMT) and for pain.[72] Revised in November 2005, the MMT guidelines represent a recent assessment of best practices for

prescribing methadone for opioid dependence. The 2005 guidelines replace those from August 1996 and October 2001, and reflect more of a "harm reduction" rather than an "abstinence" framework. (Harm reduction strategies broadly refer to any policy or program that aims to reduce drug-related harms.[73]) Treatment goals are more flexible, with a focus on reducing rather than stopping illicit drug use and associated risk behaviours.

The methadone maintenance guidelines for physicians address the following areas:

- criteria for admission to MMT
- assessment of the person
- methadone dosing issues
- urine drug screening
- counselling
- carry policy
- involuntary dismissal from care
- methadone and acute pain
- MMT in a correctional facility

The MMT guidelines reflect evidence-based research and clinical consensus, and are not meant to replace sound clinical judgment. A recent study found high levels of compliance with the guidelines one year after physicians completed their MMT training. Physicians complied, on average, 90% or more with the guidelines in 18 specific areas (range, 70%–100%). The four areas with the lowest levels of compliance were psychosocial issues, carries, urine toxicology and blood screening.[74] Studies have not yet been done to determine longer-term compliance with the guidelines.

In addition to the MMT guidelines, the CPSO develops and releases policies when the need arises. Physicians are also guided by other resource documents, such as the Centre for Addiction and Mental Health's publication, *Methadone Maintenance: A Physician's Guide to Treatment*.[75] The CPSO also sends out a quarterly newsletter to all MMT prescribers and supports the Addiction Clinical Consultation Service run by the Centre for Addiction and Mental Health.

The task force agreed that guidelines play an important role in promoting best practices. A very few task force members felt that the CPSO's methadone maintenance treatment guidelines need to be updated. Suggestions for updates include:

- The guidelines do not provide enough information on the appropriateness of MMT and other treatment options.[76] This suggestion should be considered in light of the task force's recommendation to develop a communication strategy that includes standardized information and education targeted at Ontarians who are considering MMT (Recommendation 4).
- The majority of supportive studies focus on high-risk, intravenous users of heroin, whereas the current opioid epidemic is users of oral prescription opiates.

- The guidelines should reflect new issues, such as hepatitis C screening and treatment.

Over the course of the public consultations, some additional revisions were suggested to the guidelines, including:

- Make it easy to give the pain management section of the current MMT guidelines to physicians who do not usually treat persons receiving MMT (e.g., give an information sheet to hospital-based physicians).
- Provide information on how to manage methadone patients who are elderly or medically compromised; who continue to use benzodiazepines; who have HIV or hepatitis C; or who need end stage-management and palliative care.

Concerns that were specifically raised about urine drug screening are addressed later in this chapter.

Pharmacy Best Practices

The *Narcotic Control Regulations* (NCR) contain provisions authorizing a pharmacist to dispense prescription drugs (e.g., narcotic drugs such as morphine and methadone) to the patient named in the prescription, or to his or her agent. Pharmacists can supply methadone only to a physician who has been exempted under section 56 of the *Controlled Drugs and Substances Act* or to a person who has a prescription from an exempted physician. The authority given to a pharmacist to provide methadone, or any drug product containing a controlled substance, to a practitioner applies to the provision of drugs for office use only.

In March 2006, an interim exemption for pharmacists in Ontario was issued on a pilot basis to exempt (allow) them the authority to transport, send or deliver individually labelled doses of methadone dispensed pursuant to a prescription issued by an exempted physician to that physician or qualified persons acting under his or her direction and control at a treatment location.

Pharmacists practise in accordance with the Ontario College of Pharmacists *Standards of Practice*, the *Code of Ethics for Pharmacists* and the policies and guidelines of the Ontario College of Pharmacists (OCP). Pharmacists are also guided by other best practice resource documents, such as the Centre for Addiction and Mental Health's publication, *Methadone Maintenance: A Pharmacist's Guide to Treatment*.[77] This document addresses:

- dispensing MMT
- communication with physicians
- communication with patients
- documentation
- termination of services.

Best practices require a pharmacy–patient agreement for patients receiving MMT. The practice also recommends that the physician and/or other healthcare providers be included in the pharmacy–patient agreement. It is also expected that the designated manager will sign the agreement on behalf of the pharmacy. The policy notes that pharmacies that dispense methadone that are not open seven days a week should open for a restricted period of time or collaborate with a hospital or another pharmacy to provide weekend access for patients who need daily methadone doses.[78]

It has been suggested that additional guidelines need to be developed for pharmacies offering MMT in such areas as dealing with overdoses and threats.

Nursing Best Practices

The College of Nurses of Ontario (CNO) has medication standards, and has provided guidance to nurses on administering methadone.

- Nurses may administer methadone as a "delegate" of a physician who has an exemption under section 56 of the *Controlled Drugs and Substances Act*.[79]
- Nurses are accountable for adhering to the CNO's *Medication Administration Standard*, which reflects best practices that apply to the care of persons receiving methadone.
- Since pharmacists are permitted to provide methadone to a hospital employee or a practitioner in a hospital under the *Controlled Drugs and Substances Act*, nurses are permitted to administer MMT if they are working in a hospital.[80]

Nurses are not required to take a course to administer MMT. According to the CNO, as self-regulating professionals, nurses are accountable for determining and obtaining the knowledge, education and/or experience necessary to perform any treatment procedure safely, including MMT.[81]

The task force believes that best practice standards and guidelines need to be developed for nurses who provide MMT. These are especially needed to support Recommendation 6, which promotes the role of primary healthcare nurse practitioners in prescribing and administering methadone for opioid dependence within communities and in situations where access to methadone maintenance treatment is limited.

The task force recommends that:

R8 the Registered Nurses' Association of Ontario develop best practice guidelines for nurses who provide methadone maintenance treatment services. In addition, the College of Nurses of Ontario should develop nursing standards to support the recommended role of primary healthcare nurse practitioners in prescribing and administering methadone (Recommendation 6).

Counselling Best Practices

There are no specific guidelines for counsellors who provide MMT services. MMT clients can receive counselling and case management from a wide range of individuals, including prescribing physicians, nurses, psychologists, social workers and addiction counsellors, to name a few.

The Centre for Addiction and Mental Health provides guidance on best practices for counsellors in its document, *Methadone Maintenance: A Counsellor's Guide to Treatment*.[82] This report notes that:

- the nature and intensity of counselling will vary over the span of MMT
- counselling is relevant to all parts of treatment, but may not need to be continuous
- counsellors should be familiar with the full nature of opioid dependence and the special clinical issues associated with it
- counsellors should be familiar with the medical, pharmacy and laboratory issues associated with MMT
- counsellors should be familiar with the range of community health and social services their clients may need to access.

The task force examined the important role of counsellors earlier (Chapter 8, Access to a Comprehensive Range of Integrated Services). It was noted that MMT counselling is a specialization within substance-use counselling that involves special skills, knowledge and philosophy.

The task force believes that standards and guidelines need to be established to support best practices for counsellors in addictions, especially those who provide MMT services. These standards and guidelines should include training and certification requirements, practices that support quality and the basics of addiction medicine. The Centre for Addiction and Mental Health and appropriate regulatory colleges should complete this work.

The task force recommends that:

R9 the Centre for Addiction and Mental Health, in partnership with the College of Social Work, the College of Psychologists and others as appropriate, lead the development of standards and guidelines for addiction counsellors, with a particular emphasis on methadone maintenance treatment.

Interdisciplinary Best Practices

The task force addressed the importance of interdisciplinary teams providing MMT in Chapter 8, Access to a Comprehensive Range of Integrated Services. Using members of the team to provide services to the maximum level of their training and skills will support improved access to appropriate MMT services.

The task force believes that there is a great need for interdisciplinary best practices. Those involved in MMT services – including physicians, pharmacists, nurses, counsellors and others – need to collaborate more and be guided by interdisciplinary best practice standards. For example, physicians need to establish continuous dialogue with other healthcare professionals who are treating methadone patients to avoid the risk of combined-drug toxicity.[83] Yet another example is the need for a three-way "agreement" between the physician, pharmacist and methadone patient that sets out expectations for each party.

Urine Screening Best Practices[84]

Background

Collecting urine is the easiest and least intrusive method to screen for many drugs.[85] Urine can be used to test for the recent use of prescription medications (e.g., opioids, benzodiazepines, amphetamines, barbiturates) and illegal substances (e.g., heroin, cocaine, marijuana, phencyclidine or PCP).[86] Urine drug screening provides more information, including more historical information, than testing blood (i.e., drugs are often cleared from blood within minutes or hours but can be detected in urine either directly or through their metabolites for about one to three days).[87] Currently, other substances, such as saliva, sweat and hair, are not widely used in drug screening for various reasons (e.g., not accessible, inaccurate, expensive).

Testing the urine of persons receiving MMT to monitor their drug use is partly based on the assumption that some people taking methadone cannot be trusted to tell the truth about their use of other drugs.[88] Research has shown that asking people about drug use (self-reporting) reveals as much information about their drug use as testing urine.[89] However, self-reporting combined with urine drug screening gives more accurate results than either method alone.[90]

Urine drug testing is used to help verify an MMT patient's self-report of substance abuse, assess compliance with methadone and evaluate a patient's response to treatment.[91] Urine drug screening in MMT has benefits and disadvantages.[92]

Urine drug screening is *beneficial* because it:

- provides objective information for clinical decision-making about a person's compliance with taking methadone and abstinence from non-prescribed and illicit drugs
- deters and potentially reduces illicit drug use among persons taking methadone
- provides objective evidence to support a client's recovery from illicit and non-prescribed licit drug use
- increases contact with the MMT provider team and is a basis for establishing a bond between clients and team members
- provides evidence of whether patients – especially those receiving take-home doses (carries) – have taken methadone
- provides quantifiable information for program evaluation purposes.

The *disadvantages* of urine drug screening are that it:

- can be expensive. Depending on how often the urine is tested and the method of testing, the cost per patient of urine testing in Ontario in a year can range from about $1,500 (once-a-week dip-stick testing) to $6,000[93] (more frequent testing, using more sophisticated technology).
- is an imperfect indicator of drug use and is subject to a certain degree of both false-positive and false-negative results
- can be humiliating for persons who are directly observed when they are providing a urine sample and can be a burden for patients who need to travel and/or take time from work and other commitments to provide samples. This requirement may discourage people from staying in treatment. As one methadone client noted in the community consultations, "I don't like giving them. No one likes it."

Generally, there are two main types of urine drug testing.[94] One, immunoassay drug testing – which includes testing using a dip-stick – is usually done at the "point of care" (in the physician's office) but can also be done in a laboratory. Immunoassay drug tests are the most common method of urine drug testing, and are highly sensitive and usually less specific (they screen whether a member of a certain class of drugs is present or absent in the urine using an arbitrary cut-off level). Physicians can bill the Ontario Health Insurance Plan for office-based point-of-care tests performed in their own offices on their own patients. The second main type of urine drug test is laboratory-based specific drug identification, which is sometimes referred to as "confirmatory testing." This testing, which usually occurs in a laboratory, is more specific and more complex, and is used to confirm the presence of a specific substance and identify drugs not included in a screening test. MMT prescribers may send out some or all of their urine samples to regional labs.

The methadone maintenance guidelines of the College of Physicians and Surgeons of Ontario include best practices for urine drug screening that set out how often urine should be tested for persons taking methadone.[95]

- Prior to starting methadone maintenance treatment, the guidelines provide the following pieces of advice: "Patients should have CPSO approval to begin, *or* at least a minimum of one urine screen that is negative for methadone and positive for opioids. … a conditional start may be appropriate if the clinical circumstances warrant it (i.e., recent incarceration or pregnant), and the reasons are documented."[96] The guidelines further note that "a urine drug screen should be completed and interpreted prior to initiation of MMT. The results should confirm the presence of opioids and identify the patient's primary opioid of abuse. … methadone may be initiated even if the urine screen is negative, if the patient is HIV-positive, pregnant, or recently incarcerated."[97] The guidelines also note that "one urine must be collected, interpreted and documented prior to initiation onto methadone."[98]
- During the stabilization phase (0–6 weeks), a urine drug screen should be collected at least once weekly. Weekly screening should be continued during the maintenance

phase, particularly during the acquisition of carry privileges.
- After six months of negative weekly urine drug screens and/or the patient' acquisition of full carries (i.e., six take-home doses), urine collection may be bimonthly to monthly, based on the validity of the patient's self-report, pattern of drug use and clinical stability.
- Frequency of urine collection should be increased in the event of lapse, relapse or signs of clinical instability.
- Urine collection may be biweekly or monthly for patients who are not appropriate for carries based on ongoing instability or ongoing problematic drug use. Biweekly testing is justified for clinically stable patients with occasional non-problematic drug use who receive no more than one carry per week.
- Although random urine drug screens are the gold standard, they are often impractical and are regarded by many patients as intruding on their daily lives. Clients who give urine samples according to a fixed schedule can alter their use of drugs so that they are not detected in their urine.

Health Canada's document on best practices and many other experts note that urine drug schedules may shift at various stages of treatment, and that screening of stabilized persons should be done only to evaluate the program or when clients show signs of intoxication and/or relapse.[99]

Urine drug screening was one of the most controversial issues raised during the task force's community consultations. The comments on urine testing highlighted a wide range of opinions about best practices, philosophies of care and use of testing to support and expand physicians' MMT practices.

Best Practices

Many people – primarily physicians – offered opinions about best practices for urine drug screening, both in terms of how often and how extensive testing needed to be. Physicians' opinions ranged from "We don't do urines … they aren't therapeutic" to "We feel we need to test more often than twice a week. … I'm an unequivocal advocate of two to three urines a week." Various opinions were also offered about whether testing could be done simply by dipping test strips into urine ("test strips are perfectly sufficient") to whether more complex equipment was needed to do more comprehensive urine testing in the physician's office ("this is about better-quality care").

Philosophies of Care

Physicians' views on urine testing varied depending on their philosophy of care. Generally, providers who felt that frequent testing was appropriate appeared to take a more directive approach to the care of their patients, some almost to the point of policing patients' behaviour. As one physician noted, "Urines less than two times a week will lead to transgressions." On the other hand, providers who supported less frequent urine testing tended to focus more on patients' self-reports of drug use. As one physician noted, "In my opinion, twice a week urines are nonsense. … the relationship with the patient is the best,

so you need to talk with them and foster a good relationship." Many of the physicians in this latter group felt that patients who are unlikely to get take-home doses of methadone should not have their urine tested at all.

Support and Expansion of MMT Practice

Some physicians who were consulted were forthright about performing and processing urine tests to support and expand their MMT practice. Comments included:

- "Billings from urine toxicology testing are the factor that makes community MMT practice viable for fee-for-service physicians in Ontario."
- "Billing these laboratory codes allows me to closely approximate the net income I would achieve in my previous [average] family practice, for a similar amount of time expenditure."
- "This is a business. I got out of family practice because it wasn't lucrative. Visits and urine tests are the money. … I taper patients off although it impacts on my bottom line."

A number of physicians suggested that they would no longer prescribe methadone if they were limited in the number of urine screens they could request and their incomes dropped as a consequence. One physician commented, "The task force shouldn't scare doctors away." When asked how the task force was scaring doctors away, the reply was, "Through compensation. We get paid through the urines, which is the primary funding for the system."

Observations

The task force believes that urine drug screening – using both laboratory and point-of-care testing – is an important part of MMT if it is centred on the patient, is clinically relevant to the goals of treatment and adds value to the ongoing care of the individual. Although the College of Physicians and Surgeons of Ontario has developed best practice guidelines for urine drug screening, the public consultations clearly show wide variation in how MMT physicians interpret these guidelines. In the task force's opinion, this has resulted in significant variation in practice that is costly and detrimental to the care of people receiving MMT. There are a number of issues.

One, it is a myth that physicians need to test patients frequently to provide safe MMT.[100] Too much testing may give a false sense of security about safety, focuses the patient on the test rather than the recovery process and may stand in the way of developing an ongoing therapeutic relationship between the patient and the physician.

Two, testing the urine in the physician's office with the patient present (point-of-care testing) provides immediate results that can be discussed with the patient on the spot. Some MMT prescribers in Ontario have automated their point-of-care testing by using testing equipment (an analyzer) that is usually not located in the individual physician's office and is designed to process larger volumes of samples. In some instances, the urine tests appear to be ordered and interpreted by someone other than the treating physician. This practice has moved away from the intent of immediate point-of-care testing

that focuses on the patient. Indeed, in most cases the person interpreting the urine test result must understand the clinical situation of each individual patient to decide whether a result is "normal" or "abnormal."[101] In addition, automated point-of-care testing may be viewed as an unlicensed laboratory that contravenes the *Laboratory and Specimen Collection Centre Licensing Act*. This Act enables physicians to conduct tests in their offices for the exclusive purpose of diagnosing or treating their patients in the course of their medical practice. This testing is exempt from the quality requirements that apply to licensed hospital and community laboratories (e.g., licensed laboratories must participate in external proficiency testing and laboratory accreditation based on international quality standards).[102]

Three, it is alarming that some physicians appear to be using urine tests to support and expand their MMT practices. Although it is expected that this is a small minority of physicians and that these physicians may be reinvesting some of their profits to provide comprehensive MMT services, making patients take unnecessary urine tests is poor patient care and an inappropriate way to fund other services. As noted above, the task force believes that urine testing should be used only when it centres on the patient, is clinically relevant to the goals of treatment and adds value to the ongoing care of the person. To perform urine tests in any other circumstances is unwarranted and unethical.

Four, it is expected that as a patient progresses through treatment, the frequency of urine testing should decrease in response to clinical evidence of stability and may increase during periods when the patient fails to meet treatment goals. The CPSO guidelines represent a standard of best practices based on research evidence and the expert consensus of MMT specialists.

Finally, given that the annual cost per patient of urine testing in Ontario can range from about $1,500 (once a week dip-stick testing) to $6,000[103] (more frequent tests using more sophisticated technology), funds from unnecessary and inappropriate testing could be reinvested to support other critical components of MMT, such as counselling.

The task force believes that the current CPSO guidelines on urine drug screening should be accepted as the best practice standard by MMT physicians, and be used by the Ministry of Health and Long-Term Care as the standard to reimburse point-of-care testing for physicians. The Ministry should phase in caps on the maximum number of point-of-care urine screening tests in the Ontario Health Insurance Plan (OHIP) fee schedule that will be compensated per patient within a defined period of time. OHIP should monitor physicians who exceed this cap and give physicians the opportunity to clinically justify their claims with appropriate documentation. (Urine drug testing performed in a laboratory would not be subject to the recommended cap.) As it phases in caps, the Ministry should provide appropriate physician reimbursement and funding to expand and support comprehensive MMT services (see Chapter 9.4, Appropriate Payment and Support and Chapter 10.1, Sufficient Resources).

The task force recommends that:

R10 the Ministry of Health and Long-Term Care use the current guidelines of the College of Physicians and Surgeons of Ontario for urine drug screening as the standard for reimbursing point-of-care testing for physicians who provide methadone maintenance treatment in Ontario. The Ministry should phase in caps on the maximum number of point-of-care urine drug tests in the Ontario Health Insurance Program fee schedule that will be compensated per patient receiving MMT within a defined period of time. As it phases in caps, the Ministry should provide appropriate physician reimbursement (Recommendation 15) and funds to expand and support comprehensive MMT services (Recommendations 17 and 23).

