

# **Report of the Gaps Analysis for Opioid Dependence Treatment (ODT) in Newfoundland and Labrador**

Prepared for:  
Department of Health and Community Services

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‘Scientific research suggests that opioid dependence is a chronic illness with frequent relapses. [...] Opioid dependence is often compared with other chronic diseases, such as hypertension, diabetes, and asthma (McLellan et al., 2000; WHO, 2004). There are no “cures” for chronic diseases. Nevertheless, with appropriate long-term therapy and medical care, together with encouraging behavioural change, it is possible to eliminate or reduce symptoms of the dependence and reach a high quality of life.’<sup>1</sup>



*[I would] like to see no more friends having to take their lives by killing themselves because they did not get help when needed. (Survey respondent – 50s)*

*I need help. I want my old life back. (Survey respondent – 40s)*

*This methadone program has helped me devote myself as a parent to my child. This is a good program and if people can treat it right and not abuse it, it could take people to better places. Good Luck! (Survey respondent – 30s)*

*I would like to say how grateful I am for the help of methadone program. It saved my life as well as family members lives. (Survey respondent – 30s)*

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## List of Acronyms

<b>Abbreviation</b>	<b>Description</b>
AESL	Advanced Education, Skills and Labor
ARNNL	Association of Registered Nurses NL (ARNNL)
BC	British Columbia
CME	Continuing Medical Education
CBT	Cognitive Behavioural Therapy
CPSNL	College of Physicians and Surgeons of Newfoundland and Labrador
CSC	Correctional Service Canada
GGI	Goss Gilroy Inc.
GP	General Practitioner
HCS	Department of Health and Community Services
HMP	Her Majesty's Penitentiary (HMP)
LGBT	Lesbian, Gay, Bisexual, Transgender and Questioning
MIMOSA	Management of Offender Substance Abuse
MMAP	Medical Mentoring for Addictions and Pain
MMT	Methadone Maintenance Treatment
MUN	Memorial University of Newfoundland
NL	Newfoundland and Labrador
NLASW	Newfoundland and Labrador Association of Social Workers
NLNU	Newfoundland and Labrador Nurses Union
NLMA	Newfoundland and Labrador Medical Association
NLPB	Newfoundland and Labrador Pharmacy Board
NLPDP	Newfoundland and Labrador Prescription Drug Program
NP	Nurse Practitioner
ODT	Opioid Dependence Treatment
OST	Opioid Substitution Therapy
OTC	Opioid Treatment Centre
PANL	Pharmacy Association of Newfoundland and Labrador

<b>Abbreviation</b>	<b>Description</b>
RCMP	Royal Canadian Mounted Police
RFP	Request for Proposals
RHA	Regional Health Authority
SWAP	Safe Works Access Program
UDS	Urine Drug Screening

# 1.0 Introduction

This report is provided in completion of a contract between Goss Gilroy Inc. (GGI) and the Department of Health and Community Services to undertake a gaps analysis of opioid dependence treatment (ODT) in Newfoundland and Labrador (NL). As detailed in the Request for Proposals (RFP), the gaps analysis had the following goal and objectives:

## Goal

- To provide an overview of the barriers and gaps that must be addressed to improve quality, increase access, and enhance capacity to deliver ODT for provincial addictions clients (gaps analysis).

## Project Objectives

- Describe the gaps in service for opioid dependence treatment including:
  - Individuals seeking access/accessing ODT;
  - Physicians treating individuals living with opioid dependence;
  - Pharmacies dispensing medication for opioid dependence; and
  - Other health care providers and agencies that support and advocate for individuals living with opioid dependence.
- Identify the barriers that prevent client retention and success.

It is anticipated that the outcome of the gaps analysis will inform the development of a provincial policy on ODT and provide a valuable resource when examining how to increase the capacity of ODT in NL.

# 2.0 Background and context

As described in the *Background on opioid dependence treatment (ODT) in Newfoundland and Labrador* provided with the RFP, opioids are a family of drugs prescribed for pain relief that include morphine, Fentanyl, Demerol, codeine, and Oxycodone. Opioids can also produce euphoria, making them prone to abuse. Opioid addiction is a chronic and recurrent brain disease and one of the most challenging addictions to treat. While withdrawal from opioids is not life threatening, the symptoms are so distressing that those addicted become almost exclusively focused on avoiding withdrawal. As a result, they often lead chaotic and high risk lifestyles, putting themselves at risk for violence, criminal activity, sexually transmitted diseases, physical injury, overdose and death.

The World Health Organization in its *Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence*<sup>ii</sup> describes opioid dependence as ‘a complex health condition that often requires long-term treatment and care.’ It goes on to advise that ‘as no single treatment is effective for all individuals with opioid dependence, diverse treatment options are needed including psychosocial approaches and pharmacological treatment.’

## Treatment Practices across jurisdictions

Methadone treatment for opioid dependence is delivered in diverse ways in different countries. Programs have varied regulatory frameworks, philosophies, policies, non-pharmacological treatment services, program settings, and target populations. Efforts in the United States to increase access to methadone maintenance treatment (MMT) have led to new approaches to program delivery, such as culturally sensitive, family-centered treatment; methadone clinics as primary-care sites (on-site access to primary health care services); and special primary medical care services for people living with HIV/AIDS.<sup>iii</sup>

Of interest, a number of toolkits have also been developed to support MMT, two of which were reviewed during writing of this proposal and are footnoted herein.<sup>iv,v</sup> One – the *Methadone Maintenance Treatment Intervention Toolkit*, was a combined effort of government agencies in seven Asian countries and the Australian Agency for International Development. One would surmise a level of collaboration is demanded among the countries involved in developing the toolkit should they move to create or update their own MMTs.

In the Netherlands, outpatient opioid substitution treatment (OST) is the primary approach for opiate dependence. Psychosocial interventions are more frequently provided to complement OST in order to achieve longer-term effectiveness, reduce relapses and promote social reintegration. Frequently used psychosocial treatments in drug treatment centres include motivational interviewing, relapse prevention techniques, cognitive behavioural therapies, and family, community and home-based treatment therapies. Methadone, available via various outpatient treatment providers - including office-based practitioners and mobile units - has been the most commonly prescribed substitution substance since 1968.<sup>vi</sup>

Suboxone is the drug [treatment] of choice in the United States and France.<sup>vii</sup> One clinic which is described as offering an innovative program employing suboxone is the Allied Addiction Recovery, a Pennsylvania licensed drug and alcohol outpatient clinic with a commitment to providing quality care to people struggling with addictions and mental health problems in Western Pennsylvania. Their staff includes, for example, psychiatrists, Certified Alcohol and Drug Counsellors, master's level therapists, social workers, as well as qualified mental health staff members. Allied Addiction Recovery offers a program that provides suboxone in conjunction with abstinence-based counseling. At their outpatient facility, they use suboxone to stabilize their patients and then combine this with individual and group counseling to move them to a point where they are completely clean and sober. Individuals are guided, supported and directed by the therapists as they develop personal strategies and plans to achieve their goals. Success in recovery is defined individually for each client. Counselling is designed to help clients build commitment throughout the process of behavior and attitude modification. While medical guidelines suggest that treatment can take 18 to 24 months, this centre works to get patients to the point where they can lower the level of Suboxone within six to 12 months.<sup>viii</sup>

While Health Canada approved suboxone for sale in Canada in 2007, the provinces have until recently viewed the drug as a second-line treatment, to be used for patients who cannot take methadone. British Columbia – long seen as a leader in harm-reduction strategies – added suboxone to its drug formulary as a regular benefit in October 2015, making it a first-line treatment for opioid addiction.<sup>ix</sup> Similarly In the fall of

2016, it was announced that Ontario was expanding the use of the suboxone as an alternative to methadone as part of a new provincial strategy to combat an increasing number of overdoses and deaths. It was felt that providing suboxone as a first line of treatment within a supportive primary care environment, would provide an improved level of care for the target population. Further, having suboxone prescribed by family physicians without a special license or training, would greatly expand access to treatment for patients who urgently need it.<sup>x</sup>

Another approach in Canada is the use of naloxone<sup>xi</sup> which temporarily reverses the effects of opioid overdose. Edmonton started the first naloxone program in Canada (2005), followed by Toronto (2011). Both Ontario and British Columbia (BC) started provincial Take Home Naloxone initiatives in 2012.

In March 2016, Health Canada removed naloxone from the Prescription Drug List. Jurisdictions across Canada now use a variety of systems to grant community programs permission to dispense naloxone.

One naloxone program of note is the "Toward the Heart Program" - a project of BC's Harm Reduction Program. Historically, in BC, only ambulances, hospitals, and some clinics used naloxone. However, since 2012, people who use opioids and have participated in overdose response training can receive "take-home" naloxone kits (i.e. for use in community settings) at no cost. Training and kits are available at more than 70 sites across BC.

## **Treatment Options in NL**

In NL, treatment of opioid addiction has primarily been accomplished through methadone maintenance treatment (MMT). Two regulatory bodies outline the delivery of these services: the Newfoundland and Labrador Pharmacy Board (NLPB) and the College of Physicians and Surgeons of NL (CPSNL).

Further, as stated in the background paper to the RFP, this province currently has 14 physicians who are eligible to prescribe methadone for opioid dependence, the majority of whom are located in the Eastern Health Region. There are no prescribers in Western or Labrador, with a physician from Central who services a limited number of clients in Corner Brook. At the time this research was initiated in October 2016, there were 58 community pharmacies authorized to dispense methadone: 33 in Eastern; 15 in Central; 5 in Western; and 5 in Labrador.

Although methadone has been the primary treatment for opioid dependence, alternative pharmacotherapy options such as suboxone have recently become more available (see section 6.2.1.2).

Of note, on August 31, 2016, it was announced by the Government of NL that funding will be provided to the AIDS Committee of NL and the four Regional Health Authorities (RHAs) to establish a province-wide take-home naloxone program.<sup>xii</sup>

The RHAs include Eastern Health, Central Health, Western Health, and Labrador-Grenfell Health. These bodies provide a continuum of services, including residential treatment centres, and outpatient counselling to adults and youth who are at-risk of or experiencing addictions.

The background paper also cites several models of MMT practice in the province and identifies that availability and access is often limited by geographic location. The models include:

- The Opioid Treatment Centre (OTC) operated in St. John's by Eastern Health, which has a multidisciplinary team available to prescribe and dispense methadone, do urine screens, and provide counseling.
- Her Majesty's Penitentiary (HMP), with approximately 30 patients, where a physician works with individuals who have accessed MMT prior to incarceration.
- MMT access through private physicians.
- A MMT clinic in Corner Brook maintained by a physician from Central Health and a nurse from Western Health. This clinic is capped at 60 patients.

As noted in the RFP, although historically limited to MMT, HCS recognizes that treatment extends beyond methadone. For that reason, HCS refers to the treatment of opioid addiction as 'opioid dependence treatment (ODT)' with the term being inclusive of the range of services available to treat opioid dependence. These services include both community-based and more formal services.

#### *Government – provincial programs<sup>xiii</sup>*

The Humberwood Treatment Centre, located in Corner Brook and operated by Western Health, is an adult residential treatment centre that provides three-week inpatient treatment for men and women 19+ years who are experiencing a substance use and/or gambling problem. The Centre also offers a four-week provision for those who undergo detox and the opportunity to extend a stay to up to 40 to 45 days for those who are deemed to require more time in the Centre. The Centre has 10 treatment beds and four detox beds. Individuals can refer themselves or be referred from an addictions counselor or other professional. In the program, clients participate in individual and group counselling, relaxation and leisure therapy, and educational sessions. An extensive follow-up program is provided through outpatient offices.

The Recovery Centre, located in St. John's and operated by Eastern Health, is a provincial detoxification (withdrawal management) service. Located in Pleasantville, the program provides provincial inpatient withdrawal management for 19 individuals at a time. The service is available to anyone 16 years and older, who is intoxicated or experiencing withdrawal from alcohol, drugs and/or gambling. Admissions can be self-referrals or through hospital emergency units, health professionals and community agencies. The length of stay is determined by individual need. The program focuses on stabilizing the individual's physical and psychological health throughout the withdrawal process. An Addictions Counselor is available to meet with clients of the Recovery Center for assessment, crisis counselling and discharge planning purposes. Clients also have access to in-house education and group sessions, as well as, onsite self-help meetings.

