

Countering the Crisis: Ontario's Prescription for Opioid Dependence (Draft)

This paper was developed by the Methadone Strategy Working Group

Opioid dependence is a health and social crisis in Ontario that crosses all social and economic strata. Whether it begins with efforts to treat pain or the use of illicit drugs, its impact is devastating. Dependence on opioids, such as heroin, Dilaudid and Percodan, threatens people's social and economic well-being, their quality of life and their health:

- The main causes of drug-attributable deaths are suicide, overdose and AIDS contracted from sharing needles—all of which are strongly associated with injection drug use.
- Each year, about 1% of opioid users will die from an overdose.
- In 1995, opiate poisoning was the cause of about 160 out of 804 drug-related deaths in Canada, and opioids accounted for 11% of the 6,947 hospitalizations attributed to illicit drug use. (This does not include the hospitalizations for inappropriate use of prescription opioids.)
- People who are opioid dependent are also extremely vulnerable to life-threatening blood-borne diseases, such as HIV and hepatitis C. Between 1985 and 1999, the proportion of people in Ontario diagnosed with HIV through injection drug use rose from 0.45% to almost 15%. In 1999 alone, injection drug users accounted for 24% of new HIV infections in Northern Ontario and 15% of new HIV infections in Ottawa. As of 2000, 63% of newly diagnosed cases of hepatitis C are related to injection drug use.
- In 1999/2000, drug possession or drug trafficking accounted for 7% of new admissions to correctional institutions (2110 people), 5% of new admissions to probation (1,809 people) and 16% of new admissions to conditional sentences (694 people). These figures do not include the number of people convicted of theft or other crimes to support a drug habit.
- The Ministry of Community and Social Services estimates that about 3% of users of the social assistance or welfare system have a history of drug dependency, which affects both their employability and their ability to maintain employment.

Despite the evidence that a relatively modest investment in proven treatments (combined with better co-ordination between the health, social service and law enforcement systems) has the potential to improve health and to reduce the legal, social and health costs of opioid dependence, people in Ontario with treatable drug dependencies cannot get the services they need. Little is being done to address a problem that affects not only people who become dependent and their families, but all of society.

The Cost of Untreated Opioid Dependence

Although the proportion of Ontario's population that uses opioids is relatively small (1.1% in 1996), the associated health and social costs are disproportionately high. They include not only health care costs, such as an increase in illnesses, emergency room visits, treatment for other illnesses associated with injection drug use, such as HIV, hepatitis B and C and tuberculosis and deaths, but also the social costs associated with an increase in criminal acts and law enforcement/criminal justice costs associated with prosecuting and incarcerating offenders. **In the United States, health care costs related to opioid dependence have been estimated to be \$1.2 billion per year.** Using accepted cost-of-illness methodology, researchers estimated the 1992 social cost of all illicit drug use at \$1.4 billion in Canada and \$489 million in Ontario. However, this type of top-down analysis typically only includes costs that are tracked (i.e., law enforcement costs but not the broader social costs of crime victimization).

A recent Centre for Addiction and Mental Health (CAMH) cost analysis attempted to calculate the social costs of untreated opioid use, including a broader understanding of the economic burden of opioid dependence in terms of health care, law enforcement and social harm. That report estimates that the social cost of untreated opioid use only (not all drugs) in the former Metropolitan Toronto alone is \$105 to \$171 million *per year*. That figure consists of:

- \$6.5 to \$10.6 million a year in addiction-related health care costs for people who are opioid dependent, including inpatient care, emergency services, outpatient care, physician services, ambulance services, substance abuse treatment services and prescription drugs
- \$7.4 to \$12 million a year in the cost of lost productivity for people who are opioid dependent
- \$44.4 to \$72.3 million a year in law enforcements costs, including the police costs of investigating incidents, making arrests and laying charges, the court costs of processing charges, and the correction costs of enforcing sentences
- \$46.7 to \$76.0 million a year in crime victimization costs, including victims' out of pocket expenses, pain and suffering, productivity losses, and their use of health care services.

For each person addicted to opiates followed in the study, researchers estimate that the average health and social costs are about \$44,000 per person per year - although for many people with opioid dependence, the costs will be much higher. If we use a modest estimate of 15,000 people with opioid dependence, the cost to Ontario would be \$660 million per year.

Even that figure may still significantly underestimate the actual financial impact of opioid dependence on individuals and on society. For example, it does **not** take into account the cost of:

- social assistance, housing and other social support programs for opioid users and their families.
- treating people who are opioid dependent and infected with HIV and/or hepatitis C. According to a recent analysis, the life-time health care (only) costs of treating HIV are \$215,000 per person. The cost of treating hepatitis C is estimated to be significantly higher.
- health services to treat addiction-related injuries to older adults, which can be extremely costly.

Opioid dependence, with its inordinately high health and social costs, is a crisis that will not simply go away on its own. A healthy, compassionate society should not tolerate these costs or the waste of human life - particularly when we have effective treatments for opioid dependence, which can reduce pressure on both the health and law enforcement systems, reduce crime, reduce the costs associated with dependence, and improve the quality of life for people who are addicted.

The Benefits of Treatment for Opioid Dependence

Voluntary treatment for opioid dependence can make a significant difference for the individual and for society.

People who are opioid dependent who receive treatment with methadone report:

- less illicit drug use
- better general health
- better access to health care
- greater psychologic well-being
- greater ability to acquire and maintain employment
- less reliance on public assistance
- better domestic relations
- improve ability to parent and care for children
- better social functioning.

For society as a whole, the benefits are also substantial and immediate:

- less spread of infectious diseases (The United States estimates that, if all opioid-dependent people were put into methadone treatment, the number of new HIV infections would drop by 55,000 to 70,000 each year and reduce health care costs by \$1.325 to \$1.75 billion. This does not take into account the potential impact on the spread of hepatitis B and C.)
- fewer deaths (In Drug Use in Toronto - 2000, the Department of Public Health reports a significant decline in heroin-related deaths in Ontario, from 67 in 1994 to 36 in 1998 -- which corresponded with a significant increase in the availability

of methadone treatment. The report credits the availability of methadone treatment and needle exchange services with "preventing an epidemic of heroin-related fatalities in Toronto of the magnitude experienced in Vancouver.")

- less violence
- less theft and property damage
- safer communities
- lower health, law enforcement and social assistance costs.

Effective treatment also offers society a significant cost benefit. For example, a program in Arizona that directs first-time drug offenders to treatment rather than jail reported that 77% of the offenders stayed off drugs during the year following their arrest, and the state saved \$2.5 million in prison costs.