Tapering Best Practices

People who are receiving MMT and who want to stop taking methadone can try tapering off the medication with the support of their provider. Tapering is most likely to be successful if the patient has abstained from illicit substances for a substantial period of time, does not have current untreated psychiatric co-morbidity, has strong social supports and counselling,[104] and access to abstinence-based treatment. People taking methadone who want to try tapering should be informed of the process and the risks, and have a full, informed discussion about whether tapering is safe and appropriate before a final decision is made.

Concerns have been raised through the consultations and in the course of analyzing data that some people taking methadone are not receiving the support that they would like to taper off the medication. For example, the staff of the Drug and Alcohol Registry of Treatment's (DART) 1-800 phone line provided anecdotal feedback on the issues raised by callers involved with methadone. The worst frustration was expressed by those who said they were looking for help to taper off methadone. In these situations, the only providers who could help these clients were their methadone physicians who, in many cases, were refusing to help. (The reasons for these refusals are unclear.) Although many level 2 residential withdrawal management centres will accept clients taking methadone who want to withdraw from other substances, the centres will taper clients off methadone only if they are already taking fairly low doses. It is difficult for people taking high doses of methadone who want to taper to find a medical facility or another physician to help them do this safely.

The College of Physicians and Surgeons of Ontario provides some guidance on methadone tapering. Tapering does not just entail medical intervention; it also requires psychosocial intervention. The task force believes that a number of its recommendations will help address this issue, in particular the development of a provincial strategy and policies to ensure equitable access to a comprehensive range of integrated MMT services that include – among other services – information and advice on all treatment options, counselling and support, and health promotion, disease prevention and education. Local Health Integration Networks will also be required to develop plans to ensure that people in the LHIN have access to the full range of MMT services (Recommendation 1).

Best Practices During Transitions

People who are receiving MMT undergo a great deal of stress when their regular routines change and they face problems getting methadone or encounter negative attitudes about their treatment. Stressful situations, such as going to a hospital emergency department, being admitted into a hospital or entering or leaving a correctional institution, become even more stressful for people who are receiving MMT.

With regard to healthcare services, not all emergency departments and hospitals are familiar with MMT and how it affects care. As one pharmacist noted in the consultations, "Hospitals need to take methadone seriously … it's a deadly substance." People receiving MMT may be given drugs that interact with their methadone. These interactions can reduce the effectiveness of therapy and cause clients to go into withdrawal. Healthcare providers might underprescribe pain medications for patients because they are taking methadone. Some providers may also be suspicious of MMT clients who want to be treated for other health conditions, thinking that they only want drugs. As one addiction counsellor noted, "I accompany a lot of clients to the hospital. You can visibly see the aversion in the ERs, in the hospitals." In many cases, hospitals will not have anyone on staff who is licensed to prescribe methadone, a situation that can affect clients' access to MMT in a medical emergency.

Education and information need to be provided to emergency and hospital staff on how to care for someone receiving MMT for opioid dependency. Various organizations, such as the College of Physicians and Surgeons of Ontario, the Ontario Medical Association, the Ontario Hospital Association and the Centre for Addiction and Mental Health, have a role to play in developing educational sessions on the emergency and hospital care of persons receiving MMT.

The task force recommends that:

R11 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to work in partnership with other organizations (such as the Ontario Hospital Association, Ontario Medical Association, Centre for Addiction and Mental Health and others) to develop educational sessions on the emergency and hospital care of persons who are receiving methadone maintenance therapy. These educational sessions should be targeted at hospital and medical staff and include the development of protocols for hospitals to use when treating persons who take methadone.

Although the task force was not asked to address methadone maintenance treatment in correctional institutions, the group addressed the continuity of methadone treatment when a person enters or leaves these institutions. Clearly, people who are receiving MMT at the time they enter a correctional facility need to have continuous therapy. While both federal and provincial correctional institutions provide ongoing methadone treatment, only federal institutions will begin someone on methadone. (Since people are incarcerated

in provincial institutions for shorter periods of time, it is hard to begin and maintain their MMT. Exceptions are made for pregnant offenders and for persons in certain medical circumstances.) When users of methadone are released, they need to be linked with treatment services outside the facility before they are discharged. These services include a prescribing physician, a local pharmacy that dispenses methadone, counselling and other necessary supports. Correctional facilities need to use standard admission and discharge policies and procedures for persons receiving MMT and ensure that these persons receive case management support when they are released.

The Ontario Ministry of Community Safety and Correctional Services has policies and procedures on methadone.[105] These may not be well known, since a number of individuals consulted over the course of the task force's work commented on the need to improve MMT services for people entering and leaving provincial facilities. It was noted that the Correctional Service of Canada funds case managers, a provision that enables methadone users to make an easier transition back into the community. This type of targeted support and focused discharge planning does not exist in provincial prisons.

Since methadone is a health service that is provided in a secure environment, the Ministry of Health and Long-Term Care needs to work in collaboration with the Ministry of Community Safety and Correctional Services to ensure that standard admission and discharge policies and procedures are used for persons receiving MMT who enter and leave provincial facilities.

The task force recommends that:

R12 the Ministry of Health and Long-Term Care work in collaboration with the Ministry of Community Safety and Correctional Services to ensure that standard provincial admission and discharge policies and procedures are followed for persons receiving methadone maintenance treatment who are serving in correctional facilities (including prisons, detention centres and other facilities).

9.3 Education to Ensure Appropriate Treatment

Physicians

Physicians who want to prescribe methadone must successfully complete a one-day course provided by the Centre for Addiction and Mental Health (CAMH) and a two-day preceptorship in a methadone maintenance treatment practice with a methadone prescriber approved by the College of Physicians and Surgeons of Ontario (CPSO). (Prior to 1997, physicians had to take 15 days of training in an MMT practice. The length of the training course tended to discourage physicians from becoming prescribers.) Physicians are also expected to participate in a peer assessment of their practice towards the end of their first year of holding an exemption. Currently, the CPSO is piloting an assessment of physician MMT practices when their exemptions are renewed, every three

years. These assessments are meant to be educational. The CPSO also holds an annual day-long Methadone Prescribers' Conference that addresses timely topics and publishes *The Methadone Newsletter.*

Pharmacists

Pharmacists who dispense methadone are required to be familiar with the principles and guidelines outlined in *Methadone Maintenance: A Pharmacist's Guide to Treatment.*[106] Pharmacists should also be familiar with the CPSO guidelines in the documents *Methadone Maintenance Guidelines* and *Methadone for Pain Guidelines*. The pharmacy manager is required to take the one-day methadone training course offered by CAMH or take an approved course within one year of beginning a methadone practice. In addition, at least one staff pharmacist has to take the CAMH course or an approved course. Training must be updated every five years.[107] The Ministry of Health and Long-Term Care provided funding to the Ontario Pharmacists' Association to review the training that CAMH provides for pharmacists. Currently, CAMH and the Ontario Pharmacists' Association are offering a one-day methadone education program. Pending approval, the course will fulfill the training and educational requirements of the Ontario College of Pharmacists.

Nurses

Nurses do not have to take a special course to administer methadone maintenance therapy. As self-regulating professionals, however, they are accountable for determining and obtaining the knowledge, education and/or experience necessary to perform any treatment procedure safely, including MMT.[108]

Counsellors

Counsellors have access to a comprehensive educational resource: *Methadone Maintenance: A Counsellor's Guide to Treatment*.[109] Counsellors can also access various continuing education programs offered through CAMH.

Centre for Addiction and Mental Health

The Centre for Addiction and Mental Health (CAMH) offers its one-day methadone maintenance treatment course in Toronto about eight times a year, and has offered the course in Thunder Bay and Kingston in the past year. In addition, CAMH has developed a Web-based methadone course that meets the standards established by the College of Physicians and Surgeons of Ontario. This eight-week online version of the Methadone Treatment Workshop (seven modules, taken one per week) teaches physicians, pharmacists, nurses, counsellors and others skills and guidelines for the safe management of people taking methadone for opioid dependency. The course uses online resources, individual and group activities, and small and large group discussions. The course requires a minimum time commitment of three hours per week. Only physicians are examined in writing, as one requirement to prescribe MMT.

Over the course of the consultations and the research conducted for the task force, a wide range of information and education needs and opportunities were identified. For

example, a majority of physicians attending a recent Methadone Prescribers' Conference reported that they would likely (43%) or definitely (35%) attend an addictions medicine–specific Continuing Medical Education session (see Chapter 6.7, What Are the Results of Questions Asked at the Annual Methadone Prescribers' Conference?).[110] This finding suggests that MMT physicians want more information on addiction medicine to assess, inform and manage their patients properly.

Examples of educational opportunities targeted at different groups:

- Medical school students and residents need training on treating pain and addictive diseases, and the use of methadone as a treatment.
- The number of addiction medicine fellowships needs to be increased.
- The core educational curricula for all healthcare professionals needs to include the diagnosis and treatment of addictions and appropriate pharmacotherapies for pain.[111]
- Physicians taking CAMH's one-day MMT course would benefit from additional information on such topics as hepatitis C, methadone and pregnancy, medical detoxification and concurrent disorders.
- Prescribers need follow-up and ongoing training in such areas as dealing with hard-to-serve clients, focusing on drug-seeking behaviour rather than the "addict" or the "methadone taker," setting limits and refusing to give unnecessary prescriptions. An Ontario physician survey found that over half the physicians polled saw themselves practising MMT within a "harm reduction" framework.[112] Education on the full range of harm reduction treatments and options is needed.
- Healthcare providers who do not usually work with people who take MMT need training on addictions, how to treat chronic pain and anti-stigma training. For example, all emergency physicians and selected hospital staff should be familiar with MMT.

It was suggested that innovative methods be used to make courses more accessible to people throughout Ontario (e.g., Web-based classes, videoconferencing). As well, addiction specialists, MMT users and family members who can "put a human face" on methadone should help provide educational courses to health professionals.

The task force believes there are opportunities to improve education on MMT and addictions. One opportunity is for CAMH, in consultation with the Canadian Society of Addiction Medicine, to continue developing and offering continuing education courses on addictions in partnership with schools of medicine, nursing, pharmacy, psychology and social work. CAMH, which is already working with the regulatory colleges and professional associations, should build on its successes. Clinicians taking these courses should get continuing education or continuing professional development credits with their employers, associations and/or colleges.

Another opportunity is for the College of Physicians and Surgeons of Ontario to develop educational initiatives such as a second-level methadone maintenance treatment course for prescribing physicians, a provincial mentorship program for new MMT prescribers,

addiction medicine education sessions and a clinical support system for methadone clinicians modelled after, or integrated with, CAMH's Addiction Clinical Consultation Service. These initiatives should be developed in consultation with other organizations, such as CAMH and the Canadian Society of Addiction Medicine.

The task force recommends that:

R13 the Centre for Addiction and Mental Health, in consultation with the Canadian Society of Addiction Medicine and others, continue to develop and offer educational courses in addictions in partnership with schools of medicine, nursing, pharmacy, psychology and social work in Ontario. Where possible, clinicians taking these courses should be awarded continuing education or continuing professional development credits by their employers, associations and/or colleges.

The task force further recommends that:

R14 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop educational initiatives, including: i) a second-level methadone maintenance treatment course for prescribing physicians; ii) a provincial mentorship program for new MMT prescribers; iii) addiction medicine educational sessions; and iv) a clinical support system for methadone clinicians modelled after, or integrated with, the Centre of Addiction and Mental Health's (CAMH) Addiction Clinical Consultation Service. These initiatives should be developed in consultation with other organizations, such as CAMH and the Canadian Society of Addiction Medicine.

9.4 Appropriate Payment and Support

The task force believes that Ontarians should have equitable access to a comprehensive range of integrated MMT services (Recommendation 1), and that access to these services should be enabled by appropriate payment and supports. Working with individuals who have addictions can be challenging. This chapter addresses:

- physician payment and support
- pharmacist payment and support
- counselling payment and support
- cost to the methadone user.

Physician Payment and Support

Physicians who provide MMT are generally paid fee-for-service through the OHIP Schedule of Benefits. There is no billing code that is specific to methadone; rather, physicians can bill a number of fees when caring for methadone patients for the following services: intermediate assessment (A007), general assessment (A003), primary mental

health care (K005), counselling (K013) and psychotherapy (K007). Currently, fee-for-service is the predominant way that physicians, including those who prescribe MMT, are paid in Ontario.

The task force believes that fee-for-service on its own is not an appropriate payment method to support a comprehensive range of integrated MMT, as recommended earlier (Recommendation 1). The current fee-for-service model is really a "fee for physician service" model that does not support interdisciplinary teams. It disadvantages patients who would benefit from interdisciplinary care; it disadvantages physicians who may be spending a lot of time caring for methadone patients with complex needs and in the early stages of treatment; and it disadvantages physicians who may want to work in an interdisciplinary setting but cannot financially support such a model. These views were heard in the community consultations:

- "Local doctors want to do methadone [treatment] but they don't because they can't bill fee-for-service for having a counsellor."
- "I'm paid a sessional fee. It's not economical to manage methadone patients in a fee-for-service practice. The average doctor can't do it."
- "MMT is an area of medical practice involving a high degree of overhead. … my overhead in MMT is three to five times more than it was in my family practice."

The task force discussed a number of payment options for physicians that go beyond a purely fee-for-service model. These include: i) capitation, where the physician is paid a set annual fee for each patient under his or her care (the fee can be adjusted by type of patient); ii) salary, where the physician is paid a set amount of money per hour, per session (block of hours) or per year; and iii) blended payment models, where the physician is paid in a number of ways, such as capitation or salary and fee-for-service for certain services.

As noted previously (Chapter 8, Access to a Comprehensive Range of Integrated Services), the Ontario government's Transformation Agenda – specifically Primary Care Reform – includes a number of initiatives that support access to comprehensive, integrated services. Many family physicians are now working in established group practices that include Family Health Teams, Family Health Groups, Family Health Networks, Community Health Centres and Primary Care Networks. These group practices serve an identified number of patients who "sign up" to receive their services from the group. In addition, many of these group practices get additional incentives to provide certain services. For example, physicians who work in Family Health Teams get incentive bonuses to follow recommended protocols for diabetes. Physicians in Family Health Groups can bill if they provide comprehensive primary care to patients with serious mental illness, and physicians get a premium (additional funding) when they meet threshold numbers (provide care to a certain number of patients).

When assessing reimbursement options, the task force considered whether the option increases the accessibility of MMT services, effectively provides high-quality care and

offers an incentive for physicians to provide quality care and use a shared care or integrated healthcare approach to MMT.[113]

The task force concluded that a blended payment model is the most appropriate model to support comprehensive and interdisciplinary methadone maintenance treatment in Ontario. This model should include alternative funding, such as salary or capitation, along with fee-for-service incentives. These incentives should be used to encourage existing groups, such as Family Health Teams, Community Health Centres and others, to provide MMT and primary care to people receiving MMT (see Recommendation 2). This funding model should also make the best use of other healthcare providers, such as nurses and counsellors.

It is recognized that the best chance of success is to "start small," leverage current Ministry priorities in Primary Care Reform (such as the creation of 150 new Family Health Teams since September 2004, and 22 new Community Health Centres and 17 new satellite CHCs announced in November 2005) and build on successes over time. The Ministry should phase in blended physician payment models to support MMT that include incentives and premiums. These payment models should be evaluated for their impact on access, quality, efficiency and effectiveness.

The task force recommends that:

R15 the Ministry of Health and Long-Term Care phase in blended physician payment models to support methadone maintenance treatment services. These models should build on the Ministry's priorities in Primary Care Reform, and be evaluated for their impact on access, quality, efficiency and effectiveness.

Pharmacy Payment and Support

By the nature of the services that they provide, pharmacists face risks on a daily basis. Pharmacies stock a wide range of drugs that are prone to abuse and may be the target of theft or other crimes. Many pharmacies include additional security costs as part of their ongoing business expense. This may affect the willingness of pharmacies to dispense methadone. As one pharmacist noted in the consultations:

> We have cameras and have had no break-ins. There's been some shoplifting but nothing serious. Another store had two to three break-ins and stopped dispensing methadone. Pharmacists are scared because of the clientele.

Pharmacists perform three major activities in the process of providing methadone to patients:

- preparing the medication, which involves compounding and putting the medication in a form to be given to the person

- dispensing the prescription (professional fee), which involves giving the medication to the person
- counselling and assessing the person taking the medication

In the task force's view, each of these activities needs to be assessed in terms of the effort made to complete the task and the funding that is appropriate to the effort. To illustrate: preparing a methadone drink once every six days uses more time and energy than preparing six drinks at one time. It may be reasonable to set a fee for a single dose and a different fee for six doses that are given to a person all at once to take at home. Dispensing fees – also known as professional fees – vary by pharmacy from a low of $3 to a high of $15. Medication counselling usually occurs the first time a person receives methadone and may reoccur if the need arises. For example, a person may need different levels of medication counselling depending on his or her stage of using methadone. Thus, a set fee for medication counselling and assessment may not be appropriate. It may be appropriate to pay pharmacists using capitation, where a fee is paid for each person seen. The Drug Programs Branch of the Ministry of Health and Long-Term Care uses two different approaches to reimburse pharmacists for drug costs:

- capitation: The pharmacy is reimbursed the cost to acquire the drug + compounding fee + 10% (mark-up) + $4.11/day dispensing fee. The dispensing fee is capped at a maximum of $1,500 per patient per year. No co-payment is collected from the patient.
- fee-for-service: The pharmacy is reimbursed the cost to acquire the drug + compounding fee + 10% (mark-up) + $7 dispensing fee. The pharmacy can charge the patient a co-payment fee. For any given week, pharmacists may bill for the witnessed dose plus one fee for all carries. For example, if a person has a prescription for a witnessed dose on Monday and take-home carries on Tuesday, Wednesday and Thursday, the pharmacy can bill one claim (with a fee) for Monday's dose and a separate claim (including one fee only) for the three take-home carries.

The task force agrees that it is critical to compensate pharmacists fairly and appropriately for the work that they do in MMT. As noted earlier (Chapter 8.3, The Importance of Interdisciplinary Treatment), the newly created Ontario Pharmacy Council is expected to provide expert advice on compensation models (among other issues). As part of its work, the Council should address appropriate compensation for pharmacists engaged in MMT. This should include a review of compensation practices used elsewhere. For example, in British Columbia, pharmacists get a monthly dispensing fee of $150 per patient and a patient interaction fee of $7.80 per event.[114]

The task force recommends that:

R16 the Ontario Pharmacy Council determine, and advise the Ministry of Health and Long-Term Care on, the most appropriate funding model to encourage pharmacists to dispense methadone maintenance treatment.

Counselling Payment and Support

Counselling is an important component of MMT. Currently, the Ministry of Health and Long-Term Care funds methadone case managers in community addiction programs. These individuals provide counselling as well as case management support. The task force believes that the Ministry's priority in Primary Care Reform and the creation of various types of primary healthcare groups – such as Family Health Teams and Community Health Centres – presents an ideal opportunity to support community-based addiction and MMT counselling services. This is consistent with the task force's recommendation that the Ministry strongly encourage and support Family Health Teams to provide MMT, and for Local Health Integration Networks (LHINs) to strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres to work together to provide MMT services where access to care is an issue. (Recommendation 2). This responsibility should be linked to new and ongoing funding for MMT counselling and case management services. (These could include case managers, information to help patients navigate the system on their own and other approaches.)