The Opioid Treatment Center (OTC) is an outpatient treatment program for opioid dependent individuals. It provides a multidisciplinary approach to treatment rooted in methadone maintenance for individuals experiencing opiate addiction. The patients receive support from a multidisciplinary team approach consisting of physicians, nurses, addiction counsellors and pharmacist. Clients can receive counselling and

health education from the different team members, with counselling intended to help a client make different and healthier life style choices. Clients decide how long they would like to be in the program and are encouraged to participate for at least a year.

The Grace Centre is a provincial inpatient addictions treatment centre for male and female adults, aged 18 years and older. The Grace Centre is operated by Eastern Health and located in the Town of Harbour Grace, NL. It is a voluntary program for individuals who require a more intensive, structured program than can be provided on an outpatient basis. This Centre, which opened in February 2016, was described as complementing the longstanding adult addictions treatment centre, Humberwood.

The program consists of a 28-day treatment service that is holistic in nature and addresses the individual's physical, social, psychological, and spiritual needs through individual, group and family counselling. An extended stay may be available for extenuating circumstances.

The centre is staffed with a multidisciplinary team consisting of a physician, nurse practitioner (NP), nurse, social worker, recreational therapist, occupational therapist, pharmacist, psychologist, and non-clinical support staff.

The Hope Valley Centre in Grand Falls-Windsor serves youth between the ages of 12 and 18 years that currently reside in NL. The Centre houses 12 residential beds. The Centre is a provincial service offering withdrawal management and stabilization services and residential addictions treatment specifically for youth. The Centre provides educational and recreational facilities, treatment spaces, and offices for clinical and administrative staff. There is a generous availability of indoor and outdoor space for leisure and recreational activities.

Other ODT initiatives referenced in the Province's August 31, 2016 press release include:

- Development of a safe prescribing course in partnership with CPSNL and Memorial University of Newfoundland's (MUN's) Faculty of Medicine;
- Development of a Prescription Monitoring Program; and,
- Mandatory connection by all pharmacies to the Pharmacy Network by January 1, 2017.

#### *Community-based*

- Choices for Youth's Outreach and Youth Engagement Program is the first point of contact with youth presenting at Choices. Outreach helps youth 'work toward safe and supportive housing, improved wellness, and increased support systems'. Staff work with the youth to build trust and support them to meet their own needs and goals. Through housing, employment, education, life skills, healthy lifestyles, or just access to tangible items, Outreach and Youth Engagement Programming provides at-risk youth with the appropriate support to move forward.
- The Front Step Program, launched by End Homelessness St. John's, in March 2016, provides immediate access to housing and supports for individuals experiencing chronic or episodic homelessness, based on consumer choice and the belief that everyone deserves housing and that adequate housing is a precondition for recovery and stability.<sup>xiv</sup>

- The John Howard Society of Newfoundland and Labrador offers a variety of treatment modalities to assist offenders in making informed lifestyle changes through its Moderate Intensity Management of Offender Substance Abuse (MIMOSA) program. The program targets adult male offenders with a moderate to high level of alcohol and/or drug dependence.

It is clear that there is a foundation on which to build effective and collaborative practices and approaches to ODT in the province, which can support moving individuals along a continuum to recovery. The current project, which provides an overview of barriers and gaps in ODT in NL, should inform Provincial policy needed to ensure improved quality of and increased access to ODT.

## 3.0 Methodology

### 3.1 Communication with HCS

Wayne Bishop, Consultant, Mental Health and Addictions – HCS, was the primary contact person for this project. We provided regular updates via email and/or telephone to report on progress during the research and to discuss solutions to any issues being encountered (and how these were to be addressed). Face-to-face meetings were held as required.

In mid-December 2016, we provided a summary interim report detailing our research activities to that date, as well as preliminary findings/key themes.

### 3.2 Document review

The document review focused on key provincial documents - policies, procedures, and guidelines – relevant to inform the gaps analysis and the resulting policy development on ODT, as well as documents/websites which informed effective practices in MMT/ODT. This included:

Newfoundland Resources:

- Department of Health and Community Services. Background on opioid dependence treatment (ODT) in Newfoundland and Labrador. 2016.
- College of Physicians and Services of Newfoundland and Labrador. Methadone Maintenance Treatment - Standards and Guidelines. Revised April 1, 2016. Available from <https://www.cpsnl.ca/web/files/Methadone%20Maintenance%20Treatment%20Standards%20and%20Guidelines%20-%20CPSNL%20-%20April%201%202016.pdf>.
- Newfoundland and Labrador Pharmacy Board Standards of Practice. Standards for the Safe and Effective Provision of Medication for the Treatment of Opioid Dependence January 2015 Revised August 2016. Available from [http://www.nlph.ca/media/SOPP-Medication-Assisted\\_ODT-revised-Aug2016.pdf](http://www.nlph.ca/media/SOPP-Medication-Assisted_ODT-revised-Aug2016.pdf).

- Department of Advanced Education and Skills. Income and Employment Support Policy and Procedure Manual. Chapter 7 (ii) Medical Transportation. November 15, 2016. Available from [http://www.aesl.gov.nl.ca/policymanual/pdf/is/trans\\_medical.pdf](http://www.aesl.gov.nl.ca/policymanual/pdf/is/trans_medical.pdf).

#### National/International Resources:

- Health Canada. Best Practices. Methadone Maintenance Treatment. 2002. Available from [http://www.hc-sc.gc.ca/hc-ps/alt\\_formats/hecs-sesc/pdf/pubs/adp-apd/methadone-bp-mp/methadone-bp-mp-eng.pdf](http://www.hc-sc.gc.ca/hc-ps/alt_formats/hecs-sesc/pdf/pubs/adp-apd/methadone-bp-mp/methadone-bp-mp-eng.pdf).
- Ontario College of Family Physicians. Medical Mentoring for Addictions and Pain Network. 2015. Available from <http://ocfp.on.ca/cpd/collaborative-networks/mmap>.
- Ontario Pharmacists' Association. Methadone Maintenance Treatment. Methadone Online Forum. 2017. Available from <https://www.opatoday.com/professional/resources/for-pharmacists/programs/methadone>.
- BC Pharmacy Association. More than Pills. BC Pharmacy Association 2014/15 Activity Report. 2015. Available from [http://www.bcpharmacy.ca/uploads/MoreThanPills\\_stakeholder-report-2015\\_10\\_08\\_FINAL\\_web.pdf](http://www.bcpharmacy.ca/uploads/MoreThanPills_stakeholder-report-2015_10_08_FINAL_web.pdf).
- World Health Organization. How to improve Opioid Substitution Therapy Implementation. January 2014. Available from [http://www.euro.who.int/\\_data/assets/pdf\\_file/0015/241341/How-to-improve-Opioid-Substitution-Therapy-implementation.pdf?ua=1](http://www.euro.who.int/_data/assets/pdf_file/0015/241341/How-to-improve-Opioid-Substitution-Therapy-implementation.pdf?ua=1).

Information from the documents/websites which was relevant to this gaps analysis was extracted and analyzed. The full list of primary documents/websites considered for the review is provided in Appendix “A”

### **3.3 Key informant interviews**

Key informant interviews were undertaken to gather in-depth information from specific stakeholders. In total, comprehensive individual or group interviews were held with 61 informants. They represented a range of service providers who directly or indirectly support and/or provide programs, services and/or treatment to individuals with opioid addiction, and/or provincial associations/organizations which support these service providers.

The interview guides for each of the following informant groups were similar and so samples are found in Appendix “B”.

### **3.3.1 Physicians**

We approached the Newfoundland and Labrador Medical Association (NLMA) for names of physicians who they could identify who would have perspectives /views on methadone.

#### *Physicians without an exemption to prescribe methadone/suboxone*

Eight physicians who are not prescribing methadone or suboxone were included in the consultation. This included physicians working in both a hospital as well as an individual clinic setting. They had been working for five to 20+ years and were located across the province, including Labrador. Their areas of focus included general practice, oncology, physical medicine and rehabilitation, pain management, psychiatric and/or emergency services. For ease of reference, this group will be referred to as the “non-prescribing physician informants” in this report.

#### *Physicians with an exemption to prescribe methadone and/or suboxone*

The NLMA identified four physicians with exemptions to prescribe methadone and/or suboxone. To support our efforts, the College of Physicians and Surgeons NL (CPSNL) sent a request on our behalf to the full list of those who have exemptions asking anyone who was interested in being consulted to contact GGI. Out of the potential list of 14 physicians who have an exemption to prescribe methadone and/or suboxone, we interviewed eight, as well as three other health professionals who work closely with some of these physicians.

These 11 informants were from the Island, as at the time of writing of this report, there were no physicians with an exemption to prescribe methadone and/or suboxone working in Labrador. Of note, of the 14 physicians who have exemptions, 10 are based in the St. John’s Metro Region, and the remaining physicians are based in central Newfoundland, with one of these physicians supporting a methadone program on the west coast via telehealth.

Some of the physicians have been practicing for 20+ years and others are newer in their practice. Similarly, they varied in the length of time they have been prescribing methadone and/or suboxone. In addition to their family/general practice, a few also were involved in the provision of psychiatric and/or emergency services in an urban or rural setting. Their services are offered in a clinical/health setting or within the correctional system at Her Majesty’s Penitentiary (HMP) and the Correctional Centre for Women in Clarenville.

For ease of reference, this group of informants will be referred to as the “methadone-prescribing physician informants” in this report.

### **3.3.2 Pharmacists that dispense methadone and/or suboxone**

The Pharmacists Association of NL (PANL) distributed a request from GGI for volunteers to participate in the consultation for this gaps analysis. Six pharmacists with authorization to dispense methadone and/or suboxone were consulted for this review. These pharmacists had been practicing for 10+ years and dispensing methadone and/or suboxone for four to 15+ years.

For ease of reference, this group of informants will be referred to as the “pharmacist informants” in this report.

Of note, we were not contacted by any pharmacists who do not have authorization to dispense methadone and/or suboxone. As a result, we did not consult with this population.

### **3.3.3 Government departments/divisions**

Interviews were conducted with six representatives from four government departments: *Government of NL* - Advanced Education, Skills and Labor (AESL), Labrador and Aboriginal Affairs, and Justice and Public Safety; and *Nunatsiavut Government* - Department of Health and Social Development. The informants were versed in policy relevant to this gaps analysis, and/or were directly or indirectly involved in the provision of mental health and addictions services in the community or within correctional facilities.

### **3.3.4 Regional Health Authorities**

Consultations were held with a total of 10 representatives from the RHAs:

- Eastern Health;
- Central Health;
- Western Health; and
- Labrador-Grenfell Health.

These informants were focused on, for example, mental health and addictions, chronic pain management, health promotion and/or psychiatry.

Overall, the RHAs are responsible for the delivery and administration of health and community services (e.g., preventing and/or treating illness and injury, health promotion and protection, rehabilitative services, supportive care) in community and facility/institutional settings (e.g., hospitals, health centres, treatment centres) in their health regions. Each of the RHAs has a mental health and addictions division providing a continuum of services including, for example, intake, screening and assessment, counselling, case management and/or follow-up, referral to other services, as well as mental health promotion and information on addiction.

For ease of reference, these informants will be referred to as the “RHA informants” in this report.

### **3.3.5 Treatment centres**

Consultations were held with a total of 11 representatives from the following provincial treatment centres:

- Humberwood Treatment Centre (located in Corner Brook);
- Grace Centre (located in Harbour Grace);
- Hope Valley Centre (located in Grand Falls-Windsor); and
- Opioid Dependence Treatment Centre (located in St. John’s).

### **3.3.6 Provincial associations/bodies**

Nine informants from the following provincial associations/bodies were consulted for this gaps analysis:

- Association of Registered Nurses NL (ARNNL);
- NL Nurses Union (NLNU);
- NL Medical Association (NLMA);
- College of Physicians and Surgeons NL (CPSNL);
- NL Association of Social Workers (NLASW);
- Pharmacists Association of NL (PANL);
- NL Pharmacy Board (NLPB); and
- Royal Canadian Mounted Police (RCMP).

These provincial associations and bodies vary significantly in relation to their role in ODT, ranging, for example, from prevention through to recovery. Their roles include, for example, providing educational sessions, promoting and informing health and social policy, and providing education to support and assist their practitioners' needs, to regulating standards of practice and/or ensuring quality of practice (e.g., in relation to health, safety and competencies). The Associations have significant membership across the province and, in some cases, they and/or their members participate in regional/provincial committees and/or working groups which have a focus on addiction/ODT.