Ontario can achieve similar financial benefits by investing in methadone treatment for opioid dependence. Comprehensive methadone treatment programs in Ontario (i.e., programs that providing 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. The costs of less comprehensive programs, or comprehensive programs integrated with other services (e.g., with needle and syringe exchange services or other treatment services) would be even lower.

This means that it would cost Ontario about \$9 million a year to provide comprehensive methadone treatment for 15,000 people with opioid dependence (compared to \$660 million to deal with the personal and social ramifications of their addiction).

With a relatively modest strategic investment in treatment, Ontario could reduce the costs associated with opioid dependence by 86%. This is consistent with U.S. projections which estimate that every \$1 spent on methadone offers a cost-benefit of US \$4 to \$13.

However, to achieve these health and social benefits, Ontario must actively pursue a provincial strategy to treat opioid dependence.

I. Goal

People with opioid dependence in Ontario will have access to a range of high quality voluntary treatments, including methadone-based or other opioid agonist-based treatments, which will be integrated with existing health care and addiction services and available in various settings within or near their communities.

Objectives

- **To improve treatment for opioid dependence by:**
- developing co-ordinated, sustainable treatment and support services for people with opioid dependence that are integrated with the larger substance abuse treatment system and health care system.
- increasing the province's capacity to provide harm reduction treatments for opioid dependence.
- **To improve the quality, efficiency and consistency of Ontario's treatment services for opioid dependence by:**
- identifying the treatment services in place now, and their strengths and weaknesses
- identifying gaps in treatment services
- identifying barriers to treatment services, and developing strategies to overcome them
- ensuring services are available across the province.
- **To reduce the marginalization of people being treated for opioid dependence by developing comprehensive public education.**

Principles

- **Opioid dependence is a chronic, treatable health condition.**
- **People with opioid dependence should have access to the best available treatments, and that treatment should be voluntary and client-centred.**
- **The same standard of care should be available to all people with opioid dependence, regardless of where they are in the province, in the health care system, or in the legal/correctional system, and treatment services should be available province-wide.**
- **Treatment with methadone or another opioid agonist should not be a barrier to receiving/participating in other addiction, mental health, health or social services.**

I. Background

1. Methadone and Other Drugs Used to Treat Opioid Dependence

Methadone is a synthetic compound developed in Germany before World War II, and used as a substitute analgesic for morphine. Early research in the late 1940s showed that methadone could also be used to treat withdrawal symptoms in people who were dependent on heroin. In the early 1960s, Dole and Nyswander demonstrated the feasibility of using methadone as maintenance medication - although it was actually a Canadian researcher, Dr. Robert Halliday, who set up what may have been the first methadone maintenance treatment program in the world in British Columbia in 1963.

Because methadone is a controlled substance under the federal *Controlled Drugs and Substances Act*, the prescribing of methadone is carefully controlled and monitored. Any physician in Canada who wants to prescribe methadone to treat opioid dependence must get an exemption from the federal Minister of Health. To obtain the exemption, a physician licensed in Ontario must apply to the College of Physicians and Surgeons of Ontario (CPSO) and complete an intensive, one-day workshop and a structured clinical training experience. Once the physician completes these requirements, the CPSO recommends that Health Canada issue the exemption. To prevent double doctoring and ensure patient safety, all physicians prescribing methadone are required to register patients in methadone treatment with the CPSO.

Methadone maintenance typically involves the daily oral administration of methadone over an extended period of time as a long-acting substitute for heroin or other short-acting opioids. The early stages of methadone treatment involve gradually increasing the methadone dose until the client is stable and able to begin dealing with any long-standing emotional or psychological issues. During the stabilization period, clients are seen frequently in order to determine the optimal dose. Once they are stable on methadone, subsequent daily doses should not cause sedation, analgesia or euphoria. When clients receive an optimal dose, they will not experience withdrawal symptoms, cravings, sedation, analgesia or euphoria. This will enable them to function normally. Clients who are stable on methadone may benefit from counselling and support services that can help them make significant changes in their lifestyle. Clients who are being successfully treated with methadone display few of the negative characteristics associated with addictions (i.e., compulsive or chaotic drug use, extensive drug-seeking behaviour, the willingness to sacrifice other life needs to get drugs).

or their children. For example, clinics may have to offer flexible hours as well as access to child care and transportation services. For women with children, a missed appointment should not automatically be grounds for removal from the program if the absence was due to a family need or crisis. Some women may also need help to maintain custody of their children through their treatment.

Youth

Youth - particularly those with a relatively short drug use history - may not yet have developed the kind of drug dependency that adults experience, and may benefit from different treatment approaches. For example, many may be successful on bupranorphine. Treatment programs should consider other treatment options before putting a young person on methadone, which is addictive.

Youth who are involved in intensive drug use tend to be emotionally and behaviourally immature, and many have severe psychosocial issues. They require services that are sensitive to the delay that has occurred in their emotional development, as well as knowledgeable about effective ways to work with and relate to youth (i.e., skilled in youth development, engagement and intention). Youth are not likely to volunteer for treatment programs, and must be recruited through active outreach. They are likely to

respond best within carefully structured programs that make them feel comfortable and accepted.

Older Adults

Older adults who are opioid dependent tend to fall into one of three distinct groups: those addicted to prescription opioids, those addicted to heroin and other street opioids, and those who have been on methadone for many years and are now older adults.

To help older adults addicted to prescription opioids, it is necessary to educate gerontologists and family physicians who have older adults in their practices about the risk of becoming dependent on prescription opioids, the impact of opioid use for treating other conditions (i.e., drug interactions), and available treatments. Older adults in this group may not self-identify or consider themselves dependent. The dependence may have occurred as a result of lack of co-ordination or monitoring of their care. Home care providers, nursing home and shelter staff should also be made aware of the signs and symptoms of opioid dependence, and be trained to counsel and monitor older adults on prescription opioids.

Older adults who are addicted to heroin and street opioids will need access to treatment services. They may need outreach programs that can help make them aware of available treatment services. As they are not likely to be employable at this stage in their lives, they will not be able to take advantage of training and other support programs available through the social service system, and may require long-term support.

A growing number of people who have been on methadone for many years are aging, and will need careful monitoring to ensure that their dosage remains appropriate, and that the methadone does not react adversely with any other medications they have to take for other health conditions. It's important that their care providers not be judgemental about their use of methadone and be knowledgeable about the potential for drug interaction. They should also be aware that patients on methadone who are being treated for pain may require higher doses or shorter dosing intervals, and assess their need for pain control.

Aboriginal People

Aboriginal people who live in conditions that put them at risk for drug use (e.g., poverty, low education, unstable family structure, physical abuse, poor social support network) are at high risk of substance abuse and drug use. Although the extent of drug use in Aboriginal communities is not known, alcohol and drug use are major factors in Aboriginal deaths due to accidents and suicides. Aboriginal people also make disproportionately high use of needle exchange programs and drug treatment facilities in many cities. Although this indicates that they are trying to reduce their risks, it also indicates that they may have higher rates of injection drug use than non-Aboriginal Canadians.