The task force recommends that:

R17 the Ministry of Health and Long-Term Care allocate funding to Family Health Teams for addiction and methadone maintenance treatment counselling and case management services (e.g., case managers, information to help patients navigate the system, etc.). In addition, Local Health Integration Networks should allocate funding to Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies for MMT counselling and case management services.

Costs to the Methadone User

People who take methadone face a number of different costs.

The Ontario Drug Benefit program (ODB) pays for methadone for people who are over 65 years of age or who are on Ontario Works or the Ontario Disability Support Program. People who are not eligible for ODB pay for the drug either from their own pocket or through private insurance. If the cost of drugs is high compared to one's income, a person may be eligible for the Trillium Drug Program (the province's catastrophic drug program). Most people have the cost of their methadone paid either by social assistance programs or by private drug insurance companies (i.e., employment-related benefit programs). Only a small minority pays for methadone out of pocket.[115] In 2005/06, total Ontario Drug Benefit expenditures for methadone were about $15 million (which served approximately 10,700 patients).

MMT patients who do not have easy access to prescribing physicians and/or pharmacies usually must pay to travel to get to these services. The Northern Health Travel Grant Program provides funds to defray some of the travel costs for people from Northern Ontario to see a specialist for services that are not available in their home community. The Program does not cover the cost to travel to see a general practitioner, or travel costs of

someone living in southern Ontario. Since the majority of physicians who are licensed to prescribe methadone are general practitioners, their patients' travel costs are not covered.

The task force believes that the Ministry of Health and Long-Term Care needs to identify ways to improve access to MMT services for people who live in underserved areas and have difficulties obtaining treatment. One option is to designate MMT as a specialized service for the purpose of the Northern Health Travel Grant. This approach would help meet the needs of clients in the North and would be a step towards improving access to methadone services in these communities. If the Ministry supports this option, it should also consider providing travel subsidies for people in underserviced communities in other parts of the province who must travel for MMT. Another option is to focus efforts on attracting prescribers and other providers to underserviced areas to provide MMT. For example, the Rural Locum Program of the Ontario Medical Association supports physician placements in rural and isolated communities.

The task force recommends that:

R18 the Ministry of Health and Long-Term Care identify ways to improve access to methadone maintenance treatment services for people who live in underserviced areas and have difficulties obtaining treatment. Potential options include travel subsidies for patients, and incentives to attract prescribers and other providers to underserviced areas.

9.5 Best Approaches to Integrate Methadone Maintenance Treatment into Society and Communities

Methadone maintenance treatment is not well integrated into society, in residential communities or in communities of practice providers. This chapter examines these three overlapping areas.

Integrating Methadone Maintenance Treatment into Society

There is a great deal of stigma associated with MMT and with people who use methadone to manage their opiate addictions. "Addiction," "drug user" and "methadone" are words that have negative connotations for the public and for large parts of the medical, social service and legal communities. There are a number of reasons for this perception.

- There is a common view that people choose to be addicted and that if they really wanted to stop, they could do so. Because the addict is seen as someone who has voluntarily acquired an addiction, addiction is viewed as a choice rather than a disease. As one physician noted in the consultations, "Addiction has a moral stain."
- There is the perception that people who are opioid dependent are violent, have criminal tendencies and are to be avoided at all costs. This stigma creates fear in the minds of the public. As one person noted in a consultation, "Our residents no longer feel safe."

- To many people, taking an opioid drug to treat an opioid drug problem does not make sense. People understand and accept abstinence much more easily and quickly than harm reduction. Some treatment programs for alcohol and other non-opioid drug addictions do not accept clients who use any type of drug or substance, including methadone. There is even a stigma against healthcare providers who work in the methadone field. As one methadone prescriber said, "Our colleagues ask us what the hell we're doing and why are we doing this."
- Methadone maintenance treatment has been "under the microscope" recently owing to inquests into methadone-related deaths. The public attention that methadone receives in the press adds to the stigma.

During the consultations, the task force heard from a number of people on MMT who spoke positively about the dramatic impact of this treatment on their lives:

- "Methadone changed my life and it gave me the time I needed to improve my situation."
- "Methadone is health promotion and disease prevention in action."
- "We noticed the change in the community immediately. People began spending money on their kids and grandkids, cleaning their houses. … We've seen a decrease in break-and-enter cases, Children's Aid cases, more kids are enrolled in school and they're graduating."
- "Methadone has helped me a lot. I didn't know how to live. I just knew how to get high. I'm not going back."

The task force believes that MMT needs to be viewed as any other medical service and that an anti-stigma strategy should be developed about addictions and methadone. A key message should be that MMT is one treatment for opioid addiction that – when used appropriately – promotes wellness. Although an anti-stigma strategy will have an impact on the media and health and social service providers, its primary focus should be the public. The Ministry of Health and Long-Term Care should bring stakeholders together to develop the anti-stigma strategy, including people taking methadone, the Centre for Addiction and Mental Health (CAMH), the College of Physicians and Surgeons of Ontario, prescribers, Local Health Integration Networks and others. A great deal can be learned from the experience of others. For example, CAMH launched a successful public campaign on the stigma of mental illness.

The task force recommends that:

R19 the Ministry of Health and Long-Term Care bring stakeholders together to develop a public education campaign that addresses the stigma associated with addictions and methadone maintenance treatment. Stakeholders should include people receiving MMT, the Centre for Addiction and Mental Health, the College of Physicians and Surgeons of Ontario, prescribers, Local Health Integration Networks and others. A key message should be that MMT is one treatment for opioid addiction that, when used appropriately, promotes wellness.

Integrating Methadone Maintenance Treatment into Residential Communities

There are a number of difficulties in trying to integrate MMT into residential communities, for example, fear of increased health risks from infectious diseases and concerns about safety, drug-related criminal activity and declining property values. Clinics that provide MMT services may not even realize that they have a responsibility to contribute positively to the community in which they are located.

Over the course of the consultations, it became clear that the integration of MMT practices into residential communities is generally not well done. Often, providers are not members of the community and have no local networks beyond the patients they see. As one person noted, "It's not great having a medical 'fly-in' where the doctor doesn't live in the community or have an interest in it." By the same token, task force members often heard that communities did not treat patients with respect, resulting in loss of dignity.

The task force believes that the principle of openness and community engagement should guide the integration of methadone clinics into neighbourhoods. A consistent comment heard from community members who were angry with a methadone clinic in one neighbourhood was the secrecy under which the clinic appeared. Comments included:

- "There was no prior warning, no community consultation (although this is recommended by the Centre for Addiction and Mental Health)."
- "There was a lot of secrecy about this clinic. We were told one week before the clinic was established. We should have been consulted."
- "The provider needs to be engaged with the community. Maybe this should be a criterion of licensing these clinics."

Clinics and physicians who provide MMT need to engage with and contribute to the community in which they are located. Most physicians who provide MMT are independent businesspeople who are free to establish their clinics where they want, subject to local bylaws. This is also true of pharmacists. However, organizations funded by the Ministry of Health and Long-Term Care or Local Health Integration Networks should be required to engage the community when planning to provide MMT services. "Community" should be broadly defined to include businesses, local pharmacists, the local police, local politicians, the Medical Officer of Health, media, local places of worship, landlords, people receiving MMT and others.

The community planning guide of the Centre for Addiction and Mental Health (CAMH) should also be updated and distributed as a resource.[116] Other publications should be examined for innovative ideas and approaches. For example, *Yes, in My Back Yard*[117] is a guide and tool kit for Ontario's supportive housing providers to help those creating new supportive housing. It includes tips for community consultations, tangible steps to develop a strategy and 15 predictable objections and how to deal with them. CAMH should also provide consultative support to help guide the integration of MMT services into communities.

When they are being designed and once they are established, MMT practices should have community advisory/liaison group. Providers should contact a few carefully selected neighbours, such as a resident, a retailer, a representative of the local police force, a member of the local municipal counsellor's office and, possibly, a member designated by the Local Health Integration Network. These groups would regularly review:

- community and neighbourhood needs, standards and resources
- the context and mission of the healthcare providers
- service gaps for patients and communities
- patient and public behaviour
- clinic design and non-clinical operations.

The groups would also promote and enable:

- an appropriate clinical setting that serves both patients and the community
- excellence in the clinic's form, function and environment to create peaceful co-existence of the community with the clinic
- contributions by the community to normalize the lives of the patients.

At a basic level, clinics and providers need to contribute to the community by:

- keeping the inside of the clinic well maintained
- improving and maintaining the physical environment outside the clinic
- discouraging loitering
- giving clients an appropriate place to congregate
- maintaining an effective flow of clients into and out of the clinic that is respectful of the clients and their time, and of the community.

On this last point, a few methadone prescribers noted in the consultations that they do not schedule appointments because many clients do not show up. Many other prescribers, however, commented on the value of scheduled appointments as part of treatment:

- "We make appointments, which is part of the treatment. People need structure and they need to be responsible."
- "Scheduling appointments really helps, since there aren't blocks of people appearing all at once. It keeps things orderly. We tell clients that if they like the clinic they need to keep it clean."
- One person receiving MMT noted, "Sometimes I can wait hours for a visit because there are no appointments. I know the problem is no-shows, but maybe there should be appointment days. Appointments are good for structure."

Community advisory/liaison group meetings can be called by any member of the team. It is the informal and proactive interaction that will make the work effective. According to interviews with members of the police force, this is standard practice with many social

service organizations. In addition to groups, clinics should also develop a "peer support model."[118] This would encourage clients to take pride in the clinic and its surroundings, go out into the community to tell their stories and meet regularly to address issues.

The task force recommends that:

R20 the Centre for Addiction and Mental Health, in collaboration with the Ministry of Health and Long-Term Care, update its resource book to guide the introduction of methadone maintenance treatment services into communities. This resource book should support the principle of openness, identify clear steps on engaging the community, and include requirements to establish community advisory/liaison groups and use a peer support model. In addition, CAMH should provide consultative support to help guide the integration of MMT services into communities.

Integrating Methadone Maintenance Treatment into Communities of Practice Providers

In an earlier recommendation, the task force supported equitable access to a comprehensive range of integrated MMT services (Recommendation 1). Providers need to know what services are available in the community for their MMT clients. Not only is this information important for MMT prescribers, pharmacists, nurses and counsellors, it can also be used to help providers establish communities of practice for the benefit of patients. For example, peer support workers can play a valuable role connecting clients with community services, including detoxification services, housing, emergency dental care and counselling. Peers can inform patients and encourage them to follow through with the recommended course of action. The task force was told that peers are especially valuable to patients who are in crisis.

Over the course of the task force's work, it became clear that a comprehensive list of services to help develop these communities of practice does not exist in Ontario. In Quebec, a list of services and contact information is available for each regional Agence de la santé et des services sociaux du Québec. Since many Local Health Integration Networks have subdivided their areas into neighbourhoods, the LHINs are ideally suited to use and support the development of local lists of services relevant to users and providers of MMT and addiction services. LHINs should take on this initiative in consultation with ConnexOntario, Health Services Information (which operates the Drug and Alcohol Treatment Information System, the Ontario Program Gambling Helpline and Mental Health Service Information Ontario).

The task force recommends that:

R21 Local Health Integration Networks, in consultation with ConnexOntario, Health Services Information, develop comprehensive lists of services relevant to users and providers of methadone maintenance treatment and addiction services.

9.6 Public Accountability for Quality Assurance

It is necessary to know who is accountable for ensuring that methadone maintenance treatment services work well and, if there are problems, who is responsible for fixing them. Currently, different organizations are responsible for different pieces of the MMT system. This is not surprising, since the system is very complex and includes a broad range of services and providers (see Chapter 5, Who Does What in Methadone Maintenance Treatment). This chapter examines who has public accountability for making sure that methadone maintenance treatment services work well.

Public Accountability for Professionals Who Provide Methadone Maintenance Services

Regulatory colleges are accountable for developing standards and ensuring that their individual members meet these standards. The two colleges that are most directly involved in methadone maintenance treatment services are the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists.

The *College of Physicians and Surgeons of Ontario* (CPSO):

- determines the education, training and other qualifications that Ontario physicians must meet to prescribe methadone maintenance treatment (Chapter 9.3, Education to Support Appropriate Treatment)
- develops guidelines on best practices for MMT (Chapter 9.2, Standards and Guidelines to Support Best Practices)
- carries out peer methadone assessments to ensure that high-quality services are provided
- acts on complaints received about physicians, including those who prescribe MMT.

With regard to peer assessment, all MMT prescribing physicians are assessed towards the end of the first year in which they receive their exemption to prescribe methadone. This assessment includes a review of 10 patient charts and a general discussion about the physician's methadone practice. The assessment helps determine whether the physician is following the guidelines and practising appropriately. The Methadone Committee (a committee appointed by the Council of the CPSO) reviews the results and determines whether any actions are required (e.g., a physician who is performing poorly could have his or her exemption revoked). Exemptions to provide methadone are renewed every three years.

The *Ontario College of Pharmacists*:

- determines the educational requirements of pharmacists who dispense methadone (Chapter 9.3, Education to Support Appropriate Treatment)
- develops standards that are specific to MMT (Chapter 9.2, Standards and Guidelines to Support Best Practices)

- acts on complaints received about pharmacists, including those who dispense methadone.

As a result of Health Canada's interim exemption to allow the pilot of a non-traditional model for the provision of methadone (March 2006), the Ontario College of Pharmacists and the College of Physicians and Surgeons of Ontario are jointly developing a policy to ensure accountability with this new model.

In addition to the two main colleges noted above, different areas of the *Government of Ontario* are accountable for monitoring certain areas. For example, the Ontario Health Insurance Plan (OHIP) monitors physicians' fee-for-service billings and is responsible for identifying potential billing issues. This activity is not limited to methadone maintenance treatment. In April 2005, Supreme Court Justice Peter Cory completed his review of Ontario's Medical Review Committee, an agency of government administered by a committee of the College of Physicians and Surgeons of Ontario that probes physicians' OHIP bills (April 2005). Justice Cory recommended overhauling the Medical Review Committee and establishing a new audit system. On December 12, 2006, the government introduced the Health System Improvements Bill that proposes a number of changes. One of these is a new medical billing review process and review board for checking physicians' OHIP billings. Changes would include more professional education, payment review, a new review board and an appeal process.

Public Accountability for Groups That Provide Methadone Maintenance Services

Many different groups provide methadone maintenance services. In some instances, there are clear public accountabilities for how a group practises; in others, there are none. Examples:

- Groups that are funded by government ministries – such as the Ministry of Health and Long-Term Care and the Ministry of Community and Social Services – are accountable to these organizations for their operations (e.g., Family Health Teams are accountable to the Ministry of Health and Long-Term Care). As noted in Chapter 8 (Access to a Comprehensive Range of Integrated Services), Ontario's 14 Local Health Integration Networks will assume full responsibilities for funding, planning and integrating health-care services at the local level on April 1, 2007. These services are delivered by hospitals, long-term care homes, Community Health Centres, community support services, Community Care Access Centres and mental health and addictions agencies.
- A number of publicly funded organizations are monitored and assessed by provincial or national bodies. For example, the Ontario Association of Community Health Centres accredits Community Health Centres. Hospitals (such as the Centre for Addiction and Mental Health) voluntarily agree to be reviewed and accredited by the Canadian Council of Health Services Accreditation.
- Partnerships and group practices made up of physicians who receive funding from OHIP are professionally accountable to their regulatory colleges but are not publicly accountable for their business practices and operations. Different terms are used to

describe these practices, including clinics, facilities, health centres and offices. Although these practices can be quite large, they may not be incorporated and, thus, would not have to meet any requirements of the *Corporations Act* (e.g., board, membership, annual meeting, audited financial statements, etc.).

In the task force's opinion, the regulatory colleges do a good job of providing public accountability by overseeing professionals who deliver methadone maintenance treatment services. There are some opportunities for improvement.

- One, physicians are not required to demonstrate ongoing competency over the course of their careers. Generally, a physician's skills decrease the longer he or she is out of medical school unless efforts are made for lifelong learning about new approaches and developments. The task force believes that MMT physicians should be reassessed when their three-year methadone exemption is renewed to ensure that they continue to follow best practices and provide safe care. This action was recommended by a Coroner's Jury in 2004.[119] The task force is pleased to note that the CPSO has just begun to pilot a reassessment of methadone practices. When the pilot is complete and the program refined and improved, reassessments should be made mandatory.
- Two, the CPSO Methadone Registry collects basic information and monitors such information as whether someone is going to more than one MMT physician. The Registry was set up neither to monitor performance improvements nor as a tool for accountability. To help identify areas for improvement, the Registry would have to collect information on non-opiate drug use, injection drug use, infectious disease status, methadone dosages and physician/practice treatment philosophy.[120] The Coroner's Jury in 2004 recommended that statistical tracing be included as an element of the MMT program.[121] Suggested statistics to be tracked include measurements of success and failures (targets met), reasons for leaving the program, and deaths and associated causes of death for those in the MMT program.

In Chapter 8 (Access to a Comprehensive Range of Integrated Services), the task force identified the accountability of government- and LHIN- funded Family Health Teams, Community Health Centres, Community Care Access Centres, and hospitals to provide a comprehensive range of integrated methadone maintenance treatment services (Recommendations 1, 2 and 7). In the task force's opinion, public accountability is also needed for partnerships and group practices made up of physicians who receive funding from OHIP to provide MMT services. Over the course of the consultations, a number of concerns were raised about some aspects of these partnerships and practices. For example:

- "Clinics should not direct the patient to their pharmacy that provides the methadone. It's illegal for physicians to own or have an interest in a pharmacy. This is not ethical and impacts on best practices. Where are the rights of patients if they are pressured to use a pharmacy that's not of their own choosing?"
- "These groups aren't part of an integrated system and don't want to be. They don't connect with the community and don't really provide comprehensive care."

- "I don't like the business aspect of 'peddling' methadone."
- "The end justifies the means. I'll run three urines to pay for interdisciplinary counsellors."

The task force discussed the feasibility of setting up a system of licensing partnerships and group practices made up of physicians who receive funding from OHIP for their MMT practices. The Independent Health Facilities model was considered as a template for this approach. However, the task force concluded that licensing would be a complex and lengthy process that could be considered only in the longer term. A viable short-term solution, however, builds on the Methadone/Independent Health Facilities program that is funded by the Ministry and managed by the College of Physicians and Surgeons of Ontario. This program audits individual methadone prescribers one year after they receive their exemption. Currently, a pilot is being tested to evaluate individual prescribers about every three years. The task force believes that these evaluations should include an assessment of a group's practices, policies, procedures and organization of services.

The task force recommends that:

R22 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop and implement a plan to assess physician group practices that provide methadone maintenance treatment. These assessments should review a group's practices, policies, procedures and organization of services, and include clear accountabilities for standards, guidelines and best practices. As part of ongoing public accountability, the Ministry and Local Health Integration Networks should continue to oversee the services provided by government-funded organizations (e.g., hospitals, Community Health Centres, Community Care Access Centres, addiction and mental health agencies, Family Health Teams, etc.).

Notes

35. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.
36. This section was informed by Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
37. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
38. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada; National Institute of Drug Abuse. 1999. *Principles of Drug Addiction Treatment: A Research-Based Guide*. Ottawa: Canadian National Institute of Health.
39. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
40. Erdelyan, M. 2000. *Methadone Maintenance Treatment: A Community Planning Guide*. Toronto: Centre for Addiction and Mental Health.
41. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.

42. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
43. British Columbia Ministry of Health Services. 2005. *Harm Reduction: A British Columbia Community Guide*. Retrieved March 30, 2007. <http://www.housing.gov.bc.ca/ptf/hrcommunityguide.pdf>.
44. National Institute on Drug Abuse. 1999. *Principles of Drug Addiction Treatment: A Research-Based Guide*. Ottawa: Canadian National Institute of Health.
45. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
46. Ontario Ministry of Health and Long-Term Care. 2005 (September 27). *Guide to Chronic Disease Management and Prevention*. Toronto: Author.
47. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
48. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines*. Toronto: Author.
49. Centre for Addiction and Mental Health. 2003. *Methadone Maintenance Treatment: A Client Handbook* (2nd ed.). Toronto: Author.
50. Erdelyan, M. 2000. *Methadone Maintenance Treatment: A Community Planning Guide*. Toronto: Centre for Addiction and Mental Health.
51. Strike, C.J., K. Urbanoski, B. Fischer, D.C. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
52. Strike, C.J., K. Urbanoski, B. Fischer, D.C. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
53. Fischer, B., D. Cape, N. Daniel and L. Gliksman. 2002. "Methadone Treatment in Ontario After the 1996 Regulation Reforms: Results of a Physician Survey." *Annals of Internal Medicine* 153(7): 2S11–2S21.
54. Dobson, R.T. et al. 2006. "Interprofessional Health Care Teams: Attitudes and Environmental Factors Associated with Participation by Community Pharmacists." *Journal of Interprofessional Care* 20(2): 119–32.
55. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines*. Toronto: Author.
56. Martin, G., B. Brands and D. Marsh, eds. 2003. *Methadone Maintenance: A Counsellor's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.
57. Personal communication, Marisa Kraus, Administrator, Agency Store Program, Liquor Control Board of Ontario, February 19, 2007.
58. College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses*. Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.
59. Fischer, B. 2000. "Prescription, Power and Politics: The Turbulent History of Methadone Maintenance in Canada." *Journal of Public Health Policy* 21(2): 187–210.
60. Fischer, B. 2000. "Prescription, Power and Politics: The Turbulent History of Methadone Maintenance in Canada." *Journal of Public Health Policy* 21(2): 187–210.
61. Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
62. Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
63. Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
64. Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.
65. Isaac, P., A. Kalvic, E. Janecek and J. Brands, eds. 2004. *Methadone Maintenance: A Pharmacist's Guide* (2nd ed.). Toronto: Centre for Addiction and Mental Health.
66. College of Physicians and Surgeons of Ontario. n.d. Application for An Exemption to Prescribe Methadone (letter).
67. College of Physicians and Surgeons of Ontario. n.d. *Expectations in Methadone Prescribing for Opioid Dependence*. Toronto: Author.
68. College of Physicians and Surgeons of Ontario. n.d. Re: Request for an Exemption with Respect to the Use of Methadone (letter).
69. College of Physicians and Surgeons of Ontario: Methadone Administration in the Treatment of Opioid Dependence Policy #2-06. Approved by Council February 2006.

70. Isaac, P., A. Kalvic, E. Janecek and J. Brands, eds. 2004. *Methadone Maintenance: A Pharmacist's Guide* (2nd ed.). Toronto: Centre for Addiction and Mental Health.
71. Ontario College of Pharmacists. 2006 (March 16). *Interim Policy for the Provision of Methadone in Ontario.* Retrieved March 31, 2007. <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Methadone+Maintenance+Treatment+-+March+16+2006/$file/Methadone+Maintenance+Treatment+-+March+16+2006.pdf>.
72. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines.* Toronto: Author; College of Physicians and Surgeons of Ontario. 2002. *Methadone for Pain Guidelines*. Toronto: Author.
73. Ogborne, A.C., V. Carver and J. Wiebe. 2001 (September). *Harm Reduction and Injection Drug Use: An International Comparative Study of Contextual Factors Influencing the Development and Implementation of Relevant Policies and Programs.* Ottawa: Health Canada. Retrieved April 1, 2007. <http://www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/harm_reduction_e.pdf>.
74. Carol Strike, Centre for Addiction and Mental Health, November 16, 2006, verbal communication.
75. Brands, B. and J. Brands, eds. 1998. *Methadone Maintenance: A Physician's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.
76. Additional information could include the American Society of Addiction Medicine's Patient Placement criteria which uses an algorithm (formula) to help determine what level of treatment is required for various types and levels of substance-abuse disorder. The tool is based on scientific evidence and aims to direct the patient into the most optimal treatment.
77. Isaac, P., A. Kalvic, E. Janecek and J. Brands, eds. 2004. *Methadone Maintenance: A Pharmacist's Guide* (2nd ed.). Toronto: Centre for Addiction and Mental Health.
78. Ontario College of Pharmacists. 2006 (March 16). *Interim Policy for the Provision of Methadone in Ontario.* Retrieved March 31, 2007. <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Methadone+Maintenance+Treatment+-+March+16+2006/$file/Methadone+Maintenance+Treatment+-+March+16+2006.pdf>.
79. College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses.* Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.
80. College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses.* Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.
81. College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses.* Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.
82. Martin, G., B. Brands and D. Marsh, eds. 2003. *Methadone Maintenance: A Counsellor's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.
83. Curie, C.G. and H.W. Clark. 2004. *Methadone-Associated Mortality: A Report of a National Assessment. Substance Abuse and Mental Health Services Administration.* Washington, DC: US Department of Health and Human Services.
84. Thanks are extended to Dr. Douglas Gourlay (Centre for Addiction and Mental Health and Mount Sinai Hospital, Toronto) for meeting with the task force, informing its discussions and presenting (Rational Drug Testing in Methadone Maintenance, March 21, 2007).
85. Anderson, M. 1998. "Chapter 5: Urine Toxicology Screening." In B. Brands and J. Brands, eds. 1998. *Methadone Maintenance: A Physician's Guide to Treatment* (pp. 45–58). Toronto: Centre for Addiction and Mental Health.
86. Gourlay, D., Y. Caplan and H. Heit. 2006 (November 1). *Urine Drug Testing in Clinical Practice: Dispelling the Myths and Designing Strategies* (3rd ed.). Stamford, CT: PharmaCom Group.
87. A metabolite is a product of metabolism or chemical changes in the body.
88. Health Canada (Office of Canada's Drug Strategy). 2002. Literature Review: *Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
89. Health Canada (Office of Canada's Drug Strategy). 2002. B*est Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
90. Perrone, J. et al. 2001. "Drug Screening versus History in Detection of Substance Use in ER Psychiatric Patients. *American Journal of Emergency Medicine* 19(1): 49–51.
91. College of Physicians and Surgeons of Ontario. 2005 (November). Methadone Maintenance Guidelines. Toronto: Author.
92. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
93. Personal communication, Gail Czukar, Centre for Addiction and Mental Health, January 24, 2007 and March 13, 2007 (CAMH Recommendations for Improved Treatment of Opioid Dependence in Ontario.) This estimate is determined using Ontario Health Insurance Program fee guidelines and assumptions about the frequency and nature of the tests.
94. Gourlay, D., H. Heit and Y. Caplan. 2006 (November 1). *Urine Drug Testing in Clinical Practice: Dispelling the Myths and Designing Strategies* (3rd ed.). Stamford, CT: PharmaCom Group.
95. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines.* Toronto: Author.

96. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines* (p. 7). Toronto: Author.
97. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines* (p. 8). Toronto: Author.
98. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines* (p. 28) Toronto: Author.
99. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
100. Gourlay, D. Presentation to the Methadone Maintenance Treatment Practices Task Force, March 21, 2007. Rational Drug Testing in Methadone Maintenance.
101. Personal communication, Dr. Douglas Gourlay, March 28, 2007.
102. Personal communication, Dr. Gregory Flynn, Managing Director, Quality Management Program – Laboratory Services, Ontario Medical Association, March 13, 2007.
103. Personal communication, Gail Czukar, Centre for Addiction and Mental Health, January 24, 2007 and March 13, 2007 (CAMH Recommendations for Improved Treatment of Opioid Dependence in Ontario.) This estimate is determined using Ontario Health Insurance Program fee guidelines and assumptions about the frequency and nature of the tests.
104. College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines*. Toronto: Author.
105. Ontario Ministry of Correctional Services. 1999 (October). *Health Care Services Policy and Procedures: Methadone*. Toronto: Author; Ontario Ministry of Community Safety and Correctional Services. 2007 (February). Clinical Services: Methadone. Toronto: Author.
106. Isaac P., A. Kalvic, J. Brands and E. Janecek, eds. 2004. M*ethadone Maintenance: A Pharmacist's Guide to Treatment* (2nd ed.). Toronto: Centre for Addiction and Mental Health.
107. Ontario College of Pharmacy: Policy for Dispensing Methadone – Effective September 1, 2006. Toronto: Author.
108. College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses*. Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.
109. Martin, G., B. Brands and D. Marsh, eds. 2003. *Methadone Maintenance: A Counsellor's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.
110. College of Physicians and Surgeons of Ontario, Annual Methadone Prescribers' Conference, November 27, 2006.
111. Fischer, B. et al. 2004. "Determinants of Overdose Incidence among Illicit Opioid Users in 5 Canadian Cities." *Canadian Medical Association Journal* 171(3): 235–39.
112. Fischer B., D. Cape, N. Daniel and L. Gliksman. 2002. "Methadone Treatment in Ontario After the 1996 Regulation Reforms: Results of a Physician Survey." *Annals of Internal Medicine* 153(7): 2S11–21.
113. Dewa, C.S., J.S. Hosch and P. Goering. 2001. "Using Financial Incentives to Promote Shared Mental Health Care." *Canadian Journal of Psychiatry* 46: 488–95.
114. Personal communication, Dr. Diane Rothon, Medical Director, Addictions Medicine, Vancouver Island Health Authority, March 30, 2007.
115. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
116. Erdelyan, M. 2000. *Methadone Maintenance Treatment: A Community Planning Guide*. Toronto: Centre for Addiction and Mental Health
117. HomeComing Community Choice Coalition. 2005. *Yes, in My Back Yard*. Toronto: Author.
118. Thanks are extended to Christopher Smith for bringing this concept to the attention of the task force.
119. Lucas, W.J., Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).
120. Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." J*ournal of Addictive Diseases* 24(1): 39–51.
121. Dr. William J. Lucas, Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).

PART D:

Conclusions and Recommendations

10. Conclusions: Success Factors

The task force identified five critical success factors that must be put in place if successful changes are to be made to MMT services in Ontario:

- sufficient resources
- an information management system
- a comprehensive long-term provincial drug strategy
- overall provincial accountability
- a commitment to implementation

10.1 Sufficient Resources

The task force believes that the Ministry of Health and Long-Term Care must provide sufficient resources to support a comprehensive range of integrated methadone maintenance treatment services that include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone dispensing (Recommendation 1). There is a particular need for treatment options and services such as detoxification, withdrawal management and self-help support. For example, many people who want to stop a low or moderate dose of oral opiate medication do not have access to appropriate detoxification and withdrawal management services (inpatient, outpatient, home detoxification). Similarly, more difficult patients with serious opiate dependencies who want to be clean of their opiates, are highly motivated and have excellent support need inpatient medical detoxification facilities.

The task force made a number of recommendations that address the need for appropriate payment and support for physicians, pharmacists and counsellors (Recommendations 15, 16 and 17). The task force also recommended a phasing in of caps on the maximum number of point-of-care urine drug tests to be compensated per patient receiving MMT, with the proviso that as caps are phased in the Ministry should provide appropriate funds to support comprehensive MMT services (Recommendation 10).

Although the Ministry invests about $2.5 million for methadone treatment services, no new funding has been targeted specifically for comprehensive methadone treatment clinics or programs over the past few years.[122] The Ministry's Addiction Programs estimates that it will cost about $5 million annually to expand existing community-based MMT services and to establish new comprehensive methadone treatment programs in parts of the province that are underserved.[123] This new funding would be used to establish or enhance such services as case management and counselling. (The funding would not be used for physician fees, which will continue to be covered by Ontario Health Insurance Plan billings; drug costs, which are covered through the Ontario Drug Benefit or Trillium

programs; or the cost of nurse practitioners, covered by other Ministry funding. In addition to the $5 million funding, the Ministry might also incur an increase in physician and drug costs for clients treated by community physicians.)

The task force recommends that:

R23 the Ministry of Health and Long-Term Care provide appropriate funds to expand and support comprehensive methadone maintenance treatment services in Ontario.

10.2 Information Management System

Currently, the College of Physicians and Surgeons of Ontario keeps a list of physicians who prescribe MMT and the patients who receive this care. Physicians who prescribe MMT use different methods to keep track of their patients. Individual physicians and those who work in MMT group practices may keep paper records or use custom-made or off-the-shelf software to support electronic patient records. There is no central database that tracks wait times for methadone services or collects data on access, quality and safety, and errors.

The task force discussed the feasibility of recommending a single information system for MMT patients but concluded that a patient record or system focused on MMT would be too narrow and limiting. The Ontario government has increased its efforts to develop larger information systems that support improved access to a broader range of services and promote the flow of patient information across organizations (e.g., Smart Systems for Health, Wait Time Information System, Enterprise Master Patient Index or patient registry, Family Health Team information systems). There have also been discussions about developing information systems that link all aspects of primary care.

In 2004, an Ontario Coroner's inquest looking at methadone-related deaths observed that other drugs played a significant role in these deaths.[124] The jury recommended a study to assess the feasibility of setting up a centralized computer monitoring system for all prescribed/dispensed drugs in Ontario that can be accessed by all regulated health professionals involved in a patient's care. The jury suggested that the study take into account a possible pilot with the methadone treatment community. Over the course of the consultations conducted by the task force, it became clear that MMT is part of a larger issue of multiple-drug prescribing, dispensing and using in many communities. These unsafe practices can lead to addictions. The task force concluded that the province needs a comprehensive information system that tracks prescribing and dispensing activity for all drugs and pharmacies across the province. As one person noted in the community consultations, "We need a provincewide tracking system for prescriptions to promote safety and avoid harm."

British Columbia established such a provincial pharmacy system in 1996. PharmaNet currently links most emergency departments, all community pharmacies, many hospital pharmacies and many medical practices to a central database. An evaluation of PharmaNet in early 2000 found that 20% of all drug profiles obtained through the service affected treatment decisions.[125] In 2005, PharmaNet captured 41 million prescriptions at community pharmacies across BC.[126] Early in 2006, PharmaNet was expanded to medical practices. Each prescription has seven individual checks. Warnings are classified by severity; 12% of them are flagged as "most significant," a designation that helps professionals avoid serious medication errors. The system is also providing a patient drug profile and drug interaction database.

The task force believes that Ontario should develop a computerized, Web-based information system to track prescribing and dispensing activity for all prescriptions in Ontario to help promote public safety. This initiative should build on current systems where appropriate, such as the Ontario Drug Benefit Program, which tracks drugs approved for ODB payment.

The task force recommends that:

R24 the Ministry of Health and Long-Term Care develop a computerized, Web-based information system to track prescribing and dispensing activity for all prescriptions in Ontario with the goal of promoting public safety. This initiative should build on current systems where appropriate, such as the Ontario Drug Benefit Program.

10.3 Provincial Drug Strategy

Methadone maintenance treatment is a valuable but small piece of the large area of addictions. Although the focus of the public consultations was MMT, the task force heard heartfelt stories about the significant impact of addictions on human lives from a wide range of people, including those with addictions, parents of children with addictions, spouses of people with addictions, families who lost loved ones with addictions through suicide or accidental overdose, physicians, nurses, pharmacists, managers, administrators, community members, the police and others. Although the stories varied and many issues were raised, the common theme was that addiction is a widespread problem that needs to be addressed immediately. Some comments included:

- "My 15-year-old son overdosed on methadone and antidepressants that he bought in the schoolyard. I found methadone purchase sites on the Internet. A search for 'purchase methadone' resulted in 9,730 sites."
- "I've seen patients in the emergency department who got prescriptions filled on the Internet and sent from a Toronto pharmacy."
- "If we're going to write prescriptions for narcotics, we need more training. Doctors are shovelling narcotics out the door without knowing what they're doing. There are real

problems treating chronic pain. We do a crappy job of chronic pain management."
- "The use of narcotics in this area has been normalized. It's what you do."
- "Methadone isn't the end of the story. If you don't deal with root causes, they will bubble up in other ways. These people are more than just methadone."

In particular, the task force heard from many representatives of First Nations communities about the widespread use of drugs both on and off reserves, in cities such as Toronto and in remote areas. There were concerns about easy access to drugs and the need for appropriate treatments that are integrated with traditional approaches to healing. The Centre for Addiction and Mental Health has made Aboriginal health a strategic priority. CAMH is able to design and deliver addiction management that includes use of the telemedicine network.

Over the past decade, there has been a dramatic change in the types of opioids used across North America.[127] The number of people who use illicit prescription opioids has increased and, in many areas of Canada, the use of illicit prescription opioids is much more common than illicit heroin use. As one person noted, "There's an explosion of prescription opioid use. It's really critical." This shift in addictive substances may be related to changes in the marketing and prescribing of controlled-release opioids.

The inappropriate use of the opioid oxycodone appeared to be of particular concern throughout the consultations. Oxycodone is a narcotic pain reliever manufactured under brand names such as OxyContin, Percocet, Percodan and Tylox. The use of oxycodone - especially OxyContin which is an oral, slow-release form of the drug - has increased in North America. OxyContin was approved in 1995 in the United States to treat moderate to severe pain lasting more than a few days. By 2001, OxyContin was the most prescribed brand-name narcotic medication for treating moderate-to-severe pain in the US. The US Drug Enforcement Administration expressed concern that the manufacturer of OxyContin (Purdue Pharma) aggressively marketed the medication for a wide range of conditions to physicians who may not have been adequately trained in pain management. It its review of OxyContin, the US General Accounting Office (GAO) found that the manufacturer encouraged physicians - including primary care specialists - to prescribe OxyContin not only for cancer pain but as an initial opioid treatment for moderate-to-severe noncancer pain.[128] OxyContin prescriptions – especially those for noncancer pain - grew rapidly and by 2003 nearly half of all OxyContin prescribers in the US were primary care physicians. The increased availability of OxyContin, how it was marketed, and the general abuse and diversion of prescription drugs in some areas all contributed to the abuse and diversion of this drug in the US.

Concerns about oxycodone abuse and diversion have also been documented in Canada. For example, the Government of Newfoundland and Labrador's Task Force on the Abuse of OxyContin found increased use of the drug among adolescents, an increase in the number of prescriptions, increased criminal activity and double doctoring to obtain OxyContin, and problems sharing information to address such issues as double-doctoring

and over prescribing.[129] In August 2004, the task force made 50 recommendations to manage OxyContin and other related narcotics abuse in such areas as individual and system practices that support misuse, education, detoxification, treatment, harm reduction strategies, legislation and policy, information and research.