Of note, we did not include representatives from the Opioid Dependence Treatment Working Group, Provincial Advisory Committee on Opioid Treatment Services, or Committee on Abuse of Prescription Medication in this consultation process. On review of their membership, it was identified that some had been consulted for this gaps analysis in their roles with their own organizations/agencies/groups and/or their perspectives had been covered via the broader consultation process.

## **3.4 Focus groups**

Two focus groups were held with community-based representatives. In total, there were ten participants in these groups. Additionally, the focus group guide was used in individual and/or email interviews with those invited to but unable to participate in the focus group process due to other commitments or location.

Overall, we consulted with 19 individuals representing and/or affiliated with 13 organizations including:

- AIDS Committee of NL's Safe Works Access Program (SWAP) – St. John's and Western sites;
- Association for New Canadians;
- Choices for Youth;
- Front Step;
- Iris Kirby House;
- John Howard Society;

- NAVNET;
- Salvation Army St. John's;
- Stella's Circle;
- The Gathering Place;
- Thrive-Community Youth Network;
- U-Turn Centre; and
- Wiseman Centre.

These organizations provide supportive services to at-and high-risk individuals, including those who are experiencing or have experienced poverty, homelessness, mental illness, and/or addictions. Their services include, for example, safe needle exchange; emergency shelter; counselling and referral; access to medical care; goal setting and planning; support groups; and/or peer support. Most work within a harm reduction framework (see section 13.0) and/or support the principles of Housing First. Some of the groups also have representation on local, regional, and/or provincial committees and working groups with a focus on ODT. These venues provide opportunities to learn from/inform other stakeholders, collaborate on joint initiatives, and share their clients' voices and perspectives.

The focus group guide also is found in Appendix "B".

### ***3.4.1 The coast of Labrador***

Due to the unique nature of the communities across the coast of Labrador, it was decided that individual discussions would be held with representatives from this region instead of a focus group. Discussions were held with a representative from each of the following coastal communities - Cartwright, Charlottetown, Hopedale and Rigolet, whose populations range from 350 to 700 people.

All of those referenced in sections 3.4 and 3.4.1 will be referred to as the "focus group participants" throughout the report.

## **3.5 Models of service**

As a component of the consultation, we sought to gather information detailing how models of ODT service are operationalized across settings – e.g., family physicians, multidisciplinary modes, private clinics, correctional facilities, and community-based. Descriptions of these models of service were to include the following elements:

- Target group
- Referral
- Intake
- Assessment
- Program overview (key components)

- Ongoing treatment/maintenance
- Any innovative techniques to support clients receiving ODT.

We also asked providers to identify any existing policies – at their organizational/agency level or provincially, which support or constrain delivery of their ODT model of service.

Within the resources allocated for this project, the most efficient method for collecting this information was through a template given to providers who deliver ODT (see Appendix “C”).

As we moved through the consultations, we were challenged to request that providers complete such a template, primarily due to their limited time to engage in the consultation process. Given the small number we received, we have not provided any summary information on how models are operationalized in each setting. However, we have extracted information from these models, which is directly relevant to the findings, and provided it herein.

Information on the few models of service we received is provided in a separate document.

## **3.6 Consulting the target group**

### ***3.6.1 Individuals with lived experience***

The final aspect of the consultation targeted individuals with lived experience of accessing methadone or suboxone for ODT in NL. Given the privacy considerations related to undertaking this consultation (and as no prior agreement had been given by this target group to participate in research and/or share their contact information), the following approach was undertaken to access this target group.

We sought and received the cooperation of four MMT service providers to distribute a survey to a number of their patients who have lived experience accessing methadone.

The client survey sought limited demographic information (e.g., age range, gender, number of years experiencing addiction, region of the province), focusing primarily on their experience currently or formerly accessing methadone or suboxone. These surveys sought their perspectives on the adequacy of access to these therapies and other ODT options, challenges to/supports needed for retaining individuals on methadone or suboxone and ultimately moving along the continuum to recovery. It also sought their perspectives on gaps in relation to ODT in NL and ways/means to fill these gaps.

In total, 45 surveys were completed by individuals receiving methadone. For ease of reporting, those who responded to the methadone survey will be referred to as the "methadone survey respondents".

A copy of the methadone users survey is found in Appendix “D”.

### 3.6.1.1 Profile of the methadone survey respondents

#### *Region in which they were living*

At the time they completed the survey, the majority of the methadone survey respondents (71%) resided in the Avalon region, with 22% coming from the western and 2% coming from the eastern region. Four percent of the respondents reported “other”—i.e., living in Newfoundland.

Table 1: Location of methadone survey respondents (N= 45).

<b>Region</b>	Avalon	Eastern	Central	Western	Other*
%	71%	2%	0%	22%	4%

#### *Age and gender*

Forty-nine percent of the methadone survey respondents were female; 51% were male. They ranged in age from 21 to 63 years of age, with the majority being in their 30s (see Table 2).

Table 2: Age range of the methadone survey respondents (N= 44).

<b>Age Ranges</b>	< 20	20-29	30-39	40-49	50-59	60+
%	0%	32%	52%	9%	5%	2%

#### *Marital status*

As can be seen in Table 3, the majority of the methadone survey respondents were single (62%) or common law/living together (18%).

Table 3: Marital status of the methadone survey respondents (N=45).

<b>Marital status</b>	Single	Married	Separated/divorce	Common-law/ living together	Other
%	62%	0%	11%	18%	11%

#### *Level of education*

The majority of the methadone survey respondents (42%) indicated that they had only completed high school; another 26% had completed college (see Table 4).

Table 4: Level of schooling completed by the methadone survey respondents (N=43).

<b>Level of schooling</b>	<b>%</b>
No formal schooling	0%
Some schooling	21%
Completed high school	42%
Some post-secondary	12%
Completed post-secondary (college)	26%
Completed post-secondary (university)	0%

### *Source of income*

Of the 42 methadone survey respondents who identified their source of income, 64% were in receipt of Income Support. Twenty-nine percent of the survey respondent received income from employment, with five percent receiving employment insurance and two percent stating they have no source of income.

### *Experience with drug dependency/addiction*

As can be seen from Table 5, almost a quarter of the methadone survey respondents stated using drugs for one to four years before entering MMT, with one participant stating that they had been using drugs for 20 years. Thirty percent of participants provided a vague timeline on their prior drug usage, e.g., “years” of use.

Table 5: Length of time of taking drugs before entering the methadone program (N=44).

<b>Years</b>	1-4 years	5-8 years	9-12 years	13-16 years	17-20 years
<b>%</b>	23%	14%	18%	11%	5%

### *Experience in MMT*

The methadone survey respondents varied in their duration in the methadone program from two weeks to 11 years. Most survey respondents had been in the methadone program for one to three years (42%), with 18% of participants enrolled in each of the following: less than a year, four to six years, and seven or more years. Three percent of respondents cited being enrolled in the program for “years”. (See Table 6)

Table 6: Length of enrolment in methadone program (N=33).

<b>Years</b>	<1 year	1-3 years	4-6 years	7+ years
<b>%</b>	18%	42%	18%	18%

When asked where they accessed their methadone (and they could provide multiple responses), the majority of the methadone survey respondents reported accessing it from their pharmacist (98%), with 27% also citing their physicians. Twenty percent of the methadone survey respondents also were accessing take-home doses.

### **3.6.2 Clients seeking ODT**

Given that this project is focused on a gaps analysis, it was considered to be beneficial to include a small complement of potential ODT clients. This target group included those with addictions who have tried to and/or who are ready to avail of existing pharmacotherapy treatment options, but are challenged to do so. Given the privacy considerations related to undertaking this consultation (and as no prior agreement had been given by this target group to participate in research and/or share their contact information), we sought the support of our contacts from community-based organizations and the pharmacy informants in identifying individuals to participate in the non-methadone users survey.

This non-methadone survey also sought limited demographic information (e.g., age range, gender, number of years experiencing addiction, region of the province), focusing primarily on their experience currently accessing services or their efforts to so do. The surveys sought their perspectives on, for example, the

adequacy of access to ODT options, and on gaps in relation to ODT in NL and ways/means to fill these gaps.

In total, 29 non-methadone surveys were completed. For ease of reporting, those who responded to the non-methadone survey will be referred to as the "non-methadone survey respondents".

A copy of the non-methadone survey is found in Appendix "E".

### 3.6.2.1. Profile of the non-methadone survey respondents

#### *Region in which they were living*

At the time they completed the survey, the majority of the non-methadone survey respondents (79%) resided in the Avalon region, with 3% coming from each of the central and western regions. Of those who cited coming from "other" areas, they cited living out of province or out of country. (See Table 7.)

Table 7: Location of non-methadone survey respondents (N= 29).

<b>Region</b>	Avalon	Eastern	Central	Western	Other*
<b>%</b>	79%	0%	3%	3%	14%

\*Toronto (2); Lancaster, England (1); NL (1)

#### *Age and gender*

Thirty-eight percent of the non-methadone survey respondents were female; 62% were male. They ranged in age from 21 to 65 years of age with the majority being in their 20s. Of note, 7% were over 60 years of age. (See Table 8.)

Table 8: Age range of the non-methadone survey respondents (N= 28).

<b>Age Range</b>	< 20	20-29	30-39	40-49	50-59	60+
<b>%</b>	0%	43%	18%	14%	18%	7%

#### *Marital status*

As can be seen in Table 9, the majority of the non-methadone survey respondents were single (59%) or common law/living together (21%).

Table 9: Marital status of the non-methadone survey respondents (N=29).

<b>Marital status</b>	Single	Married	Separated/divorce	Common-law/ living together	Other
<b>%</b>	59%	3%	10%	21%	7%

#### *Level of education*

The majority of the non-methadone survey respondents (59%) indicated they only had some schooling; 24% of the respondents had completed college (see Table 10).

Table 10: Level of schooling completed by the non-methadone survey respondents (N=29).

Level of schooling	%
No formal schooling	0%
Some schooling	59%
Completed high school	10%
Some post-secondary	3%
Completed post-secondary (college)	24%
Completed post-secondary (university)	3%

#### *Source of income*

Of the 28 non-methadone survey respondents who identified their source of income, just over 70% were in receipt of Income Support. Twenty-one percent were working or in receipt of a pension; the remaining respondents cited having no income.

#### *Experience with drug dependency/addiction*

The majority of the non-methadone survey respondents were between 10 and 19 years of age when they first used drugs. Of note is that 3% said they were younger than 10 years of age.

Table 11: Age at which survey respondents first used drugs (N= 29).

Age	<10 years	10-19	20-29	30-39	40-49
%	3%	66%	17%	7%	7%

Seventy-two percent of the non-methadone survey respondents indicated that there were times that they were not using drugs. In terms of the drugs they were using at the time of the survey, marijuana, opiates and cocaine were prevalent; just under 40% cited being on three or more different drugs. Fourteen percent of the non-methadone respondents cited not being on drugs at that time of the survey.

## **4.0 Existing ODT Services**

While the primary focus of the research was on gaps in ODT, those consulted for the gaps analysis were asked to identify options (e.g., resources, programs, and services) available in the region/ province to support individuals struggling with opioid dependency.

While few expanded on the reasons for their choices, the following resources, programs, and services were identified.

### **4.1 Access to Methadone and Suboxone**

Most of the informants and focus group participants spoke to access to methadone and suboxone as being critical ODT services.

### **4.1.1 Methadone**

As per the MMT Standards and Guidelines (Section 1.0 Introduction):

MMT is based on a harm reduction philosophy and represents one component of a continuum of treatment approaches for opioid-dependent individuals. MMT is a substitution therapy that allows a return-to-normal physiological, psychological and societal functioning. It is one possible treatment for opioid dependence. [...] Methadone alone does not constitute effective treatment of opioid dependency. Effective MMT services would ideally comprise the following components:

- an appropriate methadone dose
- routine medical care
- treatment for other substance dependence
- counseling and support
- mental health services
- health promotion, disease prevention and education
- linkages to other community-based services
- outreach and advocacy.