For Aboriginal people, methadone or any other treatment for opioid dependence will be more effective when it is integrated with traditional/cultural approaches to healing, and with other health and social services. Methadone or other harm reduction approaches to treatment are often an issue for the strongly abstinence-based treatment programs that serve Aboriginal people. Communities, agencies and staff will need education to accept the harm reduction approach, and elders and healers should be directly involved in designing services to treat members of the community with opioid dependence. Delivering methadone programs to on-reserve communities will often be complicated by the lack of pharmacies. Agencies may have to find other ways to manage the dispensing of methadone.

At the current time, Aboriginal people living in the northern parts of the province are unable to receive treatment because of the lack of services in the north.

Multiple Drug Dependencies

Multiple drug dependencies are common in people seeking methadone treatment, and all treatment providers should have the expertise to identify multiple drug dependencies, determine patients' primary drug use (e.g., the opioid may not be the drug of choice but the client may use it before assessment to get methadone to relieve other withdrawal symptoms), and prescribe appropriate treatment.

People who are addicted to an opioid and other substances (e.g., alcohol, crack, cocaine, benzodiazepines, anti-depressants) are likely to need a more comprehensive assessment of their other dependency. They are also more likely to lead unstable lives, and need help with affordable housing, life skills and transportation to appointments.

Clients with multiple drug dependencies will benefit from a comprehensive harm reduction approach, particularly when there may be no treatment for their secondary dependency. It is also important that clients have access to the full range of services they may need. Programs that treat non-opioid dependencies must be willing to accept clients who are on methadone.

Concurrent Disorders

Clients with mental illness as well as opioid dependency need integrated services that can treat both disorders effectively. These clients tend to spend a significant amount of time seeing physicians and other health care providers. Adding yet another physician or treatment service will likely be a barrier so, whenever possible, methadone treatment should be integrated with their other care.

To provide effective integrated services for these clients (e.g., through a community health centre), all care providers should be skilled and knowledgeable in the treatment/management of both disorders, and be able to link clients to any ancillary services they may need. The most common problem that people with concurrent disorders face is drug interactions, so these integrated services must also have the

capacity to monitor clients closely. It also important that those providing mental health services be non-judgemental about methadone treatment and supportive of a harm reduction approach.

People with HIV/Hepatitis C

Clients with HIV and/or hepatitis C as well as opioid dependency will also need access to integrated services that can treat both conditions effectively. Drug interactions can be a significant problem for this population, and their ability to tolerate treatments must be monitored closely. Every effort should be made to integrate their care and group tests (e.g., bloodwork) for both conditions, in order to reduce the number of appointments required. Health care providers should also be aware of the combined stigma of HIV and opioid dependency, and be able to help clients link with support services. Because of the risk of HIV transmission - sexually and through shared needle use - treatment services also have a responsibility to ensure that clients are aware of precautions and have the information and support they need to prevent the spread of HIV.

People in the Correctional System

Clients who are incarcerated while being treated for opioid dependence need some reassurance that they will be able to maintain their treatment and not miss doses when in a correctional facility. Clients receiving methadone treatment should also be linked with treatment services outside the facility prior to discharge. Ideally, clients should be able to be assessed and started on methadone while in custody, and then continue in treatment when they are released. In fact, correctional facilities can be an effective setting to assess people and get them stable on treatment.

It is important for medical staff in correctional facilities to comply with treatment policies, and not to arbitrarily withhold treatment (e.g., because client is non-compliant or staff interpret symptoms of withdrawal as "being high"). Staff need ongoing education and training in methadone treatment issues so that they can give clients relevant information and help clients maintain their treatment program.

Francophones

Francophone clients need access to services in French. At the current time, two or three physicians who are licensed to provide methadone treatment in Ontario offer services in French. However, more will likely be needed to provide equitable access to treatment services. Access to French-language services is most important in centres with a large French-speaking population, such as Ottawa, the northeast and the northwest.

Diverse Communities

Some clients may come from different cultural communities or have unique communication needs (e.g., people who are hearing impaired, people who are illiterate). These clients need care that can take into account both their need for information in a

form or language they can understand and their need for culturally sensitive care. To be able to reach members of diverse communities and provide culturally sensitive services, methadone treatment services will have to link with existing ethno-specific services and with services for people with communication issues.

Homeless People

People who are homeless tend to lead chaotic lives, and may not have the resources or stability to participate in a highly structured methadone program. As a result, they may not be accepted into regular treatment programs. However, given the risks that these clients face on the street (e.g., multiple drug use, prostitution, exposure to HIV and hepatitis C, incarceration, death), they would likely benefit from access to "low threshold" methadone treatment programs.

Low threshold programs have minimal entry criteria, do not require the same level of attendance/compliance (e.g., urine testing), and do not offer the same privileges (e.g., carries) as more structured programs. 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.

To meet the needs of homeless people, treatment programs will have to develop strong outreach capabilities, appropriate delivery mechanisms, and effective links to other services.

III. Strategies to Overcome Barriers to Effective Treatment

The Barriers

Ontario's ability to provide integrated, co-ordinated, sustainable treatment and support services for people with opioid dependence is hindered by:

- **long-standing negative attitudes towards methadone use in the medical, social service and legal community**

Unless they are working in addictions treatment, health care providers are generally poorly informed about addictions and addiction treatment. Many continue to believe that an addiction can just be "stopped" and to see methadone treatment as another form of addiction - rather than a treatment. Many - even those within the addiction treatment system - continue to believe that abstinence is the only effective way to overcome an addiction. Because of this attitude, some treatment programs for alcohol and other (non-opioid) drug addictions will not accept clients who are using any type of drug or substance, including methadone. This can prevent clients who are on methadone treatment from getting other services they may need.

Even health care providers who accept harm reduction strategies and understand methadone treatment may let their attitudes towards opioid dependence and methadone treatment affect other treatment decisions. For example, they may be suspicious of methadone clients who seek treatment for other health conditions, and see it as drug seeking behaviour as opposed to a legitimate request for care. This may be particularly true of emergency room staff.

Many health care practitioners are also unaware of the potential interactions between methadone and other drugs, and how other treatments may reduce the effectiveness of methadone treatment and cause clients to go into withdrawal. Because they do not understand the tolerance that people who are opioid dependent have developed to opioids, they may tend to under-prescribe pain medications patients require. In many cases, hospitals will not have anyone on staff who is licensed to prescribe methadone, which can affect clients' access to methadone in a medical emergency.