Another example of concerns about oxycodone is the City of Greater Sudbury's OxyContin/Narcotic Abuse Task Force which found a significant use of illegal OxyContin in the city, an apparent lack of understanding of how dangerous and addictive the drug is when used inappropriately, people from all walks of life who are addicted to the drug for a variety of reasons, and young people as early as grade seven who are experimenting with such drugs without concern.[130] Representatives of the OxyContin/Narcotic Abuse Task Force came to the MMT community consultation held in Sudbury. This task force has identified local solutions targeted at schools, physicians and pharmacists, the general public, and people addicted to drugs. The task force is continuing to research the problems and opportunities associated with OxyContin/narcotic abuse and misuse.

A final example of concerns with oxycodone are the words of the public and providers who came to the MMT community consultations:

- "OxyContin and Percocets are having a devastating effect on our community. These are the drugs of choice for most users with addictions. Three years ago, we never heard about them."
- "OxyContin is a real concern. Giving people a month supply of this drug is a problem."
- "We're seeing huge prescriptions for OxyContin, especially from walk-in clinics that seem to overprescribe. The Ministry should stop paying for this drug."
- "Big pharma is really pushing opiates. I have many patients who are addicted to pain medication such as OxyContin. I'm even prescribing methadone to a former patient who got addicted to the pain medication that I prescribed for him."

The Task Force believes that the issues surrounding drug addiction are complex and need to be addressed using the following "four pillars:"

- health promotion and prevention strategies to promote healthy families and communities, prevent or delay the start of substance use and reduce harm associated with substance use
- programs for those who need treatment for drug addiction, including outpatient and peer counselling, daytime and residential treatment, methadone maintenance treatment, housing support and ongoing medical care
- enforcement activities that improve public safety, respond effectively to crime and criminal behaviour and link drug users to needed services
- harm reduction strategies that focus primarily on reducing adverse health, social and economic consequences of mood-altering substances in people who take drugs, their families and communities

These four pillars should be part of a comprehensive long-term provincial drug strategy that identifies solutions to meet the needs of Ontario's diverse population (e.g., multicultural urban populations, First Nations, etc.). The importance of a comprehensive provincial drug strategy has been noted by others.[131] Recognizing that it will take time to partner with appropriate groups to develop a comprehensive strategy for Ontario, the Ministry of Health and Long-Term Care should begin by addressing the critical issue of the abuse and diversion of oxycodone in the province. This work should build on the work being done in Ontario, Canada and other countries, and serve as the first step towards the development of a comprehensive long-term drug strategy for the province.

The task force recommends that:

R25 the Ministry of Health and Long-Term Care address the critical issue of the abuse and diversion of oxycodone in the province. This should build on the work being done in Ontario, Canada and other countries, and serve as the first step towards the development of a comprehensive long-term drug strategy for the province that includes health promotion and prevention strategies, treatment programs, enforcement activities for public safety and harm reduction strategies.

10.4 Provincial Accountability for Methadone Maintenance Treatment

A number of organizations have responsibility for various pieces of MMT in Ontario. As noted in Chapter 5 (Who Does What in Methadone Maintenance Treatment), the College of Physicians and Surgeons of Ontario administers the prescribing of MMT in Ontario. Within the provincial government, the Ministry of Health and Long-Term Care oversees a number of areas and initiatives that affect MMT. In addition, other organizations, such as the Centre for Addiction and Mental Health, play an influential role in MMT services, education and research.

The current system of diverse accountabilities makes it difficult to know who is responsible for and should champion MMT issues. For example, although the task force was mandated to examine MMT, it discovered that buprenorphine is a treatment for opioid addiction that has promising potential. Unlike Australia, Germany, the United Kingdom and the United States, Canada has not seen an expansion of its range of available opioid substitution treatment beyond MMT (e.g., buprenorphine, LAAM and naltrexone).[132] In some countries such as France, primary care physicians provide buprenorphine in their community practices.

The task force believes that there should be clearer accountability for MMT in Ontario. The Ministry of Health and Long-Term Care should identify a single point of authority and accountability for MMT within the Ministry that would coordinate MMT efforts and maximize the use of resources for the benefit of people who use MMT. The Ministry

should strike an interdisciplinary group of advisers – including people using MMT, prescribers, pharmacists, nurses, counsellors and others – to meet regularly to provide strategic advice on MMT issues and trends.

The task force recommends that:

R26 the Ministry of Health and Long-Term Care identify a single point of authority and accountability for methadone maintenance treatment within the Ministry that would coordinate MMT efforts and maximize the use of resources for the benefit of Ontarians who use MMT. The Ministry should also strike an Advisory Panel – made up of people using MMT, prescribers, pharmacists, nurses, counsellors and others – to provide ongoing strategic advice on MMT issues and trends.

10.5 Commitment to Implementation

After gathering of information, input, study and discussion, the task force offers 26 recommendations to the Deputy Minister of Health and Long-Term Care for his consideration. A commitment to implementation represents a willingness to follow through with recommended changes. To assist the Ministry to implement the task force's report, a work plan is presented (Chapter 12).

11. Consolidated List of Recommendations

Access to a Comprehensive Range of Integrated Services

The task force recommends that:

R1 the Ministry of Health and Long-Term Care develop a provincial strategy and policies to ensure that Ontarians have equitable access to a comprehensive range of integrated methadone maintenance treatment (MMT) services that include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone dispensing. Local Health Integration Networks (LHINs) should develop plans to ensure that people living within the LHIN have access to the full range of MMT services (e.g., designate an MMT expert lead to advise on access to comprehensive services within the LHIN).

R2 the Ministry of Health and Long-Term Care build on its Primary Care Reform priorities by strongly encouraging and supporting Family Health Teams to provide comprehensive methadone maintenance treatment where access to care close to home is an issue. Local Health Integration Networks should strongly encourage and

support Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies to work together to provide comprehensive MMT where access to care close to home is an issue. LHINs should link this responsibility to new and ongoing funding in their accountability agreements with these organizations.

R3 the Ontario Telemedicine Network develop and submit to the Ministry of Health and Long-Term Care a telemedicine methadone maintenance treatment plan that includes a work plan, deliverables and resource requirements for using telemedicine technology to improve access to comprehensive MMT in underserviced, rural and remote areas of the province. This plan should support best practices, be consistent with federal legal requirements, conform to MMT guidelines and policies from the provincial regulatory colleges, and serve as a foundation for a full telemedicine addiction counselling and case management program in Ontario in the long term.

The Importance of an Initial Comprehensive Assessment and Standard Information on Treatment Options

The task force recommends that:

R4 the Ministry of Health and Long-Term Care – in consultation with addiction specialists, methadone prescribers, specialists in medical ethics, users and non-users of methadone maintenance treatment (MMT) and pharmacists – develop a communication strategy that includes standardized information and education provided in innovative ways and targeted at Ontarians who are considering MMT. Options that should be considered include Web-based and visual tools (e.g., a CD) in multiple languages on the range of treatment options, what to expect with MMT and questions to ask before consenting to methadone treatment.

The Importance of Interdisciplinary Treatment

The task force recommends that:

R5 the Ontario Pharmacy Council develop and submit to the Ministry of Health and Long-Term Care a plan to enhance the role of pharmacists in methadone maintenance treatment. This plan should include training requirements and practice guidelines, and identify any legislative requirements that may be needed.

R6 the Ministry of Health and Long-Term Care support amendments to provincial regulations that would enable primary healthcare nurse practitioners to prescribe and administer methadone for opioid dependence within communities and in situations where access to methadone maintenance treatment is limited. Additional training, standards and guidelines, a system of practice audits and clear accountabilities should be put in place to support these activities. Furthermore, to enable this change, the Ministry should seek support from Health Canada for appropriate amendments to the federal legislation.

R7 Local Health Integration Networks strongly encourage and support public acute care hospitals that have pharmacies to dispense methadone to meet the needs of local communities where access to methadone maintenance treatment is limited.

Standards and Guidelines to Support Best Practices

The task force recommends that:

R8 the Registered Nurses' Association of Ontario develop best practice guidelines for nurses who provide methadone maintenance treatment services. In addition, the College of Nurses of Ontario should develop nursing standards to support the recommended role of primary healthcare nurse practitioners in prescribing and administering methadone (Recommendation 6).

R9 the Centre for Addiction and Mental Health, in partnership with the College of Social Work, the College of Psychologists and others as appropriate, lead the development of standards and guidelines for addiction counsellors, with a particular emphasis on methadone maintenance treatment.

R10 the Ministry of Health and Long-Term Care use the current guidelines of the College of Physicians and Surgeons of Ontario for urine drug screening as the standard for reimbursing point-of-care testing for physicians who provide methadone maintenance treatment in Ontario. The Ministry should phase in caps on the maximum number of point-of-care urine drug tests in the Ontario Health Insurance Program fee schedule that will be compensated per patient receiving MMT within a defined period of time. As it phases in caps, the Ministry should provide appropriate physician reimbursement (Recommendation 15) and funds to expand and support comprehensive MMT services (Recommendations 17 and 23).

R11 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to work in partnership with other organizations (such as the Ontario Hospital Association, Ontario Medical Association, Centre for Addiction and Mental Health and others) to develop educational sessions on the emergency and hospital care of persons who are receiving methadone maintenance therapy. These educational sessions should be targeted at hospital and medical staff and include the development of protocols for hospitals to use when treating persons who take methadone.

R12 the Ministry of Health and Long-Term Care work in collaboration with the Ministry of Community Safety and Correctional Services to ensure that standard provincial admission and discharge policies and procedures are followed for persons receiving methadone maintenance treatment who are serving in correctional facilities (including prisons, detention centres and other facilities).

Education to Ensure Appropriate Treatment

The task force recommends that:

R13 the Centre for Addiction and Mental Health, in consultation with the Canadian Society of Addiction Medicine and others, continue to develop and offer educational courses in addictions in partnership with schools of medicine, nursing, pharmacy, psychology and social work in Ontario. Where possible, clinicians taking these courses should be awarded continuing education or continuing professional development credits by their employers, associations and/or colleges.

R14 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop educational initiatives, including: i) a second-level methadone maintenance treatment course for prescribing physicians; ii) a provincial mentorship program for new MMT prescribers; iii) addiction medicine educational sessions; and iv) a clinical support system for methadone clinicians modelled after, or integrated with, the Centre of Addiction and Mental Health's (CAMH) Addiction Clinical Consultation Service. These initiatives should be developed in consultation with other organizations, such as CAMH and the Canadian Society of Addiction Medicine.

Appropriate Payment and Support

The task force recommends that:

R15 the Ministry of Health and Long-Term Care phase in blended physician payment models to support methadone maintenance treatment services. These models should build on the Ministry's priorities in Primary Care Reform, and be evaluated for their impact on access, quality, efficiency and effectiveness.

R16 the Ontario Pharmacy Council determine, and advise the Ministry of Health and Long-Term Care on, the most appropriate funding model to encourage pharmacists to dispense methadone maintenance treatment.

R17 the Ministry of Health and Long-Term Care allocate funding to Family Health Teams for addiction and methadone maintenance treatment counselling and case management services (e.g., case managers, information to help patients navigate the system, etc.). In addition, Local Health Integration Networks should allocate funding to Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies for MMT counselling and case management services.

R18 the Ministry of Health and Long-Term Care identify ways to improve access to methadone maintenance treatment services for people who live in underserviced areas and have difficulties obtaining treatment. Potential options include travel subsidies for patients, and incentives to attract prescribers and other providers to underserviced areas.

Best Approaches to Integrate Methadone Maintenance Treatment into Society and Communities

The task force recommends that:

R19 the Ministry of Health and Long-Term Care bring stakeholders together to develop a public education campaign that addresses the stigma associated with addictions and methadone maintenance treatment. Stakeholders should include people receiving MMT, the Centre for Addiction and Mental Health, the College of Physicians and Surgeons of Ontario, prescribers, Local Health Integration Networks and others. A key message should be that MMT is one treatment for opioid addiction that, when used appropriately, promotes wellness.

R20 the Centre for Addiction and Mental Health, in collaboration with the Ministry of Health and Long-Term Care, update its resource book to guide the introduction of methadone maintenance treatment services into communities. This resource book should support the principle of openness, identify clear steps on engaging the community, and include requirements to establish community advisory/liaison groups and use a peer support model. In addition, CAMH should provide consultative support to help guide the integration of MMT services into communities.

R21 Local Health Integration Networks, in consultation with ConnexOntario, Health Services Information, develop comprehensive lists of services relevant to users and providers of methadone maintenance treatment and addiction services.

Public Accountability for Quality Assurance

The task force recommends that:

R22 the Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop and implement a plan to assess physician group practices that provide methadone maintenance treatment. These assessments should review a group's practices, policies, procedures and organization of services, and include clear accountabilities for standards, guidelines and best practices. As part of ongoing public accountability, the Ministry and Local Health Integration Networks should continue to oversee the services provided by government-funded organizations (e.g., hospitals, Community Health Centres, Community Care Access Centres, addiction and mental health agencies, Family Health Teams, etc.).

Conclusions: Critical Success Factors

The task force recommends that:

R23 the Ministry of Health and Long-Term Care provide appropriate funds to expand and support comprehensive methadone maintenance treatment services in Ontario.

R24 the Ministry of Health and Long-Term Care develop a computerized, Web-based information system to track prescribing and dispensing activity for all prescriptions in Ontario with the goal of promoting public safety. This initiative should build on current systems where appropriate, such as the Ontario Drug Benefit Program.

R25 the Ministry of Health and Long-Term Care address the critical issue of the abuse and diversion of oxycodone in the province. This should build on the work being done in Ontario, Canada and other countries, and serve as the first step towards the development of a comprehensive long-term drug strategy for the province that includes health promotion and prevention strategies, treatment programs, enforcement activities for public safety and harm reduction strategies.

R26 the Ministry of Health and Long-Term Care identify a single point of authority and accountability for methadone maintenance treatment within the Ministry that would coordinate MMT efforts and maximize the use of resources for the benefit of Ontarians who use MMT. The Ministry should also strike an Advisory Panel – made up of people using MMT, prescribers, pharmacists, nurses, counsellors and others – to provide ongoing strategic advice on MMT issues and trends.

Notes

122. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
123. Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.
124. Lucas, W.J., Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).
125. Kent, H. 2000 (April 18). "BC's PharmaNet System Proving Convenient." *Canadian Medical Association Journal* 162(8): 1192.
126. "British Columbia Expands PharmaNet." 2006 (May 25). *Canadian Healthcare Technology*. Retrieved April 1, 2007. <http://www.canhealth.com/News359.html>.
127. Czukar, G. and B. Savage. 2007 (January 24). R*ecommendations for Improved Treatment of Opioid Dependence in Ontario*. Toronto: Centre for Addiction and Mental Health.
128. US General Accounting Office. 2003 (December). Report to Congressional Requesters. *Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*. Washington, DC: Author. Retrieved April 1, 2007. <http://www.gao.gov/new.items/d04110.pdf>.
129. Government of Newfoundland and Labrador. 2004 (June 30). *OxyContin Task Force Final Report*. Submitted to the Honourable Elizabeth Marshall (Minister of the Department of Health and Community Services), the Honourable John Ottenheimer (Minister of the Department of Education) and the Honourable Tom Marshall (Minister of the Department of Justice).
130. City of Greater Sudbury OxyContin/Narcotic Abuse Task Force. 2005 (November 21). *OxyContin/ Narcotic Abuse Task Force*. Sudbury: Author.
131. For example, see The Toronto Drug Strategy Advisory Committee. 2005 (October). *The Toronto Drug Strategy: A comprehensive approach to alcohol and other drugs*. Toronto: Author.
132. Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.

12. Work Plan

The task force presents the following work plan for the Deputy Minister's consideration.

Recommendations can be implemented in the short term (1–6 months), medium term (6–12 months) or long term (12–18 months). Some recommendations are ongoing in nature. A number of medium- and long-term recommendations require planning and development before they can be implemented. This planning should begin immediately.

Recommendation	Responsibility	Timing
R1 The Ministry of Health and Long-Term Care develop a provincial strategy and policies to ensure that Ontarians have equitable access to a comprehensive range of integrated methadone maintenance treatment (MMT) services that include information and advice on all treatment options, medical care, counselling and support, case management, health promotion, disease prevention and education, and methadone dispensing. Local Health Integration Networks (LHINs) should develop plans to ensure that people living within the LHIN have access to the full range of MMT services (e.g., designate an MMT expert lead to advise on access to comprehensive services within the LHIN).	Ministry of Health and Long-Term Care: develop strategy and policies. Consider with Recommendation 25 Local Health Integration Networks: develop plans	Medium term
R2 The Ministry of Health and Long-Term Care build on its Primary Care Reform priorities by strongly encouraging and supporting Family Health Teams to provide comprehensive methadone maintenance treatment where access to care close to home is an issue. Local Health Integration Networks should strongly encourage and support Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies to work together to provide comprehensive MMT where access to care close to home is an issue. LHINs should link this responsibility to new and ongoing funding in their accountability agreements with these organizations.	Ministry of Health and Long-Term Care: pilot/phase in the changes Local Health Integration Networks: identify and address areas with significant access issues	Immediate planning Long term Ongoing
R3 The Ontario Telemedicine Network develop and submit to the Ministry of Health and Long-Term Care a telemedicine methadone maintenance treatment plan that includes a work plan, deliverables and resource requirements for using telemedicine technology to improve access to comprehensive MMT in underserviced, rural and remote areas of the province. This plan should support best practices, be consistent with federal legal requirements, conform to MMT guidelines and policies from the provincial regulatory colleges, and serve as a foundation for a full telemedicine addiction counselling and case management program in Ontario in the long term.	Ontario Telemedicine Network: develop plan Ministry of Health and Long-Term Care: consider approval to implement	Short term
R4 The Ministry of Health and Long-Term Care – in consultation with addiction specialists, methadone prescribers, specialists in medical ethics, users and non-users of methadone maintenance treatment (MMT) and pharmacists – develop a communication strategy that includes standardized information and education provided in innovative ways and targeted at Ontarians who are considering MMT. Options that should be considered include Web-based and visual tools (e.g., a CD) in multiple languages on the range of treatment options, what to expect with MMT and questions to ask before consenting to methadone treatment.	Ministry of Health and Long-Term Care: convene group and develop strategy	Medium term
R5 The Ontario Pharmacy Council develop and submit to the Ministry of Health and Long-Term Care a plan to enhance the role of pharmacists in methadone maintenance treatment. This plan should include training requirements and practice guidelines, and identify any legislative requirements that may be needed.	Ontario Pharmacy Council: develop plan Ministry of Health and Long-Term Care: consider plan for support	Long term