### **4.1.2 Suboxone**

As per the MMT Standards and Guidelines (Section 3.3.1):

Buprenorphine/naloxone (Suboxone) is a sublingual partial agonist<sup>xv</sup> that relieves withdrawal symptoms and cravings for 24 hours or more when administered in appropriate doses. Suboxone combines buprenorphine (a partial agonist), which is an effective therapy for opioid dependence, and naloxone (an opioid antagonist), which is intended to limit intravenous misuse and the potential for diversion.

Suboxone has a ceiling effect which means that when taken at increasingly higher doses, a user will not derive any additional psychological euphoria from suboxone, but they will from Methadone.<sup>xvi</sup> Because it has a ceiling effect, suboxone appears to be safer in overdose compared to methadone. However, buprenorphine may also be somewhat less effective than methadone at retaining patients in treatment.

The maximum dose for suboxone (24 mg) is probably less effective than methadone at doses above 60 or 80 mg; therefore, methadone may be more appropriate for patients who are dependent on large doses of opioids. Patients who have failed at suboxone treatment may be switched to MMT; switching from methadone to suboxone is clinically more difficult. MMT is considered first-line therapy.

## 4.2 Community-based services

There is a range of community-based services available in the province, although these resources are primarily available in the St. John's Metro Region/Avalon area. While it is acknowledged the list of resources is long, the organization most often cited across the informant groups and focus group participants as being a critical resource for individuals addicted to opioids was SWAP - the needle distribution service offered by the AIDS Committee of Newfoundland and Labrador.

SWAP is a health promotion and education service for people who use drugs. Working from a public health perspective, SWAP strives to reach people "where they are". The goal is to reduce the negative consequences of a particular behaviour, rather than requiring that the behaviour stop. This approach may result in the eventual reduction of the behaviour itself. Any positive change is considered harm reduction.<sup>xvii</sup> SWAP has offices in St. John's and Corner Brook and provides needle distribution service across the province via mail. As commented by one health care informant,

*Preventative measures need to be supported to prevent addicts from contracting HIV, Hep C. Treatment centres help, and we need more of them. I totally agree with SWAP. We should be looking more at safe use – a place to go and use safely. Public washrooms and parking lots with needles lying discarded are not the answer, and if people find discarded needles, they don't know what to do with/about them.*

Other organizations referenced as being integral to supporting individuals struggling with drug dependency included Choices for Youth, Stella's Circle, U-Turn and self-help groups such as Narcotics Anonymous.

## 4.3 Naloxone kits

As of the fall 2016, Naloxone kits were made available in NL. Naloxone, is a safe and effective compound that reverses the effects of opioid overdose. Through an investment of \$180,000, approximately 1,200 naloxone kits are being distributed to target populations by the RHAs and SWAP.<sup>xviii</sup> This was described by a few of the informants and focus group participants as an important recent initiative by the Provincial Government.

## 4.4 Clinical services

Available clinical resources also were cited by some informants and focus group participants as being important to support individuals struggling with opioid dependency. Examples included mental health and addictions resources, including e-mental health services (where available), out-patient clinics, programs and services at the Waterford, and provincial treatment centres including the Recovery Centre (St. John's), Opioid Treatment Centre (St. John's), Humberwood (Corner Brook), Grace Centre (Harbour Grace), Paradise Youth Treatment Centre, and Hope Valley Centre (Grand Falls-Windsor).

## 4.5 Atlantic Mentorship Network<sup>xix</sup>

A regional resource identified by a few of the physician informants is the Atlantic Mentorship Network, described as the largest pain and addiction providers' network in Canada. This network offers education, clinical support and continuing medical education (CME) credit to health care practitioners. More specifically, the Network provides its members with:

- Connection to more than 200 pain and addiction providers;
- Access to a clinic mentor;
- A community of practice;
- Small group learning and discussions in your home community;
- Monthly online discussion of pain and addiction topics;
- An annual network conference (additional fee);
- Links to practitioners across Canada; and
- 12-15 hours of CME credit per year.

The network is primarily funded by the Nova Scotia Department of Health and Wellness and the Newfoundland Department of Health and Community Services, with additional support from the QEII foundation.

### *Mentorship program*

Anyone involved in front line care of an individual suffering from chronic pain and addiction is invited to participate in the Network's mentorship program, fostering an interdisciplinary network. The unique group allows participants the opportunity to access the knowledge and expertise of different disciplines to then apply this information to their own situation.

Groups are "guided" by mentors who may not necessarily be experts in their field, however they have training in mentorship and potentially extra training in pain or addiction management. Mentors are provided with compensation for their time. Three times during the year, the small group of mentees and mentor met to discuss cases, hear an expert on topic raised by the group, or have a demonstration of a technical skill.

## 4.6 Correctional Services

Her Majesty's Penitentiary (HMP) in St. John's has a health care unit including a NP, an addictions coordinator, staff nurses, as well as a general practitioner (GP), two psychiatrists, and a psychologist.

Outside St John's, the remaining four correctional facilities are staffed by NPs who work on contract to a maximum of 20 hours a week. All newly admitted inmates undergo a health assessment, and anyone who presents with an issue or concern is seen by an NP. As well, inmates in these facilities have monthly access to a psychiatrist.

There is a psychologist on contract (five to eight hours per week) at the West Coast Correctional Institution (Stephenville) and the NL Correctional Centre for Women in Clarenville (eight hours per week), and efforts are now being made to institute such a service at the Labrador Correctional Centre. Women incarcerated at the NL Correctional Centre also have weekly access to a staff from Stella's Circle who provides gender-specific addictions services, which continue post-release to those who relocate to/live in St. John's.

Individuals incarcerated in Lock-ups in the province also have access to NPs, and in St. John's there is access to psychiatrists 24/7 for suicide intervention or fitness assessments.

It was stated that there is addictions programming available in all of the province's correctional facilities (with some of the support provided by community-based groups and/or the RHAs). In particular, HMP has an addictions coordinator and offers a continuum of programming (see Appendix "E"), including MMT and a mandatory weekly group for any inmate who is receiving methadone. Of note, male inmates who are in receipt of methadone prior to entering a correctional institution are housed in HMP; female inmates on methadone are held at the NL Correctional Centre for Women, or possibly HMP, depending upon overflow.

#### **4.6.1 Integrated Correctional Program Model<sup>xx</sup>**

The Correctional Service Canada (CSC) offers correctional programs that address multiple risk factors. These factors contribute to an offender's criminal activity. They are identified and addressed during their sentence using the Integrated Correctional Program Model. There are three program streams in the model: multi-target programs, Aboriginal multi-target programs, and sex offender programs, which are offered at moderate and high intensity levels.

The Integrated Correctional Program Model is based on CSC's most effective offender programs. These programs have been proven to significantly reduce reoffending. The program model targets multiple risk factors (including addictions) that most offenders have, in an efficient and comprehensive way. Offenders learn to understand the risk factors that are linked to their criminal behaviour and to use the skills they gain from the program in challenging or stressful situations.

The model has four components that complement the main program.

1. The introductory phase consists of 10 to 11 group sessions. Each is 2 to 2.5 hours long. The goal is to provide general direction to offenders and to focus on areas where they have trouble. Such areas could include their risks, lifestyles and relationships, or their ability to manage emotions and thoughts.
2. The goal of the motivational component is to encourage offenders who are not motivated to participate or stay in correctional programs. It also aims to help those who are having trouble understanding program concepts.
3. The community program consists of 20 to 25 group sessions. These are each 2 to 2.5 hours long. It is offered to offenders who have not fully completed all of their required correctional programs while incarcerated. They learn to understand their personal risk factors. They develop basic skills to help reduce risky or harmful behaviours before they participate in the maintenance component.

4. The maintenance component consists of cycles of 12 group sessions. The sessions are offered in the institution and community. They are each 2 hours long. The goal is to teach offenders how to apply the skills they learned in the main program to real-life situations. This helps to reduce their risk of reoffending.

The Integrated Correctional Program Model is offered in HMP, the West Coast Correctional Institution and the Labrador Correctional Centre.

## **5.0 Utilizing technology to improve access to ODT**

From a provincial perspective, telehealth can be utilized to offer MMT and continued follow up to individuals who live in rural and remote communities, if the appropriate technology is in place. This is seen to be an efficient approach, in particular since it reduces the need for long-distance travel.

For example, a methadone-prescribing physician in central Newfoundland provides services to methadone patients in western Newfoundland (supported by nurse in that region). More recently, telehealth has been used by a methadone-prescribing physician in the St. John's Metro Region who has been following a patient in Labrador.

Informants from one of the RHAs noted that they are looking to enhance their technology to connect with individuals who cannot physically come to their offices. They also felt that email and texting are under-used resources for connecting to their patients.

A few informants felt that use of telehealth would need to be approached cautiously and should not replace face-to-face interaction, which is critical for individuals who might be returning to their home communities and have given up all of their other former/negative networks. It also was stated that telehealth needs to be supplemented by local resources on the ground. An example of this approach is the methadone nurse on the West Coast who has face-to-face interaction with methadone patients who are being supported by the methadone-prescribing physician from central Newfoundland.

A similar caution was exercised in relation to overuse of phones and the Internet for intake into ODT, with a few informants stating that these approaches do not work for everyone (e.g., those who are not technologically competent and/or are not computer literate; those with cell phones and limited plans), and can be intimidating and impersonal. These informants felt that there must be opportunities for in-person intake/assessment.

# GAPS IN OPIOID DEPENDENCE TREATMENT

## 6.0 Methadone Maintenance Treatment

### 6.1 The methadone providers' roles

According to the MMT Standards and Guidelines for Physicians, the physician's role in MMT includes the following activities:

#### Intake:

During the initial patient assessment, the physician is responsible for learning about the patient's medical and personal history (drugs used, high risk behaviours, psychiatric history, social situation, chronic or recurrent pain, addiction treatment history), performing a focused physical examination (including urine drug screening) and determining whether the patient exhibits factors that might place them at risk for methadone toxicity. Through learning about the person, physicians can evaluate whether the patient meets the requirements of the Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> edition) criteria for opioid dependency.

If the patient meets the requirements for MMT, the physician is required to go over the treatment description, including the physician patient agreement, to ensure that both parties are aware of the expectations.

#### During:

Physicians are expected to monitor the progress of the individual throughout the program. This includes tracking their overall functioning, the start and end dates of the treatment and dose, when witnessed ingestions occur, the number of take-home doses given to the patient (when applicable) and the patient's daily dose. Before changing the dose, the physician must assess the patient in person or over the telephone, and subsequently record the change in dose. It is expected that the physician will follow the dose administration regulations stated by the college. The physician should counsel the patient on strategies to avoid methadone toxicity and ways to prevent overdose. These suggestions include avoiding benzodiazepines or other drugs to relieve withdrawal symptoms, to lessen if not eliminate the use of alcohol or other drugs, to take the dose in the morning, and to educate other family members on signs of overdose.

For patients who are willing to receive counseling supports, physicians can provide this service themselves or refer a patient to counseling services in the community. For those who administer counseling, physicians should create a non-judgmental, collaborative environment so that patients and physicians are better equipped to create a constructive relationship. This relationship will allow the patients to feel comfortable and will provide them a platform to select their treatment goals to work on. It is the physician's responsibility to support the patient in developing a treatment plan, however they are to ensure that the patient chooses their own goals. These goals may focus on medical and wellness, life skills and practical help, and/or practical support.

According to the NLPB's Standards for the Safe and Effective Provision of Medication for the Treatment of Opioid Dependence, the **pharmacist's role** in MMT includes the following activities:

#### 4) Operational Standards for Participation in Medication-Assisted Opioid Dependence Treatment

*Pharmacy Layout and Design.* The pharmacy must be designed and laid out to allow for all pharmacist-patient discussions, witnessed doses, and the provision of take-home doses to take place in a patient care environment that ensures visual and acoustical privacy and confidentiality and that is clean, safe, and comfortably furnished for the patient.

b) *Hours of Operation.* When a pharmacy accepts a patient who requires daily witnessed ingestion of medication, the pharmacy should be prepared to accommodate this dosing requirement and maintain hours of operation necessary to do so. Pharmacies that do not operate seven days a week must facilitate arrangements to enable the patient to acquire their doses on the days the pharmacy is closed.

c) *Pharmacy Network.* In order to allow for documentation in the patient's provincial health record, it is strongly recommended that pharmacies participating in opioid dependence treatment are connected to the provincial electronic health record through the Pharmacy Network.

d) *Staff Education.* It is the responsibility of the pharmacist-in-charge to ensure that all pharmacist and non-pharmacist staff are appropriately educated and trained and understand the scope of their role in the provision of medications for the treatment of opioid dependence.