Negative attitudes towards methadone treatment can also affect clients' access to the drug. Some pharmacies may be unwilling to dispense methadone, for fear that it will make them vulnerable to theft. Some insist that methadone clients come only at certain hours or go to a back door to get their methadone. Some do not allow them to buy other items or spend any time in the store, out of fear that the clients will shoplift. Despite professional guidelines, some fail to provide the kind of privacy that clients have a right to expect.

Many of these attitudes are, in part, a result of the long-standing criminalization of opioid use. The legal stigma associated with opioid dependence may make many opioid users reluctant to seek treatment. It also means that the legal system, which is generally uninformed about methadone treatment and has preconceived assumptions about opioid users, is more likely to consider punitive rather than treatment measures to deal with the problem. This may keep people from getting the treatment they need.

- **social service and law enforcement attitudes towards methadone treatment**

Negative attitude toward methadone treatment may also affect clients' perception of the social service system and law enforcement personnel. In the case of child protection agencies, such as the children's aid societies, methadone treatment itself or the signs of any relapse (e.g., positive urine screen) may be considered evidence that a parent is unfit and used as a reason to remove children from the parent or home. Faced with the risk of losing their children, many people - particularly women - will not enter a methadone treatment program, even though they want help managing their addiction.

Most police officers are poorly informed about methadone treatment and its potential benefits in terms of crime reduction. They do not necessarily understand the importance of regular daily doses, and may not respond quickly or appropriately when people in their custody disclose that they are on methadone. In some cases, they refer clients inappropriately to a detox centre, rather than ensuring they are able to continue on their

methadone regimen. This can make it extremely difficult for clients to remain stable, and may lead to relapse.

- **public attitudes** towards/discrimination against people who are opioid dependent

The public perception of people who are opioid dependent continues to be extremely negative. Many see them as potentially violent people who are likely to be involved in criminal activities to support their addiction - a stereotype that is continually reinforced by television and the media. Unlike other people who suffer from a health condition, the public appears to have little compassion for opiate addicts. Like many health professionals, they see addiction as something that people should just be able to "stop." They do not understand the nature of addiction or the benefits of methadone treatment - both for people who are opioid dependent and for society. They do not see opioid addiction as a problem that affects them or their families.

For most people, treatment for opioid dependence is not a priority. These attitudes make it difficult for governments to provide funding and other resources for methadone treatment. They also make it difficult for clinics to find sites to operate where they do not have to deal with community fears and protests. Several clinics have had to close or move because of actions by neighbours who were concerned about a possible increase in crime. In addition, negative public attitudes may make it more difficult for clients, who feel the impact of the social stigma on their sense of self worth, to seek or stay in treatment.

- **lack of resources** for comprehensive methadone treatment

Few resources in the system are targeted specifically for methadone treatment, and there is no specific new funding available for new comprehensive methadone treatment clinics or programs. However, many involved in the addiction treatment system believe there are adequate resources in the health and legal system to provide comprehensive methadone treatment - the challenge is to allocate and use those resources more appropriately.

While there may be enough money in the system to meet the needs for methadone treatment, the way funding is provided and allocated can be a barrier to developing effective services. Current funding decisions are not based on comprehensive planning, evidence-based services or outcome evaluations. The existing system puts too much emphasis on one-time funding and funding for new projects, as opposed to providing stable, ongoing funding for programs that demonstrate their ability to meet changing needs.

This encourages a lack of integration of existing services. As a result, programs appear to be more interested in protecting their turf than in meeting client needs. Communities are also able to use lack of specific methadone funding as a reason or "excuse" for not providing methadone treatment services.

Another barrier is the cap or limits set on certain laboratory services that are required in methadone treatment. For example, most laboratories have a cap on the number of urinalyses they can charge for in a year, and may be reluctant to accept requests for testing for methadone patients because the high demand for urinalysis will put them over their cap. Some methadone treatment programs report that labs have refused to renew their testing contracts because of these issues.

- **ashortage of physicians willing to prescribe methadone**, which is compounded by the overall shortage of physicians and primary care services in certain communities in Ontario.

In many communities, access to methadone treatment is very precarious because it is dependent on one or two physicians. If one goes on holiday, becomes ill, retires or decides to give up the methadone part of his/her practice, the program becomes very vulnerable. There is also a shortage of physicians who have the skills to treat people with concurrent disorders or gerontologists who are also able to prescribe methadone.

The College of Physicians and Surgeons of Ontario continues to work with its members to recruit physicians who are willing to provide methadone treatment, but many physicians are reluctant to get involved in methadone treatment because of:

- lack of education about opioid dependence and methadone treatment in medical school
- perceived negative impact that treating methadone clients may have on the rest of their practice
- the lack of support in the medical community for methadone treatment
- the demands of methadone treatment - which can be extremely time consuming, particularly in the early weeks and months of treatment, and which require physicians to be available every week to prescribe
- the methadone clients' need for extensive counselling and support services
- the strict controls on methadone, which require physicians to have special training and a license to prescribe
- the fees paid to physicians for prescribing methadone are not sufficient to allow the physician to hire other professionals to provide counselling services.

The challenge of recruiting physicians to prescribe methadone has been exacerbated by the shortage of physicians in rural and remote areas. Already overworked, most physicians in these underserved areas are reluctant to take on this type of practice.

It is also interesting to note that a significant proportion of physicians who attend the intensive one-day workshop on prescribing methadone do not go on to take the structured clinical experience. Some of these physicians may decide that methadone prescribing may not be appropriate for them; others find the time required for the clinical experience and the loss of clinical income to be a barrier.

The process of recruiting physicians has also become more complicated. Although the CPSO is funded to fulfill this role, other organizations - such as the CAMH and community organizations - also seem to be involved in active physician recruitment programs, and the various roles and relationships are not clear. In addition, the funding provided for the CPSO to manage the program is in the form of a one-time grant that has to be reviewed each year, which makes it difficult for the organization to develop longer term physician recruitment initiatives.

- **law enforcement/corrections policies** that make it difficult for people to get or stay on treatment when incarcerated, and the lack of integration between health and corrections services

To be effective, methadone treatment must be given daily in the right dose and at the right time. The correctional services system has policies and guidelines that should ensure that inmates who are on methadone can continue their treatment regimen while in detention. However, not all facilities follow the guidelines. In some cases, prison medical staff may have different attitudes towards methadone treatment and may reduce dosages or attempt to taper clients off methadone involuntarily while in they are incarcerated. Many facilities do not have their own pharmacy, and have difficulty getting a community pharmacy to dispense methadone when required - although in some cases community advocacy has been effective in getting pharmacies involved.