Recommendation	Responsibility	Timing
R6 The Ministry of Health and Long-Term Care support amendments to provincial regulations that would enable primary healthcare nurse practitioners to prescribe and administer methadone for opioid dependence within communities and in situations where access to methadone maintenance treatment is limited. Additional training, standards and guidelines, a system of practice audits and clear accountabilities should be put in place to support these activities. Furthermore, to enable this change, the Ministry should seek support from Health Canada for appropriate amendments to the federal legislation.	Ministry of Health and Long-Term Care: examine and support amendments to provincial regulation; seek support from Health Canada	Immediate planning Long term
R7 Local Health Integration Networks strongly encourage and support public acute care hospitals that have pharmacies to dispense methadone to meet the needs of local communities where access to methadone maintenance treatment is limited.	Local Health Integration Networks: consult with hospitals to implement	Short term
R8 The Registered Nurses' Association of Ontario develop best practice guidelines for nurses who provide methadone maintenance treatment services. In addition, the College of Nurses of Ontario should develop nursing standards to support the recommended role of primary healthcare nurse practitioners in prescribing and administering methadone (Recommendation 6).	Registered Nurses' Association of Ontario: develop guidelines, College of Nurses of Ontario: develop standards	Medium term
R9 The Centre for Addiction and Mental Health, in partnership with the College of Social Work, the College of Psychologists and others as appropriate, lead the development of standards and guidelines for addiction counsellors, with a particular emphasis on methadone maintenance treatment.	Centre for Addiction and Mental Health, in partnership with colleges of social work, psychologists and appropriate others: develop standards and guidelines	Medium term
R10 The Ministry of Health and Long-Term Care use the current guidelines of the College of Physicians and Surgeons of Ontario for urine drug screening as the standard for reimbursing point-of-care testing for physicians who provide methadone maintenance treatment in Ontario. The Ministry should phase in caps on the maximum number of point-of-care urine drug tests in the Ontario Health Insurance Program fee schedule that will be compensated per patient receiving MMT within a defined period of time. As it phases in caps, the Ministry should provide appropriate physician reimbursement (Recommendation 15) and funds to expand and support comprehensive MMT services (Recommendations 17 and 23).	Ministry of Health and Long-Term Care: develop process and procedures to phase in caps	Immediate planning Long term
R11 The Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to work in partnership with other organizations (such as the Ontario Hospital Association, Ontario Medical Association, Centre for Addiction and Mental Health and others) to develop educational sessions on the emergency and hospital care of persons who are receiving methadone maintenance therapy. These educational sessions should be targeted at hospital and medical staff and include the development of protocols for hospitals to use when treating persons who take methadone.	Ministry of Health and Long-Term Care: provide support College of Physicians and Surgeons of Ontario: consult with appropriate partners and develop courses and protocols	Medium term planning Long term to implement
R12 The Ministry of Health and Long-Term Care work in collaboration with the Ministry of Community Safety and Correctional Services to ensure that standard provincial admission and discharge policies and procedures are followed for persons receiving methadone maintenance treatment who are serving in correctional facilities (including prisons, detention centres and other facilities).	Ministry of Health and Long-Term Care: consult with Ministry of Community Safety and Correctional Services on policies and procedures, and communicate to field	Short term
R13 The Centre for Addiction and Mental Health, in consultation with the Canadian Society of Addiction Medicine and others, continue to develop and offer educational courses in addictions in partnership with schools of medicine, nursing, pharmacy, psychology and social work in Ontario. Where possible, clinicians taking these courses should be awarded continuing education or continuing professional development credits by their employers, associations and/or colleges.	Centre for Addiction and Mental Health: Develop in consultation with others, and offer educational courses with schools	Ongoing

Recommendation	Responsibility	Timing
R14 The Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop educational initiatives, including: i) a second-level methadone maintenance treatment course for prescribing physicians; ii) a provincial mentorship program for new MMT prescribers; iii) addiction medicine educational sessions; and iv) a clinical support system for methadone clinicians modelled after, or integrated with, the Centre of Addiction and Mental Health's (CAMH) Addiction Clinical Consultation Service. These initiatives should be developed in consultation with other organizations, such as CAMH and the Canadian Society of Addiction Medicine.	Ministry of Health and Long-Term Care: provide support College of Physicians and Surgeons of Ontario: consult with others to develop educational initiatives	Short term planning Long term to implement
R15 The Ministry of Health and Long-Term Care phase in blended physician payment models to support methadone maintenance treatment services. These models should build on the Ministry's priorities in Primary Care Reform, and be evaluated for their impact on access, quality, efficiency and effectiveness.	Ministry of Health and Long-Term Care: develop process and procedures to phase in blended physician payment models for MMT; pilot and/or phase in changes	Immediate planning Long term
R16 The Ontario Pharmacy Council determine, and advise the Ministry of Health and Long-Term Care on, the most appropriate funding model to encourage pharmacists to dispense methadone maintenance treatment.	Ontario Pharmacy Council: determine funding model and advise Ministry	Short term to begin work Medium term to complete
R17 The Ministry of Health and Long-Term Care allocate funding to Family Health Teams for addiction and methadone maintenance treatment counselling and case management services (e.g., case managers, information to help patients navigate the system, etc.). In addition, Local Health Integration Networks should allocate funding to Community Health Centres, hospitals, Community Care Access Centres, and mental health and addiction agencies for addiction and MMT counselling and case management services	Ministry of Health and Long-Term Care: allocate funding. Consider with Recommendation 23 Local Health Integration Networks: allocate funding	Medium term
R18 The Ministry of Health and Long-Term Care identify ways to improve access to methadone maintenance treatment services for people who live in underserviced areas and have difficulties obtaining treatment. Potential options include travel subsidies for patients, and incentives to attract prescribers and other providers to underserviced areas.	Ministry of Health and Long-Term Care: identify and support improvements	Short term planning Long term to implement
R19 The Ministry of Health and Long-Term Care bring stakeholders together to develop a public education campaign that addresses the stigma associated with addictions and methadone maintenance treatment. Stakeholders should include people receiving MMT, the Centre for Addiction and Mental Health, the College of Physicians and Surgeons of Ontario, prescribers, Local Health Integration Networks and others. A key message should be that MMT is one treatment for opioid addiction that, when used appropriately, promotes wellness.	Ministry of Health and Long-Term Care: convene group and develop strategy. Consider with Recommendations 1 and 25	Short term to begin work Long term to implement
R20 The Centre for Addiction and Mental Health, in collaboration with the Ministry of Health and Long-Term Care, update its resource book to guide the introduction of methadone maintenance treatment services into communities. This resource book should support the principle of openness, identify clear steps on engaging the community, and include requirements to establish community advisory/liaison groups and use a peer support model. In addition, CAMH should provide consultative support to help guide the integration of MMT services into communities.	Centre for Addiction and Mental Health (in collaboration with Ministry of Health and Long-Term Care): update resource book and provide support	Medium term
R21 Local Health Integration Networks, in consultation with ConnexOntario, Health Services Information, develop comprehensive lists of services relevant to users and providers of methadone maintenance treatment and addiction services.	Local Health Integration Networks (in consultation with ConnexOntario): plan process and develop service lists	Medium term to begin work Long term to implement

Recommendation	Responsibility	Timing
R22 The Ministry of Health and Long-Term Care provide support to the College of Physicians and Surgeons of Ontario to develop and implement a plan to assess physician group practices that provide methadone maintenance treatment. These assessments should review a group's practices, policies, procedures and organization of services, and include clear accountabilities for standards, guidelines and best practices. As part of ongoing public accountability, the Ministry and Local Health Integration Networks should continue to oversee the services provided by government-funded organizations (e.g., hospitals, Community Health Centres, Community Care Access Centres, addiction and mental health agencies, Family Health Teams, etc.).	Ministry of Health and Long-Term Care: provide support College of Physicians and Surgeons of Ontario: develop and implement plan to assess practices. Ministry and LHINs: continue to assess services provided by government-funded organizations	Short term to begin work Long term to implement Ongoing
R23 The Ministry of Health and Long-Term Care provide appropriate funds to expand and support comprehensive methadone maintenance treatment services in Ontario.	Ministry of Health and Long-Term Care: allocate funding. Consider with Recommendation 17.	Immediate Ongoing
R24 The Ministry of Health and Long-Term Care develop a computerized, Web-based information system to track prescribing and dispensing activity for all prescriptions in Ontario with the goal of promoting public safety. This initiative should build on current systems where appropriate, such as the Ontario Drug Benefit Program.	Ministry of Health and Long-Term Care: plan and implement in phases	Short term to begin work Long term to implement
R25 The Ministry of Health and Long-Term Care address the critical issue of the abuse and diversion of oxycodone in the province. This should build on the work being done in Ontario, Canada and other countries, and serve as the first step towards the development of a comprehensive long-term drug strategy for the province that includes health promotion and prevention strategies, treatment programs, enforcement activities for public safety and harm reduction strategies.	Government of Ontario: Address issue and develop strategy. Consider with Recommendation 1	Short term to begin work Long term to implement
R26 The Ministry of Health and Long-Term Care identify a single point of authority and accountability for methadone maintenance treatment within the Ministry that would coordinate MMT efforts and maximize the use of resources for the benefit of Ontarians who use MMT. The Ministry should also strike an Advisory Panel – made up of people using MMT, prescribers, pharmacists, nurses, counsellors and others – to provide ongoing strategic advice on MMT issues and trends.	Ministry of Health and Long-Term Care: identify single authority and strike advisory panel	Short term to identify authority Medium term to strike panel

Appendices

Appendix A: Appointment Letter from the Office of Deputy Minister including Terms of Reference of the Methadone Maintenance Treatment Practices Task Force

Ministry of Health and Long-Term Care

Office of the Deputy Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 1R3
Tel (416) 327-4296
Fax (416) 326-1570

Ministère de la Santé et des Soins de longue durée

Bureau du Sous-Ministre

10th étage, Édifice Hepburn,
80 Rue Grosvenor
Toronto ON M7A 1R3
Tél (416) 327-4296
Téléc (416) 326-1570

Ontario

I06-02518

APR 2 5 2006

Mr. Anton Hart
Publisher
Longwoods Publishing
18 Eastern Avenue
Toronto ON M5A 1H5

Dear Mr. Hart: Anton

I am pleased to appoint you as chair of the Methadone Maintenance Treatment Practices Task Force. This appointment is effective for one year.

The positive value of methadone treatment for people with opioid addictions and society as a whole is significant. Our government wants to make sure there is access to high quality methadone treatment in Ontario and that this treatment is provided in a safe, effective and affordable manner.

The complexity of methadone maintenance treatment has been highlighted in the recommendations from a recent coroner's inquest into the methadone-related deaths of four people in Oshawa as well as various media reports on methadone treatment clinic practices. Issues have been identified that require improvements to the provision of methadone and the need for guidance and leadership in this field. It is with this in mind that I have established the Methadone Maintenance Treatment Practices Task Force.

The work and advice of the Methadone Maintenance Treatment Practices Task Force is important in ensuring that people who are opioid dependent continue to have access to excellent care in our province. The task force is made up of experts in the field of methadone treatment, representation from regulatory bodies, consumers and other important stakeholders. Your perspective will be invaluable to the work of the task force.

Mr. Anton Hart

I appreciate your willingness to accept this responsibility and hope it will prove to be a valuable and rewarding experience. I have enclosed a copy of the terms of reference for your information. If you have any questions, please contact Ms. Carrie Hayward, Director, Mental Health and Addictions Branch at (416) 314-1864.

Thank you for your interest in this task force. Please accept my best wishes and I look forward to receiving the task force's report.

Sincerely,

Ron Sapsford
Deputy Minister

Enclosure

Methadone Maintenance Treatment Practices Task Force

Background:
Methadone maintenance treatment (MMT) is still the clinical standard and the most widely used form of treatment for people who are dependent on opiods. (Health Canada, Best Practices Methadone Maintenance Treatment, 2002) The ministry is committed to ensuring access to high quality methadone maintenance treatment across the province. It has been 10 years since Health Canada's regulations with respect to methadone prescription were modified to increase accessibility to treatment. During that time, Ontario has seen tremendous growth in the demand for methadone maintenance services from the 1970's when the Centre for Addiction and Mental Health opened their first clinic in Toronto to treat 100 clients. There are now over 14,600 people in Ontario receiving MMT from 280 physicians. It is timely to review Ontario's approach.

The majority of MMT is currently provided by physicians in solo or group practices, who bill OHIP for the services they provide. Some physicians have partnered with local community-based organizations and provide their methadone care at these locations. This approach enables clients to access other addiction services in a seamless fashion. The ministry also provides funding to two multi-disciplinary clinics in Toronto and 14 case managers across the province affiliated with existing community-based organizations and health units who also make space available to local physicians prescribing methadone. Client access to the methadone maintenance services, including transportation, is an important factor in siting clinics however responding to community issues, such as stigma also needs to be addressed.

There are a number of regulatory bodies that have responsibility for the administration and delivery of MMT services. Health Canada is responsible for granting physician exemptions to prescribe methadone under the *Controlled Drugs and Substances Act* (*CDSA*). The College of Physicians and Surgeons of Ontario (CPSO) is responsible for recommendations to Health Canada regarding exemptions of physicians and is funded by the Ministry of Health and Long-Term Care to recruit physicians, provide quality assurance and maintain a patient registry. The Ontario College of Pharmacists (OCP) is responsible for pharmacy practice in the dispensing of methadone. In addition, the Centre for Addiction and Mental Health (CAMH) has been responsible for implementing training and the internship for physicians wishing to receive an exemption as well as training for pharmacists and counsellors.

The complexity of MMT was highlighted in the recommendations from a recent coroner's inquest (2005) into the methadone-related deaths of four people in Oshawa as well as various media reports on methadone treatment clinic practices. The inquest recommended that Ontario establish a working group to review methadone maintenance treatment program, assess its effectiveness, quality, multi-disciplinary matters.

Issues have been identified that require improvements to the provision of methadone including practices, payment and the need for guidance and leadership in this field. With this in mind, the ministry has established the Methadone Maintenance Treatment Practices Task Force.

Purpose:
The purpose of the task force is to provide the Ministry of Health and Long-Term Care with advice on the best approaches for the provision of methadone maintenance treatment in Ontario.

Objectives:
The Methadone Maintenance Treatment Practices Task Force will provide advice and guidance to the ministry in the following five areas:

1. **Access to Methadone and Appropriate Regulatory Regime**
   The task force will examine issues associated with meeting the needs of people requiring methadone maintenance treatment and specifically the following:
   - Recommendations regarding the exemption process under Section 56 of *CDSA* and associated methadone regulations
   - Advice on evaluation of the interim exemption project
   - Recommendations on changes to provincial statutes or regulations regarding audit of clinics providing methadone maintenance treatment
   - The development of model(s) for community methadone maintenance treatment

2. **Best Practices and Training**
   Guidelines have been established for Ontario physician and pharmacist practice. The task force will provide advice on the need to update these guidelines and training. Specifically:
   - Recommendations on changes to the training for physicians, pharmacists and counsellors as well as specific training for nurses
   - Recommendations for practice guidelines for physicians, pharmacists, counsellors and "delegated persons" as well as the carry policy
   - Recommendations for delegation process and requirements
   - Recommendations on updating of physician internship and possible internship for other professionals

3. **Fair Payment Models**
   Payment for methadone maintenance services includes physician services, laboratory testing, and the dispensing and administration of methadone. It is important to ensure that providers are appropriately compensated for this important service. It is also important that costs associated with these services are manageable and predictable. The task force will provide advice on:
   - Appropriate payment models for physicians prescribing methadone and pharmacists/physicians for dispensing/administering methadone including models related to physician services, laboratory testing and dispensing and administration of methadone.

4. **Quality Assurance and Assessment**
   Quality assurance programs for professionals and assessment of methadone maintenance treatment practices are essential in ensuring safety for people receiving methadone as well as others in the community. The task force will provide advice on:
   - Quality assurance models, content and enforceability

5. **Community Engagement**
   The majority of methadone treatment is provided within community-based practices. The task force will provide advice on:
   - The development and implementation of effective community engagement processes for the establishment or relocation of clinics or practices

Composition:

- College of Physicians and Surgeons of Ontario
- Ontario College of Pharmacists
- College of Nurses of Ontario
- Ontario Medical Association
- Ontario Pharmacists' Association
- Registered Nurses Association of Ontario
- Registered Practical Nurses Association of Ontario
- Providers – Physicians
  - Pharmacists
  - Community methadone case management agencies (2)
- Consumers (2)
- LHIN representatives (2: urban, rural)
- Centre for Addiction and Mental Health
- Office of the Chief Coroner
- Office of Controlled Substances, Health Canada
- Director, Mental Health and Addiction Branch, MOHLTC

Chair: Independent Person with Extensive Health Care Knowledge

Role of Members:
Task Force members will represent their perspectives on the task force and contribute to the advice presented to the ministry. Each member will be responsible for consulting their stakeholders on an as needed basis and bringing those views to the task force.

Reporting:
The task force will report to the Deputy Minister of Health and Long-Term Care.

Task Force Operations:
Initially, meetings will be held monthly moving to quarterly depending on the issues.

Time-limited subgroups to address specific issues will be created to report back to the larger task force. The subgroups may involve additional people with specific expertise.

Other experts in the methadone field may be consulted or invited to attend meetings on specific issues as required by the task force.

A website address will be established should people be interested in making written submissions to the task force.

Secretariat Support and Expenses:
MOHLTC will provide secretariat services for the task force.

MOHLTC will pay travel expenses for in-person meetings based on Ontario government guidelines and format.

MOHLTC will arrange for any teleconference meetings.

Timeframe:
The timeframe will be 12 months and may be extended at the discretion of the ministry. Recommendations will be submitted to the ministry as they are completed.

Background

Methadone maintenance treatment (MMT) is still the clinical standard and the most widely used form of treatment for people who are dependent on opioids.[133] The Ministry of Health and Long-Term Care is committed to ensuring access to high-quality methadone maintenance treatment across the province. It has been 10 years since Health Canada's regulations with respect to methadone prescription were modified to increase accessibility to treatment. During that time, Ontario has seen tremendous growth in the demand for methadone maintenance services from the 1970s, when the Centre for Addiction and Mental Health opened its first clinic in Toronto to treat 100 clients. There are now over 14,600 people in Ontario receiving MMT from 280 physicians. It is timely to review Ontario's approach.

The majority of MMT is currently provided by physicians in solo or group practices, who bill OHIP for the services they provide. Some physicians have partnered with local community-based organizations and provide their methadone care at these locations. This approach enables clients to access other addiction services in a seamless fashion. The Ministry also provides funding to two multidisciplinary clinics in Toronto and 14 case managers across the province affiliated with existing community-based organizations and health units that also make space available to local physicians prescribing methadone. Client access to methadone maintenance services, including transportation, is an important factor in siting clinics; however, community issues, such as stigma, also need to be addressed.

There are a number of regulatory bodies that have responsibility for the administration and delivery of MMT services. Health Canada is responsible for granting physician exemptions to prescribe methadone under the Controlled Drugs and Substances Act (CDSA). The College of Physicians and Surgeons of Ontario (CPSO) is responsible for recommendations to Health Canada regarding exemptions of physicians and is funded by the Ministry of Health and Long-Term Care to recruit physicians, provide quality assurance and maintain a patient registry. The Ontario College of Pharmacists (OCP) is responsible for pharmacy practice in the dispensing of methadone. In addition, the Centre for Addiction and Mental Health (CAMH) has been responsible for implementing training, the internship for physicians wishing to receive an exemption, and training for pharmacists and counsellors.

The complexity of MMT was highlighted in the recommendations from a recent coroner's inquest[134] into the methadone-related deaths of four people in Oshawa as well as various media reports on methadone treatment clinic practices. The inquest recommended that Ontario establish a working group to review methadone maintenance treatment programs and assess their effectiveness, quality and multidisciplinary aspects.

Issues have been identified that require improvements to the provision of methadone, including practices, payment and the need for guidance and leadership in this field. With this in mind, the ministry has established the Methadone Maintenance Treatment Practices Task Force.

Purpose

The purpose of the task force is to advise the Ministry of Health and Long-Term Care on the best approaches for the provision of methadone maintenance treatment in Ontario.