[...]

#### 5.2 Establishing the Pharmacist – Patient Relationship

a) *Verbal Discussion.* Pharmacists should arrange for an initial meeting with the patient to discuss the services that they will provide, along with the obligations and expectations of both the pharmacy staff and the patient within this relationship. The patient should be given the opportunity to ask questions and relevant written information should be made available to supplement the discussion.

b) *Written Agreement.* A written Pharmacy-Patient Agreement serves to outline the roles, expectations and obligations of both parties and can go a long way to prevent and/or handle any misunderstandings that may occur in the future. Such an agreement must be developed by the pharmacy and read and signed by both the patient and the pharmacist prior to methadone being dispensed.

[...]

#### 5.5 Releasing the Prescription

a) *Providing Witnessed Doses.* The pharmacist is required to witness the ingestion of the dose. This function may not be delegated to a pharmacy technician or any other member of the pharmacy team.

### **6.1.1 Perspectives of the providers**

In describing what delivering the MMT entails, most of the methadone-prescribing physician informants stated that the individuals who have opioid dependency are referred via self, as well as another health care provider and/or service (including, for example, Emergency Departments). Intake and/or assessment can be done by a nurse, addictions counsellor, social worker, administrative staff, and/or the physician. New methadone patients are seen twice a week/every three to five days for the first few weeks to ensure they are stable.

The methadone prescribing physicians varied in how frequently they see patients who are considered to be stable and in the extent to which treatment plans for the patients are developed. For example, in some cases, the follow-up included quick visits and provision of prescriptions; for others, there was a level of cognitive behavioral therapy (CBT) available/provided and/or a treatment plan undertaken to ensure the patients' psychosocial supports were in place.

In describing what dispensing methadone or suboxone entails, most of the methadone-dispensing pharmacists described the process as detailed in section 6.1. A few of the informants stated that sometimes the patients first come to the pharmacist and then are connected to a physician for a prescription. It also was stated by a few of the informants that there is ample time to talk to and/or counsel the patients given they come to the pharmacy every day. For those pharmacies that are not open 365 days a year, it was stated that alternate arrangements are made as necessary to accommodate patients either through the provision of take-home doses (if this is warranted) or through access to another pharmacy that dispenses methadone and/or suboxone.

## **6.2 Factors impacting individuals access to the MMT**

### **6.2.1 Lack of physicians and pharmacists participating in MMT**

The majority of the informants and focus group participants highlighted that a significant gap in ODT is the lack of access to MMT, arising primarily from the small numbers of physicians prescribing and the few pharmacies which are dispensing methadone, and/or those who have instituted ceilings on the numbers they will include in their program. This concern was seen to be magnified in recent times, as it was felt that increasing numbers of individuals are being approved for methadone. The depth of disparity in availability between rural and urban areas is perhaps best demonstrated when comparing access to the methadone program in the St. John's Metro Region with rural areas.

The provincial MMT program is operated out of the OTC located in Pleasantville. (The OTC was intended as a regional service but in the absence of comparable services elsewhere, it has taken referrals from other regions.) As described in section 2.0, the OTC is an outpatient treatment program for opioid dependent individuals, providing a multidisciplinary team approach (physicians, nurses, addiction counsellors and pharmacist) to treatment mainly through methadone maintenance for individuals experiencing opiate addiction.

In addition to this holistic resource, individuals in the Avalon region needing access to methadone have several physicians to which they can be referred, as well as pharmacists from which they can access their daily dose. There also are well-established public- and para-transit systems and several taxi companies in the City (which also service some of the neighbouring municipalities) and which methadone patients can access to travel to and from their methadone doctor appointments and their daily visit to their pharmacy.

Contrast this with the limited services available to those in the Corner Brook Region, where one methadone nurse works with methadone patients:

*There is only one nurse working on consultation with addictions counselors. With existing resources, we're not going to be able to provide others. There is a wait list of up to a year, and people don't want to stay on it that long. They get discouraged and continue using. We have regular contact with people who are waiting, but that is hard to do. There is no capacity for monitoring. We have about 60 clients receiving services and 29 waiting. The median wait time in days is 331.*

Further, in Labrador, there are no physicians or pharmacists participating in the MMT.

#### 6.2.1.1 Why physicians and pharmacists do or do not participate in MMT

When asked why they had decided to seek an exemption to prescribe methadone and/or suboxone, the methadone-prescribing physician informants stated that they wanted to make a difference, reduce addiction rates, and/or address addiction issues which arise during treatment for chronic pain.

The pharmacist informants also were asked their reasons for seeking authorization to dispense methadone and/or suboxone. Some of these informants felt that it was their responsibility as a pharmacist to dispense any medication including methadone; others were approached to provide a needed service when there were no other providers in their area/region. One of the pharmacist informants spoke at length to how methadone and suboxone can contribute to broader public safety, i.e., if they are receiving this therapy, there is less likelihood they are committing crimes to access their street drugs and/or becoming violent because of drug consumption.

Neither group identified any challenges or barriers in seeking an exemption to prescribe or an authorization to dispense methadone and/or suboxone, or to maintaining their exemption or authorization.

In terms of why physicians choose **not** to seek an exemption to prescribe and pharmacists choose **not** to seek authorization to dispense methadone or suboxone, similar reasons were identified by physician and pharmacist informants and/or their provincial bodies/associations. These included, for example:

- The target population is challenging and can “wear you down”, create a negative environment, and/or pose a crime risk;
- There is significant stigma around and fear of this population;
- Delivering a methadone program is time consuming for physicians, in particular if they are to provide CBT;

- Physicians want to continue to focus on their own areas of practice and have concerns about the potential to sustain the added service of prescribing methadone/suboxone; and,
- There are gaps in available support services to help patients in their individual offices/clinics and to which they can refer patients.

A few of the informants and focus group participants felt that both pharmacists and physicians have their own personal biases to treating people with addictions, noting that both groups may refuse to prescribe or dispense methadone or suboxone, but will prescribe and dispense opiates. It also was stated that contributing to lack of access to MMT is that many physicians and pharmacies do not embrace harm reduction.

Comments included,

*The clientele being served are challenging and stigmatized. I think it relates to crime (e.g., shoplifting). They are a negative presence and their behaviour in the pharmacy creates a negative image, e.g., if three or four are in the pharmacy waiting for methadone and on the other end of the counter a mother is waiting with a sick child - negative environment.*

*The spectrum of patients that you treat through ODT is broad. Some are motivated and have strong support and effective coping strategies. Others, and often more, may have experienced terrible circumstances, have mental health or other additional health concerns. These patients may not be truthful, punctual, and will require long-term treatment, especially as sobriety may not be the final goal.*

*Because of clientele. They aren't the neat and tidy folks that usually come to a doctor's office. Physicians try not to have overlap and have clinics separate from their regular patients. It's the same thing with pharmacists – the people coming in for their doses. Only about half a dozen pharmacies filling prescriptions. They might lose some other clients so most won't do it. They get fed up with the methadone clientele.*

*Population is aging so an increasing number of seniors coming to pharmacies; they want to know they are going to a safe place. If they start to feel that it is not a safe place because of those coming to get their methadone (and they are known as many of them have tattoos and piercings and are making noise waiting for their drink), they will go somewhere else. Pharmacies and pharmacy owners do not want to jeopardize their regular clientele by taking on individuals on methadone who can be a deterrent to the overall patrons.*

Additional challenges cited to underlie why more pharmacies do not dispense methadone include, their sites would have to have sufficient staff to keep up with the demand, should this be significant, and have extended daily hours and/or days of operations (e.g., open on Sundays/holidays).

### 6.2.1.2 Accessing suboxone

In early December 2016, the Minister of Health and Community Services - NL, announced that suboxone would no longer require special authorization under the NL Prescription Drug Program (NLPDP).<sup>xxi</sup> It is anticipated that this change will lead to increased access to this treatment.

While many informants and some of the focus group participants spoke positively to this recent announcement, a few felt that the issues which deter physicians from prescribing methadone (e.g., a challenging population) also will impact the number of physicians choosing to prescribe suboxone. Other potential barriers to increasing access to suboxone are provided below.

A few of the methadone-prescribing physician informants explained that when a patient first takes suboxone, they are monitored the first day to adjust the dose. After their first dose, the patient must come back several hours later on the same day to see if they have achieved maximum effect and, as necessary, the dose is adjusted. Overall, individuals who are taking suboxone are monitored more frequently initially than those on methadone, especially the first week. It was stated that individuals on suboxone can be stabilized sooner than those on methadone, but, on an ongoing basis, they would still be seen as often as those on methadone (depending on the frequency of their urine checks.)

Some of the informants said that there will be resistance from pharmacists to dispense suboxone because it takes significantly longer to administer than methadone. Witnessed dosing can be prolonged as it can take from two to 10 minutes for the sublingual tablet to dissolve, with it being stated that it tends towards the high end of 10 minutes. As an example, dispensing to 100 suboxone patients daily could take an extra 1000 minutes of the pharmacists' time. If their administration time goes up four- or five-fold, their capacity to see patients diminishes. It was stated by a few informants that not all pharmacies can afford to add more staff, and there has not been any indication that there will be a fee increase for pharmacies dispensing suboxone.

Another factor which might inhibit an increase in the availability of suboxone is the misperception that physicians who prescribe suboxone do not get the premium per patient per month that they are provided when prescribing methadone. However, it is important to note, that the billing for both suboxone and methadone is the same.

### 6.2.2 Stigma

Many of the informants and focus group participants referenced the stigma experienced by methadone patients, stating, as referenced previously, that many pharmacies and physicians do not want this population in their practice and that the approach to dispensing methadone can be very demeaning. For example, at some pharmacies it was reported that methadone patients are lining up outside the pharmacies, often in the cold, to access their methadone and/or are serviced in a different line than the average pharmacy patrons. It was felt that in both situations, the methadone patients are very visible in their home communities or other communities where they travel to access methadone and this contravenes their confidentiality.

*People are lined up waiting outside in the snow to get their methadone – we do not require anyone else to wait in the freezing cold to get access to health services. No confidentiality.*

*Everywhere [around town], people can say, "I was up to the store – druggies waiting for the drink again this morning." People do not understand the program.*

*Patients complain about the pharmacies treating them like different citizens. They feel everyone is looking at them in the room at the end of the counter. Who else goes into a drugstore and drinks their medicine? No one wants to have anything to do with that clientele.*

Some of the pharmacist informants said that they make efforts to reduce the stigma associated with methadone, citing their approach to be non-judgmental and “non-punitive” i.e., they create a supportive space and place for the methadone patients, even if they falter in their treatment, or relapse.

A potential resource to support addressing stigma is the Centre for Addiction and Mental Health’s “Methadone Maintenance Treatment: A Community Planning Guide”.<sup>xxii</sup> This community-planning guide is intended for those communities interested in starting or expanding their MMT services. The guide provides practical suggestions on how to raise awareness and acceptance of MMT services in the community and foster greater public support for those struggling with opioid dependency. The manual guides the reader through the stages of establishing a community-working group, engaging the community, and planning, implementing and evaluating the program with the community.

More generally, it was felt by a few informants that a paradigm shift is needed to change the focus on blaming the person with an addiction for their circumstances to viewing addictions as a chronic problem/illness. It was felt that such a shift will facilitate programs that provide options to participants like they do for any disease (i.e., you do not victimize a diabetes patient for developing the condition, they are not “kicked” out of a program if they eat a chocolate bar).

### **6.2.3 Dispensing fees**

Dispensing fees for those receiving take-home doses (or “carries”) was cited by a small number of pharmacist informants as problematic. For those coming to the pharmacy each day for methadone, they pay on their own in cash, via third-party payers or, for individuals of low income/on Income Support, through the NLPDP. However, there is an issue that arises for those accessing take-home doses.

It was stated that the level of effort to prepare the carries is no different than for individual daily methadone doses and so the dispensing fee should be levied for each day the carries cover. However, it was stated that, currently, for those on Income Support or covered under the NLPDP, only the cost of the medication is covered. Hence, these individuals are required to pay the difference in the price, and it was felt this is a burden to those on low income and as well a deterrent to carries, a contributor to diversion (so the individuals can access the funding needed to cover their carries), and/or a reason people can drop off the program.