Many of the issues facing methadone clients in detention relate to timing of their doses, which is extremely important if clients are to remain stable on methadone and not go into withdrawal. For example, in some cases, clients' prescriptions will be interrupted (sometimes for several days) until they can be seen by a physician or dosages may be delayed because of the scheduling of court appearances. Some of the problems are the result of staff shortages within the correctional system, rather than an unwillingness to maintain clients on methadone.

Some clients also encounter problems maintaining their treatment regimen when they are released. Health services may not know that they are being discharged and, therefore, are not able to make the necessary arrangements to transfer their prescription to a local pharmacy. As many physicians and treatment services are booked three to four weeks in advance, the timing of these arrangements is extremely important. Links should be made before clients are released.

- **lack of travel assistance**

Because many communities do not provide methadone treatment, a significant number of clients must travel to receive care and may need assistance with travel costs. The Northern Health Travel Grant Program will provide funds to defray some of the travel costs for people from Northern Ontario to see a specialist for services not available in their home community. However, it does not cover the cost of travel to see a general practitioner. As the majority of physicians licensed to prescribe methadone are general practitioners, this prevents people from getting any financial assistance with travel costs.

Even when treatment services are available locally, clients may need help getting to appointments. The cost of travel, the distance to the clinic, the travel time required can all be barriers that prevent people - particularly older adults and women with children -- from attending treatment.

- **the inflexibility of Ontario Works**, which may limit clients' access to Ontario Drug Benefits (ODB) and make it difficult for them to afford the drug costs

Many people on methadone are highly dependent on social assistance and access to the Ontario Drug Benefits Plan to be able remain in treatment. However, the new criteria for Ontario's welfare program, which require participants to participate in work fare programs, are making it increasingly difficult for some people who are opioid dependent or receiving methadone treatment to qualify and remain in the program. For example, clients who are just entering methadone treatment may not be stable enough to look for work or participate in workfare programs. Even for those who are stable on methadone, the demands of their treatment schedule may cause them to miss social assistance appointments or interfere with workfare commitments, thereby jeopardizing their coverage.

People on methadone treatment also often face some costs directly related to their treatment that are not reflected in the social assistance payments they receive. For example, many people on methadone treatment are required to attend clinic or a doctor's office weekly and the pharmacy daily and, therefore, may have higher travel costs than others welfare recipients. Lack of child care services and facilities also makes it difficult for some methadone clients, particularly women, to attend appointment or participate in vocational programs.

Although there are resources available to people on methadone treatment or those who want to start treatment through Ontario Works, they are not well communicated within the system. Front line workers appear to be unaware of them and do not routinely offer them to clients. Part of the problem may be lack of consistency within the system. Some clients report that they have had as many as four different case workers in a year.

The main problem is that, under the current ODSP legislation, addiction alone does not constitute a disability and, therefore, people in methadone treatment are not eligible for some of the assistance/flexibility given to people who are disabled.

- **lack of vocational opportunities** for people receiving methadone treatment

When people first enter methadone treatment, their treatment needs may be so intensive that employment is not possible or advisable. Some may also have complex health and social issues that have to be dealt with before they are able to considered school or work. However, those who are stable on methadone and ready to get on with their lives often suffer from lack of access to vocational assessments and vocational opportunities. Marginalized by their addiction, some lack the literacy and education to attend

established vocational programs, and may need support to be able to participate in adult education training and retraining programs. Because of the demands of their treatment schedule, clients may also be unable to attend scheduled classes consistently, which will affect their ability to learn or to get a job. Attending school may also jeopardize their access to social assistance and drug benefits.

- **the impact of drug costs on clients who are working**

Another barrier that may keep clients from receiving optimal treatment is the impact of drug costs on their incomes. Clients who are working report that, once their income reaches a certain level, they no longer qualify for social assistance or ODB. However, the cost of methadone and other drugs they may have to take (e.g., anti-depressants) often reduces their income to the point where they would once again qualify for social assistance and ODB.

It is extremely difficult for these individuals to afford both their prescribed medications and food. Many may begin to reduce their medication doses for financial reasons, which threatens their stability in treatment and their ability to maintain their jobs.

Proposed Strategies

1. Change Attitudes Towards Opioid Dependence and Methadone Treatment

The Ontario Substance Abuse Bureau, with adequate resources from the Ministry of Health and Long-Term Care, should take the lead to develop and implement programs designed to change public and professional attitudes towards opioid dependence and methadone treatment, including working with the CAMH "stigma of addiction" initiative to develop:

- a comprehensive, province-wide anti-stigma campaign for the public
- comprehensive training packages for the health, social, law enforcement, legal and corrections professions.

To develop these initiatives, OSAB should establish a steering or working group with the appropriate skills and knowledge, accountable to the Ministry of Health and Long-Term Care, the Ministry of Correctional Services and the Ministry of the Solicitor General, which would:

- identify and target key, credible spokespeople in all sectors - the public, health, social services, police, the court system and the corrections system - who will provide leadership (e.g., the chief of police, a key judge, the president of the CPSO) in educating their community about the benefits of methadone treatment
- identify community organizations that should play a key role

- identify possible partners to deliver professional training in community settings (e.g., CAMH)
- develop key messages (including the cost benefit of treating opioid dependence) and a full communications/education/anti-stigma strategy
- identify possible sources of funding, which should include the Ontario Substance Abuse Bureau, CAMH, drug companies, pharmacies, other private sector companies, and foundations that support health-related initiatives
- contract with a communications firm to develop public education materials.

For health professionals, the education program should:

- advocate for greater emphasis on addictions and addiction treatment in professional education/training programs
- organize education sessions for health professionals led by addictions specialists, consumers and family members who can "put a human face" on the problem
- provide residency opportunities for physicians and nurses in addictions agencies
- provide continuing medical education in addictions and methadone treatment
- provide continuing medical education in drug interactions with methadone and with cross-over problems, such as the potentially significant reaction with valium and phenobarbitols
- promote the use of the CAMH video to recruit physicians to methadone treatment.

For law enforcement, legal professionals, and people working in the corrections system, the education program should:

- organize education sessions led by addictions specialists, consumers and family members who can "put a human face" on the problem
- emphasize the cost/social benefits of methadone treatment, and the potential impact on crime reduction.

2. Increase the Availability of Comprehensive Methadone Treatment

The Government of Ontario should increase the availability of comprehensive methadone treatment by:

- making more effective use of existing resources
- taking an innovative, collaborative approach to funding methadone treatment

More effective use of existing resources. More equitable access to comprehensive methadone treatment across the province will depend, to a great extent, on the ability of existing addiction, mental health, needle exchange and other health/social programs to collaborate and reallocate addiction treatment funds to meet the community's needs for methadone treatment. As some communities have demonstrated over the past five years, it is possible to develop comprehensive methadone treatment programs by building them onto other existing services.