Objectives

The Methadone Maintenance Treatment Practices Task Force will provide advice and guidance to the Ministry in the following five areas:

1. Access to Methadone and Appropriate Regulatory Regime

The task force will examine issues associated with meeting the needs of people requiring methadone maintenance treatment, and specifically the following:

- recommendations regarding the exemption process under section 56 of CDSA and associated methadone regulations
- advice on evaluation of the interim exemption project
- recommendations on changes to provincial statutes or regulations regarding audit of clinics providing methadone maintenance treatment
- the development of model(s) for community methadone maintenance treatment

2. Best Practices and Training

Guidelines have been established for Ontario physician and pharmacist practice. The task force will advise on the need to update these guidelines and training, specifically:

- recommendations on changes to the training for physicians, pharmacists and counsellors, as well as specific training for nurses
- recommendations for practice guidelines for physicians, pharmacists, counsellors and "delegated persons," as well as the carry policy
- recommendations for delegation process and requirements
- recommendations on updating of physician internship and possible internship for other professionals

3. Fair Payment Models

Payment for methadone maintenance services includes physician services, laboratory testing and the dispensing and administration of methadone. It is important to ensure that providers are appropriately compensated for this key service. It is also important that

costs associated with these services are manageable and predictable. The task force will advise on:

- appropriate payment models for physicians prescribing methadone and pharmacists/physicians for dispensing/administering methadone, including models related to physician services, laboratory testing and dispensing and administration of methadone.

4. Quality Assurance and Assessment

Quality assurance programs for professionals and assessment of methadone maintenance treatment practices are essential in ensuring safety for people receiving methadone, as well as others in the community. The task force will advise on:

- quality assurance models, content and enforceability.

5. Community Engagement

The majority of methadone treatment is provided within community-based practices. The task force will advise on:

- the development and implementation of effective community engagement processes for the establishment or relocation of clinics or practices.

Composition

- College of Physicians and Surgeons of Ontario
- Ontario College of Pharmacists
- College of Nurses of Ontario
- Ontario Medical Association
- Ontario Pharmacists' Association
- Registered Nurses Association of Ontario
- Registered Practical Nurses Association of Ontario
- Providers
  - Physicians
  - Pharmacists
  - Community methadone case management agencies (2)
- Community Representatives (2)
- LHIN representatives (2: urban, rural)
- Centre for Addiction and Mental Health
- Office of the Chief Coroner
- Office of Controlled Substances, Health Canada
- Director, Mental Health and Addiction Branch, MOHLTC

Chair

Anton Hart, Publisher, Longwoods Publishing Corporation

Role of Members

Task Force members will represent their perspectives on the task force and contribute to the advice presented to the ministry. Each member will be responsible for consulting his or her stakeholders on an as-needed basis and bringing those views to the task force.

Reporting

The task force will report to the Deputy Minister of Health and Long-Term Care.

Notes

133. Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.
134. Lucas, W.J., Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).

Appendix B: Consultations[135]

Public Meetings

An asterisk (*) denotes that written material was also received.

Ottawa (Champlain Local Health Integration Network), January 17, 2006:

- Glen Barnes,* Executive Director, Addiction Services of Eastern Ontario, Cornwall
- Antranik Boghossion, Bell Pharmacy, Ottawa
- Rob Boyd,* Director, OASIS, Sandy Hill Community Health Centre, Ottawa
- Olga Cvetkovic, Bell Pharmacy, Ottawa
- Liz Kelly,* Ottawa Carlton Detention Centre, Ottawa
- Yvon Lemire,* Director, Addictions and Problem Gambling Services, Sandy Hill Community Health Centre, Ottawa
- Dr. Bruce Marshall, University of Ottawa Health Services, Ottawa
- Jean-Francois Martinbault,* Methadone Case Manager, Addictions and Problem Gambling Services of Ottawa, Sandy Hill Community Health Centre, Ottawa
- Louise Parker,* Ottawa Carlton Detention Centre, Ottawa
- Person on Methadone Maintenance Treatment (Anonymous Male)
- Bruce Ransom, Addictions Outreach, Wabano Centre for Aboriginal Health, Vanier

Belleville (South East Local Health Integration Network), January 18, 2006:

- Dr. Brian P. Hadley, Belleville
- Dr. Meredith MacKenzie,* Street Health Centre, Kingston Community Health Centre, Kingston
- Dino Marchiori, Case Work Coordinator, Ontario Works, Hastings County, Belleville
- Dr. Douglas McIntosh, Street Health Centre, Kingston Community Health Centre, Kingston
- Jai Mills,* Executive Director, Mental Health Support Network, Hastings Prince Edward Corporation, Belleville (presented on behalf of the Coordinating Group for Mental Health and Addiction Services, Hastings and Prince Edward Counties)
- Michael Piercy, Project Consultant, Central East Region, Communications, Education and Community Health (Centre for Addiction and Mental Health), Trenton
- Ron Shore, Program Director, Street Health Centre, Kingston Community Health Centre, Kingston
- Carol Wannamaker,* Director, Patient Services, Complex Continuing Care/ Rehabilitation/Mental Health, Quinte Health Care, Belleville (presented on behalf of the Coordinating Group for Mental Health and Addiction Services, Hastings and Prince Edward Counties)

Thunder Bay (North West Local Health Integration Network), January 19, 2006:

- Margaret Anderson,* Addictions Counsellor, Medically Enhanced Comprehensive Care for Addictions (MECCA), Lake of the Woods District Hospital Community Programs, Kenora
- Nancy Black,* Manager, Addiction Services, St. Joseph's Care Group, Thunder Bay
- Paul Capon, Constance Lake First Nation/Longlac First Nation
- Dr. Frank Denson, Lakeview Clinic, Lakehead Psychiatric Hospital, St. Joseph's Care Group, Thunder Bay
- Judy Desmoulin, Elected Band Council Member, Longlac First Nation
- David Engberg,* Clinical Program Manager, Community Outreach Services, St. Joseph's Care Group, Thunder Bay
- Rick Frost, Methadone Case Manager, Alcohol and Other Drug Program, Family Services, Thunder Bay
- Lori Green, Public Health Nurse, Needle Exchange, Northwestern Health Unit
- Patricia Hajdu, Addictions Planner, Thunder Bay District Health Unit; Chair, Drug Awareness Committee of Thunder Bay, Thunder Bay
- Dr. Ingrid Krampetz, Emo/Riverside Health Care Facilities Inc.
- Danette MacDonald, Nurse Practitioner, Health Access Centre
- Debra A. Maki,* Team Leader, Case Manager, Lakeview Clinic, Lakehead Psychiatric Hospital, St. Joseph's Care Group, Thunder Bay
- Dr. Sean Moore,* Emergency Medicine, Lake of the Woods District Hospital, Kenora
- Mike Morris,* Health Director, Minoyawin Health Services, Kitchenuhmaykoosib Inninuwug
- Hannah Myers, Health Director, Constance Lake First Nation
- Karen O'Gorman, Manager, Pregnancy and Health Community Outreach Project, Thunder Bay
- Person on Methadone Maintenance Treatment (Anonymous Female)
- Person on Methadone Maintenance Treatment (Anonymous Female, Pregnant)
- Connie Peterson, Program Manager/Treatment Coordinator, Oh-shki-be-ma-te-ze-win Outpatient Treatment Program
- Dr. Sandra Sas,* Medically Enhanced Comprehensive Care for Addictions (MECCA), Morningstar Centre, Kenora
- David Schwartz, Pharmacist, Pharmacy Manager, Canada Safeway
- Janet L. Sillman,* Vice President, Mental Health and Addiction Services, St. Joseph's Care Group, Thunder Bay
- Abi Sprakes, Manager, Addiction Services, Family Services, Thunder Bay
- Jeff Tilbury, Addiction Counsellor, Riverside Community Counselling Services, Fort Frances

Toronto (Corktown Residents and Business Association), January 24, 2007:

- Eighteen individuals made presentations at a consultation session hosted by the Corktown Residents and Business Association. These individuals included local residents, local business owners, a physician, a pharmacist and a person receiving methadone maintenance treatment. Ms. Suzanne Edmonds* presented a written community impact statement on behalf of the Association.

Toronto (Toronto Central Local Health Integration Network), January 26, 2006:

- Colene Allen,* Member of the Public
- Kim Bray, Simcoe Outreach Services, Barrie
- David Collins,* Toronto Harm Reduction Task Force
- Sylvia Evans,* Member of the Public
- Dr. Alan Conyer,* Methadone Prescriber, Lindsay and Peterborough
- Meredith Freyia, Simcoe Outreach Services, Barrie
- Dr. Sheldon Hershkop, Methadone Prescriber
- Jan Holland, Regional Methadone Coordinator, Correctional Service of Canada, Kingston
- Holly Kramer,* Toronto Harm Reduction Task Force
- Peter Markwell, Addictions Counsellor, John Howard Society of Toronto
- Lori Naylor, Addiction Therapist, Breakaway Satellite Opiate Addiction Clinic
- NOVX Systems representatives: Dr. Tino Alavie* (President and CEO), Erik Hanson (Vice President, Sales and Marketing) and Dan Tisch
- Jeff Ostofsky, Methadone Support Worker, Methadone Works ("The Works"), Toronto Public Health
- Corena Ryan, Two Spirited People, Aboriginal Aids
- Susan Shepherd,* Manager, Toronto Drug Strategy Secretariat, Toronto
- Anita Simon, RN, Breakaway Satellite Opiate Addiction Clinic

Sudbury (North East Local Health Integration Network), January 30, 2006:

- Angele Benard, Canadian Mental Health Association, Sudbury
- Kim Bouillon, Program Director, Salvation Army
- Lise Chamberland, Manager, Men's/Women's Withdrawal Management Service, PineGate Addiction Services, Northeast Mental Health Centre, Sudbury
- Dr. Ralph Dell'Aquila,* Methadone Prescriber, Addiction Medicine Clinic, Nipissing Detoxification and Substance Abuse Programs, North Bay General Hospital
- Lori Dempsey, Team Leader, PineGate Addiction Services, Northeast Mental Health Centre, Sudbury
- Dr. Brian Dressler, Methadone Prescriber
- Dr. Mark Dube, Methadone Prescriber, Ontario Addiction Treatment Centre
- Dr. Mike Franklyn, Methadone Prescriber, Family Physician, Brady Clinic, Sudbury

- Dr. Paul Gibb (BScPhm, CCFP), Methadone Prescriber, Chief of Family Medicine, Sudbury Regional Hospital
- Marlene Gorman, Executive Director, Sudbury Action Centre for Youth
- Perry Kayes, Addictions Counsellor, Salvation Army
- Vicky Kett,* Manager, Community Services, Access AIDS Network, Sudbury
- Jean Guy Levesque, Manager, Addictions and Mental Health, PineGate Addiction Services, Northeast Mental Health Centre, Sudbury
- Lisa Lurz, Program Supervisor, Nipissing Detoxification and Substance Abuse Programs, North Bay General Hospital
- Sergeant Todd Marassato,* Greater Sudbury Police Force
- Mike Marcotte, Intake Worker, Corner Clinic, Sudbury
- Person on Methadone Maintenance Treatment (Anonymous Female)
- Person on Methadone Maintenance Treatment (Anonymous Male)
- Dr. Stanley Shapiro,* Methadone Prescriber, Director, Oaks Camillus Centre, Elliot Lake
- Written Submission (Anonymous)

Chatham (Erie St. Clair Local Health Integration Network), January 31, 2006:

- Dr. Marc Austin,* Bluewater Methadone Clinic, Sarnia
- Dr. Gary Barwitzki,* Bluewater Methadone Clinic, Sarnia
- Dr. Delmar Donald,* Medical Director, Bluewater Methadone Clinic, Sarnia
- Deborah Gatenby, Executive Director, House of Sophrosyne, Windsor
- Dr. Antony Hammer,* Methadone Prescriber, Drouillard Road Clinic, Windsor
- Thom Maxwell,* Chatham Kent Addictions Network
- Lynda Ruddock-Rousseau,* Director, AIDS Committee of Windsor, Windsor
- Marilyn Weller,* Executive Director, AIDS Committee of Windsor, Windsor
- John Zarebski,* System Planning Consultant, Centre for Addiction and Mental Health of Ontario, Chatham

Group Meetings

Centre for Addiction and Mental Health, July 12, 2006:

- Dr. Bruna Brands, Senior Scientist
- Dr. Anita Srivastava, Head, Opioid Clinic
- Dr. Louis Gliksman, Director, Social Policy and Prevention Research
- Eva Janecek, Pharmacist
- Dr. Carol Strike, Scientist
- Gail Czukar, Executive Vice President, Policy and Planning

College of Physicians and Surgeons, Methadone Committee, January 23, 2007
College of Physicians and Surgeons, Patient Advisory Group, February 1, 2007

Methadone Community Case Managers, February 15, 2007:

- Margaret Anderson, Addictions Counsellor, Lake of the Woods District Hospital, Kenora
- Leslie Coleman, Senior Program Analyst, Addiction Program, Ministry of Health and Long-Term Care
- Jackee Evans, Methadone Maintenance Worker, Alcohol, Drug and Gambling Services, Hamilton
- Greg Howse, Executive Director, Simcoe Outreach Services
- Daniela Leca, Methadone Maintenance Treatment Case Manager, Pinewood Centre, Oshawa
- Somina Lee, Nipissing Detoxification and Substance Abuse Program, North Bay
- Lisa Lurz, Program Supervisor, and Somina Lee, Case Manager, Nipissing Detoxification and Substance Abuse Program, North Bay General Hospital
- Jean-Francois Martinbault, Case Manager, Sandy Hill Community Health Centre
- Karen Parsons, Executive Director, and Cristina Rossi, Case Manager, Peel Addiction Assessment and Referral Centre
- Kelly Sexmith, Street Health, Kingston
- Christina Rossi, Peel Addiction Assessment and Referral Centre, Mississauga

Interviews

- Janet Anderson, Manager of Practice, College of Nurses of Ontario
- Chris Baldiserra Residential Team Manager/Counsellor, Newport Centre
- Joanne Barton, Correctional Services of Canada
- Dr. Philip Berger, St. Michael's Hospital, Toronto
- Frank Bergen, Staff Sergeant Division 51, Toronto Police Services
- Ken Bednarek, Policy Adviser, Minister's Office, Health Canada
- Denise Bradshaw, Vancouver Coastal Health Authority
- Adalsteinn Brown, Assistant Deputy Minister, Health System Strategy Division, Ministry of Health and Long-Term Care
- Dr. Ed Brown, Chief Executive Officer, Ontario Telemedicine Network
- Lorraine Carter, Ontario Telemedicine Network
- Jennifer Chafe, Pharmacist, Shoppers Drug Mart, Toronto
- Sal Cimino, Manager, Pharmacy and Professional Services, Green Shield Canada
- Dr. Graeme Cunningham, Director, Homewood Addiction Division and Associate Clinical Professor Department of Psychiatry & Behavioural Neurosciences, McMaster University
- Dr. Jeff Daiter, Chief Medical Director, Ontario Addiction Treatment Centres
- Michael Decter, Chair, Cancer Quality Council of Ontario
- Betty Donderman, Director of Communications, Centre for Addiction and Mental Health

- Scott Doidge, Manager, Pharmacy Group, Non-Insured Health Benefits Program, First Nations and Inuit Health Branch, Health Canada
- Ryan Flannagan, Manager, Addictions Programs, Mental Health and Addictions Division, First Nations and Inuit Health Branch, Health Canada
- Lauren Freedman, Researcher, University of Toronto
- Gordon Gow, Consultant
- Francesca Grosso, Consultant
- Dr. Michael Guerriere, Managing Partner, Courtyard Group
- Heather Hay, Vancouver Coastal Health Authority
- Dr. Alan Hudson, Lead of Access to Services and Wait Times, Ministry of Health and Long-Term Care
- Mark Hundert, National Director, Hay Health Care Consulting Group
- Terri Irwin, Practice Consultant, College of Nurses of Ontario
- Dipen Kalaria, Pharmacy.ca
- Jan Kasperski, Chief Executive Officer, Ontario College of Family Physicians
- Dr. Wilbert Keon, Senator
- Dr. Daniel Klass, Director, Associate Registrar, Quality Management, College of Physicians and Surgeons, Ontario
- Dr. Andreas Laupacis, Director, Li Ka Shing Knowledge Institute, St. Michael's Hospital
- Dr. Peggy Leatt, Associate Dean for Academic Affairs, School of Public Health, University of North Carolina, Chapel Hill
- Mary Catherine Lindberg, Executive Director, Council of Academic Hospitals of Ontario
- Jeff Lozon, President and CEO, St. Michael's Hospital, Toronto.
- Jim MacLean, President, TA/SC Inc. for the Ontario Addiction Treatment Centres
- Pam McConnell, City Counsellor, Toronto
- John McKinley, Assistant Deputy Minister (Acting), Community Health Division, Ministry of Health and Long-Term Care
- Laurie Miller, Mother, Youth Drop-in Centre Volunteer
- Dwayne Mountney, Manager Newport Centre
- Wendy Nicklin, President, Canadian Council of Health Services Accreditation
- Dr. Pat O'Campo, Centre for Research on Inner City Health, St. Michael's Hospital
- Rhonda Penwarden, DUPPWG National Coordinator, Mental Health/Addictions, Health Canada
- Susan Pierce, Pharmacy Consultant, Addictions Programs, Mental Health and Addictions Division, First Nations and Inuit Health Branch, Health Canada
- Dr. Peter Garber, Humber River Regional Hospital
- Dr. Mark Greenberg, Humber River Regional Hospital
- Dr. Diane Rothon, Medical Director, Addictions Medicine, Vancouver Island Health Authority
- John Ronson, Managing Partner, Courtyard Group
- Ron Sapsford, Deputy Minister, Ministry of Health and Long-Term Care
- Dr. Scott, Provincial Government, Corrections, Hôtel-Dieu Hospital

- Graham Scott, Chair, Canadian Institute for Health Information
- Susan (Fish) Schiller, Ontario Municipal Board
- Dr. Peter Selby, Director of Addiction Medicine, Centre for Addiction and Mental Health
- Gail Siskind, Director of Investigations and Hearings, College of Nurses of Ontario
- Christopher Smith, PhD Candidate, York University
- David Soltis, Ontario Telemedicine Network
- Melanie Stansfield, Nurse Practitioner, Newport Centre
- Dr. Vera Tarman, Methadone Prescriber, Toronto
- Charoula Tsamis, Centre for Research on Inner City Health, St. Michael's Hospital, Toronto
- Dr. Michael Varenbut, Executive Clinical Director, Ontario Addiction Treatment Centres, Richmond Hill
- Dr. Elisa Venier, Methadone Prescriber, Toronto
- Dr. Willem Wassenaar, Wellesley Therapeutics
- Howard Waldner, Vancouver Island Health Authority
- Deborah Wild, Office of Controlled Substances, Health Canada
- Dr. Debbie Wilkes-Whitehall, Methadone Prescriber

Written Submissions

A total of 42 people made 33 submissions to the task force. (A few submissions were written by more than one person.) For reasons of confidentiality, the names of the people who made written submissions are not provided. However, these people came from the following groups:

- physicians who provide methadone maintenance treatment: 9
- people receiving methadone maintenance treatment: 8
- addiction counsellors or service providers: 7
- members of the public: 6
- administrators of addiction or health services: 5
- nurses: 3
- parents of a child receiving methadone maintenance treatment: 2
- parents of a child with an addiction: 1
- physician who does not prescribe methadone maintenance treatment: 1

Notes

135. The task force would like to extend its thanks to all those who participated in its work, including those who participated anonymously.