### **6.2.4 Perspective of the methadone survey respondents**

Almost all of the methadone survey respondents cited having challenges entering the methadone program. The most often cited issues included: waitlist, transportation costs and having to leave work. Of those

respondents who selected "other", challenges included financial limitations and admitting they had an addiction. On average, respondents cited at least two challenges when entering the program.

Table 12: Methadone survey respondents' challenges in **entering** a methadone program (N=41).

<b>Challenges in entering the program</b>	<b>%</b>
Waitlist	61%
Transportation cost	39%
Having to leave work to access my methadone	37%
I worried that someone would find out I am in the program	34%
No methadone program in my area	22%
My employer is not supportive of me leaving to get methadone	17%
Finding a physician/pharmacist to dispense the methadone	15%
Lack of information on the program	12%
I did not have any challenges	12%
No outreach into the community	10%
Criteria to get into the program	7%
Other*	7%

## **6.3 Factors impacting individuals' ongoing participation in MMT**

### **6.3.1 Witness urines**

Section 6.0 of the MMT Standards and Guidelines (Urine Drug Screening - UDS) speak to the specific requirements for the urine drug screening procedure. Excerpts from relevant sub-sections are presented below.

#### *6.1 Overview*

Urine Drug Screening (UDS) is one tool to verify patients' self-reported substance use, assess response to MMT and determine suitability for take-home doses.

#### *6.1.1 Standards*

- The MMT physician shall obtain and interpret urine drug screening (UDS) tests for routine screening of opioids (including methadone), cocaine, amphetamines and benzodiazepines for the purpose of monitoring and managing the patient.
- The MMT physician shall obtain and interpret a UDS prior to MMT initiation.
- The MMT physician shall obtain and interpret weekly UDS for 4 weeks prior to and for 4 weeks following acquisition of take-home doses (See Standards, Section 7: Take-Home Doses).

### 6.1.2 Guidelines

1. [...]
2. The MMT physician should monitor the UDS collection to minimize the risk of receiving a tampered urine sample. The MMT physician should use strategies such as:
  - a. witnessed collection or supervised collection,
  - b. checking the bathroom before the patient goes in for bags or extraneous items,
  - c. requiring the patient to remove bulky clothing and boots, and
  - d. temperature monitoring, measurement of pH, creatinine, or specific gravity.
2. The MMT physician should conduct UDS on a random schedule. If a random schedule is not possible, then a fixed schedule should be conducted on a weekly basis.
3. The physician's response to positive UDS should be non-punitive, and should assist the development of a treatment plan that promotes patient recovery.
4. The MMT physician should order UDS at a minimum of once monthly for all patients on methadone maintenance.
5. The MMT physician should take into consideration treatment benefits, as well as the effect on treatment retention, and cost where weekly (rather than monthly or bi-weekly) UDS is used during the maintenance phase.
6. Providing a tampered urine sample or failure to attend for a requested UDS within 24 hours (48 hours in occasional exceptional circumstances) should be handled in the same fashion as if the UDS is positive.

[...]

### 6.6. UDS Collection Schedule

- UDS should be obtained 1 to 4 times a month during the induction, stabilization and maintenance phases. Physicians need to consider the potential benefits of more frequent UDS tests (more likely to detect sporadic drug use and encourage accurate self-disclosure) and the interference in the patient's work and family obligations.
- Patients are expected to provide a urine sample within 24 hours of being notified.
- In cases of take-home doses, weekly UDS should be obtained for a minimum of 4 weeks after take-home doses have been initiated. It can then be decreased to twice a month for two months and once a month depending on the clinical situation.'

A few of the methadone-prescribing physician informants spoke to delays in receiving lab results from urine samples. While it is recognized that lab analysis is generally reliable, specific, and sensitive, providing accurate results, it was noted that sometimes the results take more than 10 days to get back to the physicians, as opposed to the expected three or four days. This is not only considered inconvenient, but as stated by one informant, it is a safety concern – e.g., in a situation where a patient is using other drugs without the methadone-prescribing physician being aware of this substance abuse.

A second issue relates to the process of witnessing urines. A few of the methadone-prescribing physicians said this is not the prevalent practice – leading to inconsistencies in approach and increased room for tampering with the sample. While it is felt there should be some flexibility for physicians to make decisions regarding frequency of undertaking witnessing urines, considering the risk and reward, lack of consistency could be reinforcing negative behaviour without any sense of accountability.

### 6.3.1.1 Punitive consequences for “dirty” urines

With regards to “dirty” urine and other non-compliance with the program, there appear to be varying consequences depending on the methadone-prescribing physicians consulted. As an example:

- One of the methadone-prescribing physicians said he gives a warning after the initial dirty urine and a second dirty urine results in the individual’s full dose being cut, regardless of the dose;
- Another physician gives three strikes and then the patients are cut off abruptly and completely;
- Another physician stated that they give individuals additional chances should they have a dirty urine, as there are not set rules regarding “three strikes and you are out”, and there are many false negatives and positives with urine testing as well as interference from other substances;
- Another physician said he does not do “three strikes and you are out” for dirty urine. He may see ten or twelve dirty urines. He noted that he will cut them off when he is working harder than they are and when they are not trying to get help.
- Within the correctional facilities, individuals can accumulate three strikes from having dirty urine (as well as by hoarding medication, sharing their methadone, and/or not coming to the weekly methadone groups) and they can be cut off immediately or tapered off their dose.

A few of the methadone-prescribing physician and government informants, as well as focus group participants could speak to the delivery of MMT within correctional facilities. Some felt that delivery of the program must be strict and rigorous to prevent the methadone from being abused, e.g., diverted. However, others felt that mitigating circumstances needed to be considered when assigning “three strikes” to one of the methadone patients including:

- Patients could be sharing their methadone due to fear of reprisal;
- They might not be attending the weekly methadone groups because of other participants; it might not be a safe place for them; and
- It is questionable whether the approach of “three strikes and you are out” is effective within a correctional system where individuals can be incarcerated for up to two years and have no other options for accessing methadone if they are “cut off” while incarcerated.

This inconsistency in approach to addressing “dirty” urine was concerning to some of the methadone-prescribing physicians and methadone-dispensing pharmacists. Some of the approaches were considered punitive and contrary to the philosophy of the program as stated in the MMT Standards and Guidelines – section 6.1.2 (3).

### **Involuntary withdrawal from the program**

Some of the punitive approaches described above conflict with the approached detailed in Section 8.3.2 of the MMT Standards and Guidelines in relation to the process for involuntary withdrawal.

### *8.3.2 Process for Involuntarily Withdrawing a Patient*

Recommendations to end the doctor-patient relationship effectively where MMT is being provided are as follows:

1. If possible, arrange a transfer to another MMT physician.
2. Communicate your decision clearly to the patient. This should include the details of a tapering schedule and/or end date of their methadone prescription.
3. Involuntary tapering may begin while the patient is searching for another physician. Once an appointment for transfer is confirmed, involuntary tapering should be stopped at the current dose until the patient enters the new methadone program.
4. Once involuntary tapering has begun, all methadone doses must be daily witnessed ingestion. The MMT physician should decrease the methadone dose at a rate of 5-10 mg every 3 to 7 days until a dose of 50 mg is achieved. Below 50 mg, the rate of decrease should be no more than 5 mg every 3 to 7 days.
5. Provide the patient with reasonable help to find another MMT physician. Provide the CPSNL Methadone Program phone number for assistance in finding MMT physicians in the patient's community that are accepting new patients.
6. [...]
7. In extreme circumstances related to the safety of the staff or physician or others, a patient may be discharged without tapering.

### **The Methadone Maintenance Treatment Agreement**

Of note, as per Section 4.4.1 of the MMT Standards and Guidelines, any patient seeking initiation of MMT must sign the Methadone Maintenance Treatment Agreement, which provides information about the program's rules and expectations. A review of this Agreement, which is found in Appendix "D" of the Standards and Guidelines, speaks to consequences that "may" happen if an individual in the MMT program contravenes these rules and expectations. For example, this section details several actions (e.g., arriving late; hurting or threatening to hurt the staff or other patients) which the patients are not allowed to do while in the program. Should they undertake these actions, then they "may not" get their methadone and/or they "may" have to leave the methadone program.

### **6.3.2 Lack of access to primary care**

Some of the informants and many of the focus group participants referenced the gap which methadone patients can experience in receiving holistic, primary care. It was felt that the majority of the methadone-prescribing physicians are not providing such care to their methadone patients, but only addressing any presenting issues related to methadone (e.g., prescription, dose). Should the patients have other medical issues/concerns that they want addressed, they have to access their own physician (if they have one) or access an Emergency Department (if the staff can "look past" the fact an individual has addictions/is under the influence), or their ailments remain untreated.

*Methadone is a segregated service - socially and spatially –providing a singular service: here is your prescription and bugger off; if you have Hep-C or a broken finger or need counselling, go somewhere else. Why should people who are receiving a health service be segregated from the regular population? The original intent of methadone service providers was to get them stabilized on their methadone and then shift them over to GPs once they are able to be contributing members of the workforce. May not work for everyone but could for some.*

### **6.3.3 Lack of counselling and related services**

Section 9 of the MMT Standards and Guidelines reflects on the fact that methadone programs should be more than simply writing prescriptions:

Most methadone patients struggle with several challenges, such as poverty, inadequate housing, lack of education, exposure to violence, poor nutrition, serious physical or mental health problems, interpersonal conflicts with self, family and friends, inability to secure and maintain employment, and involvement with the criminal justice system. These problems do not disappear just because the patient receives a daily dose of methadone. Methadone programs should incorporate a comprehensive biopsychosocial and, where appropriate to the patient, spiritual approach to help patients cope with their problems.

It is important for methadone prescribers not to adopt the perception that counseling is a task to be taken on exclusively by other staff or caregivers. All MMT physicians share in this significant responsibility as part of their overall mission to facilitate treatment and, ultimately, recovery.

As previously referenced, the MMT Standards and Guidelines also state that “methadone alone does not constitute effective treatment of opioid dependency” and that an effective service would include counselling and support, mental health services, and linkages to other community-based services. This perspective was reiterated by many of the informants and focus group participants with a few of the health care provider informants identifying that methadone and suboxone are tools for withdrawal over an extended period, which alone are not likely to enable individuals to focus on their recovery.

Despite this understanding, the lack of available CBT/counselling for the individuals receiving methadone or suboxone was cited as a significant concern. The majority of the focus group participants and many informants, including a few of the methadone-prescribing physicians, highlighted that there is no “program” attached to MMT and without counselling and support to address the root causes of their addiction, methadone on its own does not promote recovery. They cited the lack of CBT from the physicians who prescribe methadone, with some noting that visits to these physicians are short and “in and out”, as the focus is on checking urine test results, managing dosage and writing prescriptions.

A small number of the health care provider informants felt that the fee-for-service pay structure for methadone-prescribing physicians creates incentives to move patients through quickly. This fee structure does not entice physicians to spend time to provide CBT and/or does not provide compensation for services such as, for example, case management and advocacy. Comments included:

*Patients are being evaluated and given prescriptions, then walking out the door. This is not a complete service.*

*There need to be provincial clinics around the island with salaried physicians who are not worried about numbers and who can take the time to work with patients and support and/or refer them.*

*I do not believe that access to methadone on its own is overly helpful to individuals if the root cause of the addiction issue is not dealt with and worked through.*

*Physicians have to be compensated for their time. If the system has not set up a certain code for a certain service – the system deems it unimportant. A doctor will adjust his/her scope of practice if there is a sensible program with codes to bill. It is not about maximizing income, it is about getting paid properly for the time.*

A few of the informants felt that the methadone-prescribing physicians lack time to provide counselling due to their overall patient base and/or, for those in urban/urbanized areas, due to large caseloads of patients on methadone. As an example, in relation to other chronic illnesses, once a patient is stable, they may be seen two or four times a year; in contrast, individuals on methadone are seen weekly, biweekly, and then monthly over a two-year period (much more time intensive). In addition, in rural areas without additional support (e.g., methadone nurse, addiction counsellor), the physician also might be doing the witness urines and/or trying to provide CBT with no other supports.