To encourage that collaboration, OSAB should require all communities that receive funding for addiction treatment to provide, as part of their continuum of addiction services, comprehensive methadone services, to allocate a proportion of their funding to methadone treatment (based on patient enrolment), to include methadone treatment in their regional addictions plan and, wherever possible, extend the geographic boundaries of the area they will serve with methadone treatment. Community agencies funded to provide methadone services would have clear deliverables, such as providing the outreach, assessment, case management, counselling, and other support services that methadone clients may need. They would be accountable through their board of directors to the funding body. They would also be encouraged to employ and make effective use of consumers as peer support workers, and to provide outreach services to communities that do not have methadone treatment clinics. All services would be evaluated, and programs would be held accountable for the quality and effectiveness of their services.

Any community that does not provide/have access to methadone treatment services would then be required to demonstrate that its population does not need them.

Ontario's addictions system should also ensure that methadone clients have access to the full range of addiction treatment and support services in the community (e.g., residential drug and alcohol programs, counselling services), and are not denied service on the basis of their methadone use.

Comprehensive methadone treatment does not have to be restricted to the addictions treatment system. It can and should be provided in other settings that have the capacity to provide a range of services, such as community health centres and academic health science centres. To increase the availability of methadone treatment and take advantage of existing resources, the Ministry of Health and Long-Term Care should require globally funded health agencies located in communities with an unmet demand for methadone to provide treatment as part of their mandate.

Innovative, collaborative funding for new/enhanced services. While communities can do a significant amount with existing resources, some parts of Ontario may be reaching the limit of what they can without new or additional funding. They may not be able to expand services to meet the existing and growing need without additional financial support.

Given the link between opioid dependence, crime and justice costs, and the increase in crime and the associated justice, and the persuasive evidence that treatment can significantly reduce crime, the justice system should collaborate with health to fund and develop treatment programs that will reduce the need for law enforcement, court and incarceration costs.

The Ministry of Health and Long-Term Care should make the case with the rest of government that funding to treat opioid dependence is an investment in the health of our society and can lead to significant savings in health, social, policing, court and jail costs. It should stress the cost effectiveness of methadone treatment in all its communication

plans, and advocate for funding from all government budgets that will benefit to support new comprehensive methadone treatment services in communities that have reached their capacity.

3. Recruit More Physicians

Ontario should recruit more physicians to manage patients on methadone by:

- investing in physician education (see #1)
- developing more effective recruitment programs
- developing models of care that assist physicians
- providing mentors for physicians who are new to methadone treatment
- exploring a potential role for nurse practitioners

Given the difficulties recruiting and retaining physicians to prescribe methadone, Ontario will have to use a variety of strategies to make the practice more attractive to physicians. Physicians' reluctance to prescribe methadone is due mainly to the stigma associated with drug treatment and the time required to care for methadone patients, particularly during the stabilization period, and the lack of support services (i.e., case management, counselling), which makes the physicians' task more difficult.

Education/compensation. To attract more physicians, Ontario should implement the education initiatives discussed earlier. The Ontario Substance Abuse Bureau should also work with OHIP to ensure the fee schedule reflects the level of service provided.

Recruitment strategies. The different organizations active in physician recruitment - the CPSO, CAMH, and local clinics -- should clarify their roles and responsibilities and, whenever possible, collaborate to ensure greater impact. They should also focus their efforts on underserved areas. In future recruitment efforts, organizations should make every effort to increase their success rates by:

- developing a standard protocol/needs assessment that communities/agencies can use to inform the CPSO physician registry and OSAB when they are in need of a physician
- focusing primarily on physicians in group practices within a community, who will have colleagues who can provide back-up and coverage when the physician has to be away (the time demands are too great for solo physician practices)
- developing a profile of physicians who are likely to be interested and effective in methadone treatment and recruiting those who fit the profile
- identifying and addressing other barriers to physician recruitment, such as the training requirements to qualify for an exemption to prescribe methadone.

Every effort should be made to ensure that physicians who begin the training complete it, and that those who complete the training become involved in methadone practice.

Models of care. To help integrate more community physicians into treating clients on methadone, Ontario should promote a model of care that will help manage and reduce the demands on the physicians' time - particularly in the early stages of methadone treatment. In this model, all clients beginning on methadone or other treatment would receive their initial assessment and care at a comprehensive clinic. Clinic staff would be responsible for providing case management services, for ensuring clients have access to the range of services they need, and for working with clients until they are stable on their treatment. Methadone would be prescribed by physicians working in the clinic.

Once they are stable, clients would be referred to community physicians who would continue to monitor and prescribe their methadone and other drugs. The clients would continue to have a case manager at the clinic, to help them deal with other service needs and issues, and would continue to participate in any programs offered by the clinic. Any client who relapsed would immediately be referred back to the clinic. The community physician's role would be limited to the medical management of the stable client on methadone.

If the community physician prescribing methadone is not the client's primary care physician, then systems must be set up to ensure effective communication between the physician prescribing methadone and the primary care physician, as well as among the clinic, the physician prescribing methadone and the primary care physician. This is extremely important to ensure the client receives comprehensive care.

With this approach, Ontario should find it easier to recruit physicians, who will appreciate having the clinic to support them and the clients. This model will also prevent the current bottleneck that occurs when stable clients continue to be seen at the clinic simply because the community has not been able to recruit physicians willing to follow people on methadone.

Mentors. Many physicians may not feel they are adequately prepared or trained to prescribe methadone or to care for methadone clients - even with the training provided by the CPSO. To help these physicians develop the knowledge and skills they may need, the CPSO should work with physicians currently prescribing methadone to develop a provincial mentorship program.

Nurse practitioners. Given the current shortage of physician services, the Ministry of Health and Long-Term Care should consider alternative providers. The CPSO and the College of Nurses of Ontario (CNO) are looking at a potential role for nurse practitioners in methadone treatment - either within their current scope of practice or through delegation.

4. Develop More Effective Communication Between the Health Care System and the Correctional Services System

The Ministry of Health and Long-Term Care and the Ministry of Correctional Services should collaborate to ensure that methadone clients are able to maintain

their treatment regimen as they move in and out of the correctional services system. Specifically, the ministries should:

- hold administrators accountable for the centre's effectiveness in maintaining clients on methadone
- establish admission and discharge plans for clients on methadone
- have a standing arrangement with community physicians and pharmacies to ensure inmates are able to maintain their treatment regimen
- encourage the CPSO to work with prison physicians who are reluctant to prescribe methadone
- develop a program to promote methadone treatment and start inmates who want treatment while in the correctional system

Accountability. Facility administrations should be held accountable for ensuring that the centre provides the timely services required to maintain clients on methadone treatment. Every effort should be made to hire staff who are sensitive to the needs of inmates on methadone, or who can be educated about the benefits of methadone treatment and the importance of the treatment schedule. When recruiting/hiring new physicians, the facility should make prescribing methadone and following clients on methadone an explicit condition of the contract.