Appendix C: Organizations in the Drug and Alcohol Registry of Treatment Database, March 2007

Table 11: Organizations in the Drug and Alcohol Registry of Treatment (DART) Database That Offer Selected Services, by Local Health Integration Network (as of February 8, 2007)

Local Health Integration Network	Case Management Services for MMT *and* Accept Methadone Clients	Residential Treatment, Residential Medical/ Psychiatric Treatment, and/or Residential Supportive Treatment Services *and* Accept Methadone Clients	Residential Withdrawal Management Services *and* Accept Methadone Clients	Community Treatment Services and *do not* Accept Methadone Clients
1. Erie St. Clair	• Aids Committee of Windsor, Windsor	• Charity House (Windsor), Brentwood Recovery Home, Windsor • House of Sophrosyne, Windsor	• Windsor Regional Hospital Addiction Programs, Windsor	• House of Sophrosyne, Windsor • Juvenile Crisis Intervention Program, Windsor • Westover Treatment Centre, Thamesville, London (2), Windsor and Sarnia sites
2. South West		• Grey Bruce Health Services: Addiction Treatment Services, Owen Sound • KiiKeeWanNiiKaan, Southwest Regional Healing Lodge, Muncey • Mission Services of London: Addictions Division, London • St. Leonard's Society of London, London • Turning Point, Mornington Ave. and Wharncliffe Rd sites, London	• Centre of Hope Withdrawal Management Centre, London • Grey Bruce Health Services: Addiction Treatment Services, Owen Sound	• Saugeen Native Drug and Alcohol Counselling Centre, Southampton • Youth Prevention Oneida Human Services, Southwold
3. Waterloo Wellington	• Stonehenge Therapeutic Community, Guelph	• House of Friendship of Kitchener, Waterloo • Stonehenge Therapeutic Community, Guelph	• Grand River Hospital Corporation, Kitchener.	• Homewood Community Addiction Services, Homewood Addiction and Mental Health Division site (Guelph) and Community Alcohol and Drug Services site (Guelph) • Portage Ontario, Elora

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4. Hamilton, Niagara, Haldimand, Brant	• City of Hamilton, Alcohol, Drug and Gambling Services, Hamilton	• Haldimand-Norfolk Withdrawal Management and Rehabilitation Service, Simcoe • New Port Centre (Port Colborne General Hospital site), Port Colbourne • St. Leonard's Community Services, Addiction and Mental Health Programs, Brantford • Wayside House of St. Catharines, St. Catharines • Womankind Addiction Service, Hamilton	• Haldimand-Norfolk Withdrawal Management and Rehabilitation Service, Simcoe • Hamilton Health Sciences Corporation, Hamilton • Niagara Health System, St. Catharines site (2) • Womankind Addiction Service, Hamilton	• Alcohol and Drug Treatment Centre (Niagara), St. Catharines • Alcohol Recovery in Dignity (ARID) Group Homes, Fort Erie and Thorold • Alternatives for Youth, Hamilton • City of Hamilton, Alcohol, Drug and Gambling Services, Hamilton • Native Horizons Treatment Centre, Hagersville • New Credit Alcohol and Drug Abuse Program, Hagersville • Wayside House of Hamilton, Hamilton
5. Central West	–	–	–	–
6. Mississauga Halton	• Peel Addiction Assessment and Referral Centre (PAARC), Mississauga	• Halton Recovery House, Hornby • Hope Place Women's Treatment Centre, Milton		• Family Adolescent Straight Talk (FAST), Oakville • Halton Recovery House, Hornby • Hope Place Women's Treatment Centre, Milton and Oakville • Peel Addiction Assessment and Referral Centre (PAARC), Mississauga
7. Toronto Central		• Centre for Addiction and Mental Health, Brentcliffe Road site • Ingles House, Toronto • Jean Tweed Treatment Centre, Toronto • Native Men's Residence, Toronto • Society of St. Vincent de Paul, Toronto Central Council, Toronto • Transition House, Toronto	• Centre for Addiction and Mental Health, Brentcliffe Road site • St. Joseph's Health Care Centre, Addiction Services, Toronto • St. Michael's Hospital Addiction Services, Toronto • Toronto East General Hospital Addiction Services, Toronto • University Health Network, Addiction Services (Dundas Street and Ossington Ave. sites), Toronto	• Aboriginal Alcohol and Drug Workers Program, Toronto (administration), Sioux Lookout, North Bay, Thunder Bay and Sault Ste. Marie sites. • Centre for Addiction and Mental Health, Brentcliffe Road site • Renascent Centres, Toronto (2 sites) and Brooklin • Toronto East General Hospital Addiction Services, Toronto

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8. Central	–	–	–	• Griffin Centre, North York • Vitanova Foundation, Woodbridge
9. Central East	• Pinewood Centre, Oshawa	• Pinewood Centre, Whitby site • Salvation Army in Canada, Toronto (Admiral Road site)	• Pinewood Centre, Oshawa site.	• Bellwood Health Services, Scarborough • Salvation Army in Canada, Toronto (Pape Ave and Admiral Road sites)
10. South East	• Street Health, Kingston	–	• Kingston Hotel Dieu Hospital, Kingston	• Newgate 180, Merrickville
11. Champlain	• Addictions and Problem Gambling Services of Ottawa, Ottawa	• Addiction Services of Eastern Ontario/Services de Toxicomanie de L'est Ontario, Cornwall • Billy Buffett's House of Welcome, Vanier and Ottawa sites • Maison Decision House, Ottawa • Maison Fraternite/ Fraternity House (Cantin St. and Rue Laval sites), Ottawa • Serenity House (Alta Vista Drive, Brunel St., Walkley Road and Leopolds Drive sites), Ottawa • Serenity Renewal for Families, Ottawa	• Monfort Renaissance: Ottawa Withdrawal Management Centre, Ottawa • Royal Ottawa Hospital Substance Use and Concurrent Disorders Program, Ottawa	• Roberts/Smart Centre, Ottawa • Royal Ottawa Hospital Substance Use and Concurrent Disorders Program, Ottawa • Salvation Army Ottawa Booth Centre, Ottawa
12. North Simcoe Muskoka		• Georgianwood Concurrent Disorders Program (Mental Health Centre Penetanguishene), Penetanguishene	• Royal Victoria Hospital of Barrie, Addiction Program, Barrie	• Simcoe Outreach Services, Barrie, Orillia, Collingwood, Alliston and Midland sites

Table 11: Organizations in the Drug and Alcohol Registry of Treatment (DART) Database That Offer Selected Services, by Local Health Integration Network (as of February 8, 2007)

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13. North East	• District of Algoma Health Unit, Community Alcohol/Drug Assessment Program, Sault Ste Marie and Wawa sites • Pinegate Addiction Service (Northeast Mental Health Centre), Sudbury, St. Charles and Hanmer sites. • South Cochrane Addictions Services, Timmins	• Algoma Treatment and Remand Centre, Sault Ste. Marie • Breton House, Sault Ste. Marie • Cochrane District Detoxification Centre, Smooth Rock Falls • Iris Addiction Recovery for Women, Sudbury • Maison Renaissance de la Rehabilitation, Hearst • Nipissing Detoxification and Substance Abuse Programs, North Bay • North Bay Recovery Home, Oak Street and Rose Ave. sites, North Bay • Rockhaven, Sudbury • Salvation Army Sudbury Addictions Rehabilitation Centre, Sudbury	• Cochrane District Detoxification Centre, Smooth Rock Falls • Nipissing Detoxification and Substance Abuse Programs, North Bay • Pinegate Addiction Service (Northeast Mental Health Centre), Sudbury • Sault Area Hospital's Addiction Treatment Clinic, Sault Ste. Marie • St. Joseph's General Hospital, Elliot Lake	• Ken Brown Recovery Home, Sault Ste. Marie • Moose Cree Healing Centre, Moose Factory • Ngwaagan Gaming Recovery Centre (Rainbow Lodge), Wikwemikong • South Cochrane Addictions Services, Timmins, Iroquois Falls and Matheson sites
14. North West	• Addiction Services Kenora, Kenora • Alcohol and other Drugs Assessment Program, Family Services, Thunder Bay, Thunder Bay	• 3 C's Reintroduction Centre, Thunder Bay • Changes Recovery Homes, Keewatin and Kenora sites • Crossroads Centre, Thunder Bay • St. Joseph's Care Group, Thunder Bay • Thunder Bay Seaway Non-Profit Apartments, Thunder Bay	• Addiction Services, Kenora • St. Joseph's Care Group, Thunder Bay	• Dilico Alcohol and Drug Treatment Centre, Thunder Bay, Armstrong, Longlac, Mobert and Nipigon sites • Kenora Chiefs Advisory Addictions and Mental Health, Kenora • Migisi Alcohol and Drug Treatment Centre, Kenora • New Experiences, Thunder Bay • Oh-Shki-Be-Ma-Te-Ze-Win, Fort Francis • Riverside Community Addiction Services, Fort Frances, Rainy River and Emo sites

Bibliography

Bibliography

Anderson, M. 1998. "Chapter 5: Urine Toxicology Screening." In B. Brands and J. Brands, eds. *Methadone Maintenance: A Physician's Guide to Treatment* (pp. 45–58). Toronto: Centre for Addiction and Mental Health.

Brands, B. and J. Brands, eds. *Methadone Maintenance: A Physician's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.

"British Columbia Expands PharmaNet." 2006 (May 25). *Canadian Healthcare Technology.* Retrieved April 1, 2007. <http://www.canhealth.com/News359.html>.

British Columbia Ministry of Health Services. 2005. *Harm Reduction: A British Columbia Community Guide*. Retrieved March 30, 2007. <http://www.housing.gov.bc.ca/ptf/hrcommunityguide.pdf>.

Centre for Addiction and Mental Health. 2003. *Methadone Maintenance Treatment: A Client Handbook* (2nd ed.). Toronto: Author.

Centre for Addiction and Mental Health. 2007. "Education Is Key in Safe Opioid Prescribing, Dispensing and Managing." *Insite*. Internal staff newsletter, as provided by Barney Savage, Director of Public Policy, Centre for Addiction and Mental Health.

Centre for Addiction and Mental Health. n.d. Methadone Treatment Workshop. Toronto: Author.

City of Greater Sudbury OxyContin/Narcotic Abuse Task Force. 2005 (November 21). *OxyContin/Narcotic Abuse Task Force.* Sudbury: Author.

College of Nurses of Ontario. 2006. *Administering Methadone: Questions and Answers for Nurses*. Retrieved March 30, 2007. <http://www.cno.org/prac/yau/2006/06-04_methadone.htm>.

College of Physicians and Surgeons of Ontario. n.d. Application for An Exemption to Prescribe Methadone (letter).

College of Physicians and Surgeons of Ontario. n.d. *Expectations in Methadone Prescribing for Opioid Dependence*. Toronto: Author.

College of Physicians and Surgeons of Ontario. 2006 (February). *Methadone Administration in the Treatment of Opioid Dependence Policy #2-06*. Toronto: Author.

College of Physicians and Surgeons of Ontario. 2005 (November). *Methadone Maintenance Guidelines*. Toronto: Author.

College of Physicians and Surgeons of Ontario. 2002. *Methadone for Pain Guidelines*. Toronto: Author.

College of Physicians and Surgeons of Ontario. n.d. Re: Request for an Exemption with Respect to the Use of Methadone (letter).

Curie, C.G. and H.W. Clark. 2004. *Methadone-Associated Mortality: A Report of a National Assessment. Substance Abuse and Mental Health Services Administration.* Washington, DC: US Department of Health and Human Services.

Czukar, G. and B. Savage. 2007 (January 24). *Recommendations for Improved Treatment of Opioid Dependence in Ontario.* Toronto: Centre for Addiction and Mental Health.

Darke, S. and J. Ross. 2002. "Suicide among Heroin Users: Rates, Risk Factors and Methods." *Addiction* 97: 1383–94.

Dewa, C.S., J.S. Hosch and P. Goering. 2001. "Using Financial Incentives to Promote Shared Mental Health Care." *Canadian Journal of Psychiatry* 46: 488–95.

Dobson, R.T. et al. 2006. "Interprofessional Health Care Teams: Attitudes and Environmental Factors Associated with Participation by Community Pharmacists." *Journal of Interprofessional Care* 20(2): 119–32.

Erdelyan, M. 2000. *Methadone Maintenance Treatment: A Community Planning Guide.* Toronto: Centre for Addiction and Mental Health.

Fischer, B. 2000. "Prescription, Power and Politics: The Turbulent History of Methadone Maintenance in Canada." *Journal of Public Health Policy* 21(2): 187–210.

Fischer B., D. Cape, N. Daniel and L. Gliksman. 2002. "Methadone Treatment in Ontario After the 1996 Regulation Reforms: Results of a Physician Survey." *Annals of Internal Medicine* 153(7): 2S11–21.

Fischer, B. et al. 2004. "Determinants of Overdose Incidence among Illicit Opioid Users in 5 Canadian Cities." *Canadian Medical Association Journal* 171(3): 235–39.

Fischer, B. and J. Rehm. 2006. "Illicit Opioid Use and Treatment for Opioid Dependence: Challenges for Canada and Beyond." *The Canadian Journal of Psychiatry* 51: 621-623.

Gourlay, D. 2007 (March 21). Rational Drug Testing in Methadone Maintenance. Presentation to the Methadone Maintenance Treatment Practices Task Force.

Gourlay, H. Heit and Y. Caplan. 2006 (November 1). *Urine Drug Testing in Clinical Practice: Dispelling the Myths and Designing Strategies* (3rd ed.). Stamford, CT: PharmaCom Group.

Government of Newfoundland and Labrador. 2004 (June 30). *OxyContin Task Force Final Report*. Submitted to the Honourable Elizabeth Marshall (Minister of the Department of Health and Community Services), the Honourable John Ottenheimer (Minister of the Department of Education) and the Honourable Tom Marshall (Minister of the Department of Justice).

Health Canada (Office of Canada's Drug Strategy). 2002. *Best Practices: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.

Health Canada (Office of Canada's Drug Strategy). 2002. *Literature Review: Methadone Maintenance Treatment*. Ottawa: Minister of Public Works and Government Services Canada.

HomeComing Community Choice Coalition. 2005. *Yes, in My Back Yard*. Toronto: Author.

Hser, Y., V. Hoffman, C. Grella and M. Anglin. 2001. "A 33-Year Follow-up of Narcotics Addicts." *Archives of General Psychiatry* 58: 503–8.

Institute for Safe Medication Practices Canada (ISMP Canada). 2003. "Methadone: Not Your Typical Narcotic." *ISMP Canada Safety Bulletin* 3(12): 1–2.

Isaac, P., A. Kalvic, E. Janecek and J. Brands, eds. 2004. *Methadone Maintenance: A Pharmacist's Guide* (2nd ed.). Toronto: Centre for Addiction and Mental Health.

Joint United Nations Programme on AIDS (UNAIDS). 2002. *Report on the Global HIV/AIDS Epidemic 2002*. Geneva: Author.

Kent, H. 2000 (April 18). "BC's PharmaNet System Proving Convenient." *Canadian Medical Association Journal* 162(8): 1192.

Lucas, W.J., Coroner for Ontario. 2004 (December 2). Verdict of Coroner's Jury (held November 1 to December 2, 2004, Oshawa, Ontario).

Martin, G., B. Brands and D. Marsh, eds. 2003. *Methadone Maintenance: A Counsellor's Guide to Treatment*. Toronto: Centre for Addiction and Mental Health.

Methadone Working Group. 2003 (June). *Countering the Crisis: Ontario's Prescription for Opioid Dependence*. Developed for the Substance Abuse Bureau of the Ontario Ministry of Health and Long-Term Care.

National Institute of Drug Abuse. 1999. *Principles of Drug Addiction Treatment: A Research-Based Guide*. Ottawa: Canadian National Institute of Health.

Ogborne, A.C., V. Carver and J. Wiebe. 2001 (September). *Harm Reduction and Injection Drug Use: An International Comparative Study of Contextual Factors Influencing the Development and Implementation of Relevant Policies and Programs*. Ottawa: Health Canada. Retrieved April 1, 2007. <http://www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/harm_reduction_e.pdf>.

Ontario College of Pharmacists. 2005 (November). Memo to Pharmacists and Methadone Prescribing Physicians Regarding Methadone Prescribing and Dispensing. Toronto: Author.

Ontario College of Pharmacists. 2006 (March 16). Advisory Notice (Methadone Maintenance Treatment) from Ontario College of Pharmacists to Pharmacists. Toronto: Author.

Ontario College of Pharmacists. 2006 (March 16). *Interim Policy for the Provision of Methadone in Ontario*. Retrieved March 31, 2007. <http://www.ocpinfo.com/client/ocp/OCPHome.nsf/object/Methadone+Maintenance+Treatment+-+March+16+2006/$file/Methadone+Maintenance+Treatment+-+March+16+2006.pdf>.

Ontario College of Pharmacists. 2006 (September 1). *Policy for Dispensing Methadone*. Toronto: Author.

Ontario Ministry of Community Safety and Correctional Services. 2007 (February). *Clinical Services: Methadone*. Toronto: Author.

Ontario Ministry of Correctional Services. 1999 (October). *Health Care Services Policy and Procedures: Methadone*. Toronto: Author.

Ontario Ministry of Health and Long-Term Care. 2002. *Ontario Drug Benefit: Section 8: Special Coverage of a Non-Listed Drug Product Mechanism*. Retrieved April 1, 2007. <http://www.health.gov.on.ca/english/public/pub/drugs/section8.html>.

Ontario Ministry of Health and Long-Term Care. 2005 (September 27). *Guide to Chronic Disease Management and Prevention*. Toronto: Author.

Ontario Ministry of Health and Long-Term Care. 2006 (December 12). "McGuinty Government Introduces Comprehensive Legislation to Strengthen Health System." Press release. Retrieved April 1, 2007. <http://www.health.gov.on.ca/english/media/news_releases/archives/nr_06/dec/nr_121206.html>.

Perrone, J. et al. 2001. "Drug Screening versus History in Detection of Substance Use in ER Psychiatric Patients. *American Journal of Emergency Medicine* 19(1): 49–51.

Popova, S., J. Rehm and B. Fischer. 2006. "An Overview of Illegal Opioid Use and Health Services Utilization in Canada." *Public Health* 120: 320–28.

Strike, C., K. Urbanoski, B. Fischer, D. Marsh and M. Millson. 2005. "Policy Changes and the Methadone Maintenance Treatment System for Opioid Dependence in Ontario, 1996 to 2001." *Journal of Addictive Diseases* 24(1): 39–51.

The Toronto Drug Strategy Advisory Committee. 2005 (October). *The Toronto Drug Strategy: A comprehensive approach to alcohol and other drugs*. Toronto: Author.

Tsamis, C. and P. O'Campo. 2006 (August 9). Situation Analysis. Developed for the Methadone Maintenance Treatment Practices Task Force. Toronto: Centre for Research on Inner City Health, St. Michael's Hospital.

US General Accounting Office. 2003 (December). *Report to Congressional Requesters. Prescription Drugs: OxyContin Abuse and Diversion and Efforts to Address the Problem*. Washington, DC: Author. Retrieved April 1, 2007.

World Health Organization. 2002. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva: Author.