*Time is the biggest barrier when running a practice and ensuring that you can handle the additional workload without reducing the quality of service you provide to your patients. As an example, if you are a busy physician and doing other work (e.g., rotations in emergency, teaching) then it can be a time crunch adding addictions treatment.*

*There are also too many clients to counsel for at least 30 minutes each. There is no time to do it. Some in [rural NL] might have time because they don't have the same numbers of clients as in the city. On-going assessments are quick and dirty, e.g., any trouble with your dose, any side effects? [Counselling] is not mandatory. If it was, there would only be half as many on methadone. More flexibility and more resources are needed.*

A comparison was offered by a few of the informants and focus group participants between the approach to MMT provided by some of the physicians prescribing methadone and that offered at the OTC in Pleasantville. This treatment centre was described as having a wraparound approach and interdisciplinary team with comprehensive supports – e.g., a methadone-prescribing physician, pharmacists, nurse, and staff to provide psychosocial supports to help with crises, basic needs, and connect them with community organizations.

The majority of pharmacists indicated that they are involved in counselling and supporting the individuals receiving methadone; the remaining pharmacist said that due to volume, they are unable to undertake anything except dispensing the drug. Those who are providing more support stated that they were focused

on treating the individuals as people – asking how they are/checking in/having a conversation, advocating for the additional help they need, and/or partnering with treatment centres/organizations for educational purpose.

*The pharmacists with [me] are and should be a big part of the treatment continuum. They are a resource for those who are coming, e.g., checking in to see how they are and advocating for the help they need. As an example, those on methadone can show up at Emergency and no one will see them because they are addicts. Pharmacists have taken them to Emergency to vouch that there is something wrong and they do need to be seen.*

A few of the pharmacists suggested that new pharmacists could be provided training to support addictions counselling and cognitive behavioural skill development to the methadone patients as they are in the pharmacy every day. It also was stated however, that pharmacists who chose to undertake such an expanded role would have to be appropriately compensated for their time and efforts.

#### **6.3.4 Take-home doses**

Section 7 of the MMT Standards and Guidelines discusses take-home doses and describe this practice as being key to the success of MMT. Standards set out the conditions under which an individual can avail of a take-home dose and as well when take-home doses should not be allowed.

While, generally, the methadone-prescribing physicians and methadone-dispensing pharmacist informants cited the value of carries, they also spoke to the challenges this presents, including knowing who can be trusted. It was highlighted that only individuals who are sufficiently stable should have access to take-home doses of methadone and/or suboxone, as if not, they could choose to take more of it than prescribed per day to their detriment.

Diversion of the carries was acknowledged to occur, although it was highlighted that it can be difficult to prove. Diversion was described as a significant safety risk to those who are accessing this drug without education on its impacts and effects, and thus, for example, the risk of overdose.

The focus group participants cited, for example, individuals waiting for clients to leave pharmacies with their doses so they could purchase them, and/or to grant sexual favors behind clinics in exchange for methadone. A few of the key informants cited doses being diverted in correctional facilities – including through the methadone patients' vomiting up their dose for provision to someone else.

Some of the informants and focus group participants highlighted that it is important for some methadone patients to get carries to, for example, support their education and employment and/or more generally, to support those who are contributing to society. It also was noted that carries offset some of the stigma experienced by going to a pharmacy daily to access methadone.

*For those who are unable to get carries, and must get to a pharmacy each day to access their daily methadone, how does this impact their quality of life, access to education and/or employment? As well, it is embarrassing.*

However, it was acknowledged that there must be checks and balances in place to ensure that this opportunity is not abused.

*Accessibility is a good thing but the concerns are the support and structure – How much? Who should get carries? Is this in the public interest? Increasing access is a good idea but checks and balances have to be in place.*

It was stated by a few of the methadone-prescribing physicians and methadone-dispensing pharmacist informants that in addition to differing approaches to the witness urines, the checks and balances for take-home doses are inconsistent across physicians. They differ in when and under what circumstances, they might take away the carries and require the methadone-patients to return to daily visits to the pharmacy.

### **6.3.5 Perspectives of the survey respondents**

The methadone survey respondents spoke to the challenges they have experienced since being in the program. Since entering the program, 45% of the respondents cited transportation, 28% stating the lack of counselling in the program and 25% stating having to leave work to access their methadone as a challenge. For those who selected “other challenges”, these included financial strains, having to leave school, and a decreased connection with their doctor. On average, respondents faced two challenges when accessing methadone treatment.

Table 13: Challenges to accessing methadone treatment while **participating in the program.**

<b>Challenges <u>in</u> the program</b>	<b>%</b>
Transportation	45%
Lack of counselling in the program	28%
Having to leave work to access my methadone	25%
I worry that someone will find out I am in the program	20%
No funds for child care	18%
Other*	15%
The hours for the methadone clinic do not work well for me	15%
I do not have any challenges	13%
Lack of privacy when I get my methadone	13%
No outreach into the community	8%
My employers are not supportive of me leaving to get methadone	5%

The majority of the non-methadone survey respondents identified that they had tried suboxone or methadone, with slightly less than half noting this had not been successful because, for example, they were barred from the program and relapsed; had no income to pay the up-front cost of methadone while waiting for Income Support and so could not stay in the program; and/or were unable to access transportation.

## 6.4 Factors that can impact an individual's success in MMT

All of the pharmacist informants and the majority of the physician-prescribing informants cited low numbers/percentages of patients being successful in the methadone program. Some factors that have contributed to success include having stable mental health, an education, and/or wanting to be clean for their children and/or to prevent them from being taken into care; access to psychosocial supports including family support and employment; and individuals with better insight into their issues and/or motivation to quit.

Factors which can inhibit success include lack of support; maintaining the same negative social circles/networks once entering the program and not understanding the time needed to experience success on methadone or suboxone. It also was suggested by a few informants that having numerous patients coming to a pharmacy at any one time to access methadone can negatively impact success, as this perpetuates social networks of individuals with addictions.

*About 70% that started have completed. Of that 70, less than 20% are clean. Relapse is quite high. We've had some back here again and some who are now with other physicians. They relapse as they don't change their social situation. They want to get on and off the methadone in six months, but that's impossible. At least two years are needed. Either they don't, can't or won't change their social milieu, are living in same place, or hanging out with the same group so they can't get out of that situation.*

### 6.4.1 What defines success?

Some of the informants commented on the concept of “success” within the MMT, with a few stating there is a need to more specifically define the goal of the program. All spoke to the view that success encompasses more than being weaned off methadone, abstinence from all drugs and/or full recovery. Rather, they stated there must be realistic expectations set for the methadone patients and success measured in relation to functionality and/or public safety. Successful outcomes were considered to include:

- Ongoing attachment to the methadone program;
- Improvements in their capacity to function in their communities/lives;
- Increased engagement in their communities, training and/or employment; and
- Reduction of their criminal behavior, which contributes to enhanced public safety.

Comments included:

*We have to ensure there are realistic expectations for people. Some may never get off methadone, and if there is an ongoing focus on doing so, it is very self-defeating and impacts self-esteem.*

*The success should be measured in terms of public safety. If someone gets off and reforms that is great, but if they stay on the same dose for the rest of their life and never cause any trouble, this is success.*

*If someone can be content in their lives and feel like they can be an active member of society despite taking methadone on a daily basis, is that a poor outcome of the program? Do they need to be "off" methadone and drugs to be successful?*

*Success is the ability to function – if they can get to a point where they are functional, this is success.*

This view on success is articulated in Section 1.2 of the MMT Standards and Guidelines:

For some people, MMT may continue for life, while others may be able to eventually discontinue MMT and remain abstinent while preserving the normal level of function they attained while on MMT.

This same section of the MMT Standards and Guidelines also speak to successful outcomes through MMT as requiring knowledge, experience, vigilance, and diligence on the part of the MMT physician, the patient, and all of those involved in treatment.

It was stated by a few of the informants that while many of the existing formal services assume everyone with a dependency is interested in cessation, this is not reality. Therefore, there needs to be a focus on decreasing people’s risk and providing services that support individuals to gain some stability (e.g., SWAP) which may create the environment for them to be ready to make change in their lives and address the issues which led them to opioid dependence.

#### **6.4.2 Perspectives of the methadone survey respondents on the helpfulness of MMT**

Ninety-seven percent of the methadone survey respondents believe that methadone treatment will help them stay off drugs, and additionally that they will eventually be able to stop using methadone. Those who do not believe that the program will help them attribute this to the availability of drugs, their inability to cope with external stressors, and/or the strength of their cravings.

When asked to rate how helpful the methadone program has been in their life on a scale of one to ten, 82% provided a high rating of 8 to 10 out of 10, with 58% of this group providing a 10 out of 10. One participant wrote in ‘15’ and therefore was categorized as "other".

Table 14: Level of perceived helpfulness of methadone program by survey participants (N=33).

<b>Rank of helpfulness</b>	1	2	3	4	5	6	7	8	9	10	Other*
<b>%</b>	-	-	-	3%	9%	3%	-	21%	3%	58%	3%

When providing reasons for their rating, the most common responses included the respondent achieving a sense of normalcy, the support the program provided, the ability to be free from their addictions, and/or the program "saved" their life. The respondents who gave a lower score attributed the ranking to a bad reaction to methadone, the duration of the treatment was longer than anticipated and the trouble of transferring between doctors. Comments included:

*My life has improved 100%. My [providers] are so supportive. All and all I am finally happy with my life and who I am.*

*Well, I would have say 10 because it helped more than I can put into words. Over the years, my addiction progressed and I might not still be here if I didn't go on the methadone program.*

*The methadone program has changed my life around for the better and has helped me to become a normal person in society.*

*I have been using drugs a long time. This is the first time in [many] years that I am not using drugs, that I wake up happy.*

*The program has been very helpful for me in my life because it has taken away all withdrawals allowing me to go to work daily and feel 'normal'. Its helped me stay completely away from drugs and I'm feeling better physically and mentally. Also, it has let me form new friendships and realize I can have fun without drugs. Also, I've earned back trust with people I had lost from it.*

## **6.5 Perspectives on improving MMT**

As detailed in section 6.2.1, lack of access to physicians and pharmacists who prescribe and dispense methadone respectively, is considered a significant gap in ODT in the province, in particular in Labrador which to date does not have any such resources. Suggestions for addressing this gap were provided, with two different approaches presented:

- A small number of the pharmacist informants and focus group participants felt that methadone treatment should be considered a specialty. Like any other specialty area, once a patient has been started on treatment and then stabilized by the specialist (a methadone-prescribing physician), they should be seen by their GP/Family Physician who can renew their prescription and monitor their condition. If the individual relapses or encounters any issues, they can be referred back to their methadone doctor until they are once again stable.
- Most of the focus group participants and many of the informants spoke to the need to increase the number of methadone-prescribing physicians and methadone-dispensing pharmacies in the province. Some felt that this should be mandated – i.e., all physicians and pharmacies should participate in MMT as a component of their scope of practice, given it was questioned how this fundamentally differed from prescribing and dispensing opioids for chronic pain or medications for other chronic conditions. The majority of the pharmacist informants cited it is ethically wrong and/or irresponsible for pharmacists to not dispense methadone.

Further, it was stated that having all of the physicians involved in MMT would result in a dispersion of methadone patients across physicians, thus reducing wait-times for access to the program and the physicians' caseload of methadone patients. As well, having small numbers of this population accessing

services offsets the concern cited by many non-prescribers and non-dispensers, that large volumes of patients create negative/unsafe environments for their general patient populations/patrons. It also should reduce the stigma experienced by those accessing methadone.

*Family physicians should have to prescribe methadone so people are not stigmatized and warehoused going to see special doctors.*

*Until negotiations with the General Practitioner (GP) population in the province come to a point where physicians will take a few patients, at the end of the day, the majority of the individuals will always be "someone else's patients to take care of". Most GPs don't want the headache. Yet if every GP had five patients - one in a waiting room at a time, this would help to address the concerns re safety and comfort of the other patients and as well, the stigma of the individual accessing methadone.*

Some of the informants spoke to the need for other health care professionals, e.g., nurses, to be able to administer methadone, thus increasing the number of providers who can play an integral role in MMT.

A few of the informants also spoke to the need for methadone-prescribing physicians to provide primary care to their methadone patients as needed, instead of the patients going back to their own physicians (if they have one).

A few of the informants also felt the fee structure for MMT should be reviewed. This direction is one which has been recommended in two other provincial studies:

In British Columbia's Pharmacy Association's 2014/2015 Activity Report – More Than Pills<sup>xxiii</sup>, it makes recommendations surrounding fee structures as follows:

1. Create an independent financial oversight group that is charged with looking at physician and pharmacist fee structures to ensure no inadvertent perverse incentives exist that result in compromised care for patients.
2. Restructure the current Methadone Maintenance Payment Program to a payment program that provides a patient-focused plan with a single payment for all clinical and dispensing services received by patients on methadone.