The facility should develop systems that ensure that inmates' doses will not be delayed or interrupted by court appearances or disciplinary measures used within the facility, that methadone can be administered privately, and that clients' confidentiality is respected. It should also ensure that it has adequate health services staff to maintain treatment schedules.

Every correctional facility should keep on hand in its pharmacy an emergency supply of methadone that can be used when inmates are admitted at hours when physicians/pharmacies are not available or to deal with any urgent, immediate needs

Admission and discharge plans. The communities where correctional facilities are located should work with the facilities to promote timely and effective communication between physicians in the community who prescribe methadone, physicians and health services staff in the facilities, and community pharmacies.

Within the correctional facilities, every effort should be made to implement existing policies and guidelines, and to ensure adequate staffing levels that will allow methadone clients to receive their methadone treatment consistently.

In addition, facilities should ensure that every methadone client has a complete, current admission and discharge plan that includes the requirement for methadone treatment as well as the requirement to contact the client's physician or an agency in the community when the inmate is admitted or discharged, to ensure treatment continuity. The

community physician should be contacted at least one week before the client is discharged to be able to make appropriate arrangements.

Working relationships with outside physicians/pharmacies. Facilities that have physicians who are reluctant to prescribe methadone should establish a standing relationship with a community physician who will prescribe when/if required. If there is no physician in the community prescribing methadone, the facility should make arrangements with a community health centre to provide the medical services required. The facility should also have a standing relationship with a pharmacy/pharmacies in the community to stock and provide methadone.

Physician education. Facilities should work collaboratively with the CPSO to ensure that physicians who are reluctant to follow guidelines or prescribe methadone are able to receive education and training about the benefits of methadone treatment and the current professional standards/expectations for treatment of opioid dependence.

Promote methadone treatment. Correctional facilities can provide a controlled, supportive environment for inmates to start on methadone treatment. In some cases, treatment may be a condition of inmates' sentences. Every effort should be made to promote methadone treatment, and to make it available to clients who want treatment for opioid dependence. Facilities may want to work with established community agencies to develop an effective treatment/stabilization programs within the jails.

5. Improve Vocational Opportunities for Clients

Ontario should improve methadone clients' access to vocational opportunities by:

- working with existing vocational programs to meet clients' needs
- ensuring methadone treatment guidelines do not inhibit clients from participating in training or employment.

Vocational Programs. Treatment is only the first step is helping people with opioid dependence manage their addiction and their lives. Clients also need access to long-term job opportunities. Treatment programs should identify the services their clients need to become more employable (e.g., literacy, remedial education, counselling, special needs programs) and collaborate with existing vocational programs to develop programs that are flexible enough to meet the unique needs of methadone clients.

As a point of principle, vocational programs should not be allowed to exclude people on methadone. Vocational programs should be directly involved in regional planning of services for people on methadone. When working with vocational programs in their community, agencies should ensure that vocational staff receive appropriate training. They should also work with the programs to develop (if they are not already in place) medication policies that treat methadone the same way as any other prescribed

medication, policies that will protect client confidentiality and a flexible approach to training that can accommodate clients' treatment schedules.

Treatment Guidelines. Every effort must be made to ensure that the guidelines for managing methadone treatment do not have a negative impact on clients' ability to participate in training, or to find and maintain employment. Long-term stable clients should have access to higher number of carries (i.e., doses of methadone that the clients keep and administer themselves), and every effort should be made to ensure that clients who are not yet ready for carries are able to have their appointments and receive their doses at times that do not interfere with work responsibilities. Clients who meet the CPSO criteria for a high level of carries may be granted a higher number to allow them to travel or meet work requirements.

6. Change Provincial Policies that Limit Client Access to Methadone Treatment

The Ministry of Health and Long-Term Care should work with other ministries to ensure that government policies do not discriminate against people on methadone treatment.

Travel Issues. The Ministry of Health should designate physicians with a license to prescribe methadone as a specialized service. This would make clients in northern Ontario who have to travel for methadone treatment eligible for the Northern Health Travel Grant. However, this would only meet the needs of a small number of clients. To ensure equitable access, the same type of travel subsidy should be available in all parts of the province.

However, the ultimate goal would be to provide services locally so clients do not have to travel for care. In addition to developing comprehensive methadone treatment programs (discussed earlier), addictions treatment services should look at the potential to use technology and health providers, such as nurse practitioners, to assist in delivering care. Virtual clinics could give clients access to services not available in their communities.

To more provide more accessible services, particularly for clients in rural areas, the addictions treatment system should explore the potential of working through existing outreach programs (e.g., needle exchange vans) to provide mobile methadone treatment services.

Social Assistance/Drug Programs. To ensure that methadone treatment is not a barrier to clients qualifying for social assistance/Ontario Works programs, the Ministry of Health and Long-Term Care should advocate with the Ministry of Community and Social Services to provide social assistance programs that are sensitive to the needs of clients on methadone, and that decisions made by social assistance do not have an adverse effect on clients' access to drug benefits.

The Ministry of Health and Long-Term Care should also advocate with MCSS to ensure that the time required for methadone treatment is negotiated as part of the Ontario Works

participation agreement, that the costs associated with attending treatment (e.g., bus tickets) are covered by the program, and that the program recognizes that being in methadone treatment may have an impact on clients' ability to attend training sessions and/or look for work.

The Ministry of Health and Long-Term Care should also identify and resolve any problems or barriers that prevent people on methadone from getting or keeping Ontario Drug Benefit (ODB) cards or accessing the Trillium Program. For example, the government should consider allowing stable clients to keep their ODB card until they are earning income at a level where they do not have to choose between food and methadone.

Child Protection Policies. The Ministry of Health should work with the Ministry of Community and Social Services to ensure that child protection agencies understand the benefit of methadone treatment for clients and their children.

Given the relatively high rates of addictions in families involved with children's aid societies, the societies should be required to have an addiction specialist on staff, who can work with staff and provide advice on cases, as required. Addictions agencies should also provide ongoing training/education for child protection workers on addictions and treatments, including methadone.

To prevent children being removed from homes where parents are on methadone, the children's aid societies should revise their policies and list methadone as a prescribed rather than an illicit drug.

To protect children's safety in the home, methadone programs should ensure clients have locked boxes to store their methadone carries. If clients cannot afford one, the program should provide it.

V. Conclusion

Opioid dependence is a health and social crisis in Ontario. Not only does it damage the health and lives of those who are dependent, it creates immense pressure on our health, social service and criminal justice systems, and on the well-being of communities.

If the social and health arguments are not persuasive enough, the economics should be. Will Ontario continue to spend about \$44,000 a year in social, legal, health and criminal costs to deal with the impact of each person who is opioid dependent, or will it invest less than 15% of that -- about \$6,000 a year per person -- to provide comprehensive treatment services?

How can Ontario meet the needs of people who are opioid dependent and reduce the personal and social costs associated with dependency? Some of the resources that Ontario uses now to deal with the ill effects of opioid dependence must be redirected to effective treatment programs. Ontario needs a network of treatment services that are able to meet the needs of a wide range of clients - male and female, young and old, Aboriginal people,

members of different cultural groups, people with multiple drug dependencies and concurrent disorders, people who are incarcerated and those on the streets. The province has the knowledge, skills and expertise to develop comprehensive treatment programs for opioid dependence. It requires a commitment from the government to provide the resources required to implement this strategy. With concerted effort, Ontario can recruit the physicians required to provide care, develop support services, make methadone treatment widely available, and encourage both clients to participate.

The Ontario Substance Abuse Bureau estimates that it will cost about \$3.2 million annually to expand existing methadone treatment services and to establish eight new comprehensive methadone treatment programs in parts of the province that are underserved.

Both the new and existing programs will have a physician on staff, and will provide outreach, assessment, counselling, support, case management, housing, income support, vocational services and other health and social services that clients may need. The clinics will play a key role in getting clients into treatment and ensuring they are stable on methadone. The clinics will then link with community physicians currently prescribing methadone, referring clients who are stable to them. Because the clinics will provide the initial stabilization service as well as other services to complement physician care, they will also make it easier for communities to attract new community physicians to methadone practice.

In addition to the \$3.2 million required to fund the community-based methadone treatment services, the Ministry of Health and Long-Term Care may also incur an increase in physician and drug costs for clients treated by community physicians. At the same time that these treatment costs increase, the province should begin to see a substantial decrease in other health care costs (e.g., emergency care, treatment for HIV, hepatitis C, TB), in social assistance costs, in crime costs, and in costs associated with prosecuting and incarcerating people for drug and drug-related offences.

The strategy working group believes there is a strong business case for greater investment in methadone treatment services in Ontario. The return on investment will be substantial: improved health, longer lives, greater productivity, lower crime rates, safer communities, and more stable families.

To guide the implementation of Ontario's opioid dependence strategy, the working group strongly recommends that the Ministry of Health and Long-Term Care establish an ongoing committee, made up of representatives of the health, social service, law enforcement and correctional services systems as well as physicians, pharmacists, community-based methadone treatment services and consumers.

References

Adlaf EM, Paglia A, Ivis FJ. Drug Use Among Ontario Students 1977-1999. Findings from the OSDUS. Centre for Addiction and Mental Health. 1999.

Canadian Profile Alcohol, tobacco and other drugs. 1999. Canadian Centre on Substance Abuse, Centre for Addiction and Mental Health.

Federal/Provincial/Territorial Advisory Committee on Population Health,
Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues,
Federal/Provincial/Territorial Advisory Committee on AIDS,
Federal/Provincial/Territorial Heads of Corrections Working Group on HIV/AIDS, Multi-disciplinary Committee of Senior Justice and Health Officials Developing a Comprehensive Canada-Wide Response to Illicit Drug Use and Emerging Substance Abuse Issues. Reducing the Harm Associated With Injection Drug Use in Canada. Consultation Document. March 2001.

Fischer B. Prescriptions, Power and Politics: The Turbulent History of Methadone Maintenance in Canada. Journal of Public Health Policy. Vol. 21. No. 2 pp 187-210. 2000.

Jones HE, Velez ML, McCaul ME, Svikis DS. Special treatment issues for women. In Strain EC, Stitzer ML. Methadone treatment for opioid dependence. Baltimore. The Johns Hopkins University Press. 1999.

Methadone Maintenance Guidelines. The College of Physicians and Surgeons of Ontario. Revised 2001.

Millson P, Myers T, Calzavara L, Rea E, Wallace E, Major C, Fearon M. Prevalence of HIV and other bloodborne viruses and associated risk behaviours in Ontario injection drug users (IDU). HIV Social, Behavioural and Epidemiological Studies Unit, Faculty of Medicine, University of Toronto. February 1999.

Motiuk L, Dowden C, Natekh M. Methadone Maintenance Treatment (MMT) programming for federal prisoners: A preliminary investigation. Correctional Services Canada. February 1999.

Remis et al. The HIV Epidemic among Injection Drug Users in Ontario: the Situation in 1997.

Remis et al. 2000 Report on HIV/AIDS in Ontario 1999. Ontario Ministry of Health and Long-Term Care. 2000.

Remis et al. The HIV Epidemic Among Men who have Sex with Men: The Situation in Ontario in the Year 2000. Department of Public Health Science. University of Toronto. Nov. 2000.

Research Group on Drug Use. Drug Use in Toronto - 2000: The Changing Landscape of

Drug Use. Toronto Department of Public Health. 2000.

Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario. Ontario Substance Abuse Bureau. January 1999.

Shore R. Methadone Maintenance: Guide to Establishing a Clinic-based Program. 1999.

Van Truong M, Williams B, Timoshenko G. Ontario profile: Alcohol and other drugs, 1998. Toronto: Addiction Research Foundation; 1998.

Wall R, Rehm J, Brands B, Gliksman L, Stewart J, Medved W, Blake J. Social Costs of Untreated Opioid Dependence. Journal of Urban Health. 2000.

Appendix 1

Critical Success Factors for Effective Methadone (Opioid Dependence) Treatment

The Methadone Strategy Working Group, identified the following critical success factors that should be in place for effective treatment of opioid dependence.

A patient-centred, individualized approach (the ability to identify and meet individual patient needs).

Accessible, affordable services available at convenient hours.

A focus on best practices.

An accessible location that offers anonymity, reduces stigma (e.g., integrated within a primary care setting).

A comprehensive, ongoing physical, social and psychosocial assessment process (using standard assessment instruments such as the Addiction Severity Index and/or the Opiate Treatment Index to ensure consistency, which would help build the therapeutic relationship, influence the client's attitude toward treatment, and identify other services the client may need.

A systematic approach to treatment, which sees every interaction with patients as a therapeutic opportunity, and focuses on retaining clients (e.g., clarify policies and expectation at the beginning of treatment; offer a coherent, non-contradictory approach; establish a therapeutic relationship with client; provide relevant information when appropriate).

Clear dosage policy/procedures that are flexible enough to accommodate individual needs and ensure clients receive adequate (higher?) doses.

A non-punitive approach to illicit drug use.

The ability to maintain clear records that include key issues for individual clients.