In the Methadone Treatment and Services Advisory Committee - Final Report<sup>xxiv</sup> (2016) out of Ontario, the following was recommended:

Ministry of Health and Long-Term Care should work with the Ontario Medical Association and Local Health Integration Networks to support the variety of service models that meet patients' individual physical and mental health needs. This should include consideration around alternative physician remuneration structures in order to ensure high quality care is provided in all settings, including in high volume clinics.

## **7.0 Lack of Collaboration and Cooperation Among Service Providers**

### **7.1 Lack of cooperation and connection between and among formal government health providers**

Some of the informants and focus group participants said there is a lack of cooperation between and among formal government services in some regions. Examples were cited of treatment centres having no connection to physicians in their regions who are prescribing methadone or suboxone; and of decisions being made by health care professionals about patients' addiction treatments who do not share this information with their primary physician or others involved in their care, even when the patients have given consent for this sharing.

A few of the methadone-prescribing physician informants spoke to the lack of formal support from their RHAs and/or mental health and addiction services in supporting their methadone patients. Comments included:

*These programs function at arm's length. This places the burden solely on me to be the physician, counsellor, advocate, and addictions counsellor.*

*We don't have a good understanding of the process, of how services are delivered. How can we prescribe methadone without collaboration with other service providers? How do we support the provider and patient without collaboration with others involved?*

### **7.2 Health care practitioners lack of connection to community-based resources**

Some of the informants and a few focus group participants identified a lack of connection between health care providers and community-based organizations whose mandate includes addictions services and/or supporting individuals who have addictions. Reasons for this disconnect included health care practitioners lack of time to dedicate to finding out what is available and/or to establish and maintain relationships. Some of the focus group participants also cited the need for community-based resources to work more closely together to support a shared client group.

A few of the focus group participants also highlighted that a major barrier to supporting their clients to access services was the lack of direct access via telephone to an appropriate staff person within the formal health care system (e.g., the RHAs). They stated there is no clarity on who to call and no contact numbers available.

### **7.3 Lack of continuity of service between and among communities and regions**

A few of the focus group participants felt there was no continuity of service for individuals moving between and among communities and/or regions. For example, while they might receive services in one region, moving to another region requires starting the application program again and perhaps being on a waitlist.

## **7.4 Community and government/RHA relations**

It was reported by several of the focus group participants that government and RHA staff do not always respect the perspectives or views of community-based workers who have significant experience and expertise. These participants stated that they are professional in their activity and if they are looking for help/advocating, they are asking because of an individual need.

As an example, it was stated that even if a client says they are suicidal, the client has to be the one to tell the official in the department or agency they are calling for help. Staff with community organizations cannot talk on behalf of the individuals in those situations. Therefore, if they client does not (or cannot) tell the official on the phone what is wrong, the emergency response team will not come.

In addition, it was stated that government services are often too formal and thus intimidating to clients, in particular offices which have locked doors/keyed entry, glass partitions and/or security guards.

## **7.5 Increased levels of cooperation and collaboration are required**

Many of the informants and focus group participants highlighted the need for community and government to collaborate on concrete actions and solutions to address addictions. There must be enhanced and collective efforts towards policy development and service delivery by all stakeholders to ensure complementarity of service. This would be particularly relevant to rural areas which have fewer providers; collaborative efforts should build needed capacity and maximize use of existing resources.

*I believe we do a fantastic job of listening to each sector's experiences, statistics and opinions, but we unfortunately often fail to take this process of partnering to the next level by actually fostering change.*

There needs to be a shared vision and a model of addictions services, and providers need to know where they fit in that model and how all stakeholders can effectively work together. Comments included:

*We have to determine what is needed and create the system for it.*

*We also want equitable services: this is currently limited for some regions. To do this we need to develop a network of people willing to work together and provide supports.*

### **7.5.1 Opportunities for networking and collaborating**

It was stated that inter-professional forums should be held regularly, bringing together the continuum of urban and rural government and community providers who have a critical role on the addiction to recovery continuum. This should include front-line services providers and those with lived experience.

These forums would provide a venue for learning about the available services in each region, clarifying each other's roles in working with individuals along the addictions continuum, information sharing, facilitating a common language in relation to addictions and related treatment, reducing duplication of effort, and

identifying joint initiatives. It was noted that technology could be used to provide cost-effective ways to ensure representation from across the province.

*With technological advances, there is no reason all of the various groups and individuals from across the province cannot be around the same table sharing information and planning to address opioid addiction. To address these gaps, a collaborative partnership is needed with the Department of Health, physicians, health boards and health and community allied groups. Community programs will be vital in helping with service allocation.*

## **8.0 Opioid Dependence in Labrador**

Informants who could speak to the Labrador experience with opioid dependence indicated that currently, this is not an overarching concern in this region – e.g., there is “little to no narcotic use” in their communities. Most of the informants indicated that alcohol is the prevalent addiction, with marijuana also being available. It was noted, however, that since the inception of Muskrat Falls, opioid use in Happy-Valley Goose Bay has increased with a few individuals sent out of the region for treatment.

A few of the informants felt that reasons for this lack of opioid dependence is in part because all of the physicians are salaried and with Labrador-Grenfell Health and so individuals cannot “shop” around to get multiple prescriptions. As well, for the Aboriginal people accessing their drugs/medications through a centralized non-insured health benefits program, their drug usage can be monitored and tracked.

### **8.1 Barriers to accessing ODT**

It was identified by a few of the informants that one of the barriers to accessing addictions counselling in Aboriginal communities (if it were needed) is the speculation about and discomfort with some service providers, in particular in relation to their level of cultural competency. It was suggested that to offset this perception and concern, counsellors should be visibly engaged in the community and, for example, participating in outdoor and culturally relevant activities.

A few of the informants spoke to past breaches of trust, resulting in some residents being concerned about sharing personal information. This concern has been magnified when counsellors are from the community in question.

It was felt by a few of the informants that efforts must be made to reduce the layers of administration through which the Aboriginal populations sometimes have to wade should they need to access treatment services. As well, it was felt that efforts should be made to streamline access to treatment in the province. For example, representatives of one of the Aboriginal populations stated that to access a provincially run treatment facility (in Newfoundland or out of province), individuals have to be assessed by a Labrador-Grenfell Health mental health staff. One of their own Aboriginal government mental health staff cannot complete the assessment. In contrast, if they are accessing a National Native Alcohol and Drug Abuse Program Treatment Centre<sup>xxv</sup>, one of their own staff can complete the assessment.

## 9.0 Residential treatment centres

Residential treatment centres were cited as an important component on the opioid dependence treatment continuum, although several of the focus group participants and informants highlighted concerns with their policies and approaches.

Generally, it was stated that wait times to get into treatment centres can be a deterrent to those who “in the moment” (in particular, youth) decide to seek help. This is considered a significant barrier, given the lack of access to other services such as addiction counselling while waiting for a treatment centre.

Criteria for accessing some of the treatment centres (e.g., the need to be abstinent before entry) was considered unreasonable for many of the target group. Further, the RHA’s no smoking policy limits individuals’ access to treatment as it is estimated that most of those with addictions also smoke, and so they can struggle with having to simultaneously give up smoking as well as their drugs, resulting in some leaving their programs.

The focus group participants and some of the informants also highlighted the inadequacy of the short stays at the province’s treatment centres. They stated that three to four weeks is insufficient to address the increasing complexities of the target population and the range of drugs which are now available to them. Comments included:

*A three-week stay in the Humberwood program is next to useless. Pleasantville, useless. Harbour Grace almost useless. Three weeks in a centre will not get you out of your situation. Clients can’t even smoke in the centres.*

*Three and four week programs were fine 30 years ago, when alcohol was the prevalent drug; but with the changes in the type of drugs, people having concurrent disorders and rising addictions, we need longer programs. Twenty-eight days might be enough to level out, but then you are thrown back into the community with no follow-up. The results are poor.*

*The long-standing six to nine month centres are the best chances. If centres would have longer programs, it would work better. If clients smoke, they’re kicked out - foolishness! Programs need to be longer and more lenient in terms of clients’ other problems.*

*[Why would a centre] have a requirement for individuals to be “clean” before admittance? Would you need rehabilitation if you had the ability to stay clean for two weeks [on your own]?*

Most of the informants associated with the treatment centres spoke to the need for more comprehensive inter-disciplinary resources to build their capacity to address the increasingly complex caseload. This would include, for example, NPs, methadone nurses and/or other health care professionals who can administer methadone, addiction counsellors and other clinical support staff, recreation therapists, and staff to support vocational rehabilitation and planning for after care.

*When looking at resource allocation, look at it equitably. We are all working with this population who are more chronic and near the end of the continuum with more issues. No one person or one physician or one nurse can do it all. We need support for the patients and our teams. Interdisciplinary teams can support each other and offset turnover and burnout.*

*Lack of available psychosocial supports. There is no [ready]access to psychiatric follow-up. Many clients come through with drug addictions and when they get through that, the mental health issues emerge. We try to touch base with the client every couple of days, return their calls, etc., but there is no time for that, and we're not psychiatrists and aren't sure what to do. It's hard to run a centre with a main focus on addictions knowing your client isn't able to be adequately treated.*

## **10.0 Access to resources and waitlists**

Many of the focus group participants spoke to the fact that when individuals are living with an addiction, accessing help when they identify being ready for change is critical to a successful recovery. However, there are barriers to such immediate access including that individuals often must first try and find a program or service, and, as possible one in their region; meet the criteria, which can be quite restrictive; and then go on a waiting list, sometimes for months. Numerous health care informants also said that they struggle to identify an available and appropriate counselling and supporting resource to whom they can refer their patients with addictions. Comments included:

*When they are ready to reach out for help, the help has to be there. We have a [very long] waitlist for methadone services...It is just as well we say we do not provide the service, although we are monitoring [those on our list] and do what we can. Without any more resources, it will be a long time before they are getting services. Yet, we know we have to get people when they are ready. If they have to wait - some will die and some will be lost. Help has to be available when it is needed.*

*Longstanding issue is timeliness of access. Had a young person call the Recovery Centre from a service provider's phone. Wanted to come right away – was told to call back the next day and perhaps they could do assessments. Assessments are now only done Monday to Friday and most before 3 o'clock. No weekend assessment. This is because they now do medical detox and as such need a prescriber on staff; while the nurse practitioner can prescribe, she is only there during the week.*

*Monday to Friday 9 to 5 does not work for the population. There is no timeline for crisis. Why not work 12 to 10 and open weekends?*

Many of the informants and focus group participants identified waiting lists for critical ODT- related services such as methadone programs (depending on where one is living in the province); mental health and addictions counsellors, psychologists and psychiatrists; and residential treatment centres.

As an example, as of September 2016, it was stated that waitlists for Eastern Health were:

- Addictions Counselling, St. John's - three to nine months (78 on the waiting list)

- Addictions counselling, rural – no wait to six months (55 on the waiting list)
- OTC – two weeks (26 on the waiting list)

One contributing factor to waiting lists for these and other ODT services is lack of capacity. For example, it was stated by one provider that they could avail of telehealth services from a methadone-prescribing physician, if they had a local on-the-ground methadone support staff (e.g., nurse or NP).

The issue of waitlists is a concern not only for those who wish to initially access services, but also for those coming out of treatment centres who need follow-up. As well, it was stated that even when an individual accesses services, sometimes there is too long a period between one appointment and the next to sustain a person's resolve or treatment plan.

*The follow-up waitlist is extremely challenging. Had a client who went to detox – no follow-up; then came out of [residential] treatment, went through intake and went on to a waitlist. All these processes and no follow-up. How do we ensure people's [status] is maintained?*

Few answers were provided to the issue of lack of available resources and/or waitlists. Overall, the message was that services (in particular, counselling) must be readily available to those who need it. Individuals should not be waiting months for services, when their motivation to change might be diminished and/or their circumstances might have changed.

#### *Scheduled appointments*

A significant challenge cited by a few of the informants and many of the focus group participants is the expectation that individuals with opioid dependency will have the capacity to adhere to a schedule for appointments without any flexibility within the relevant systems. Examples provided included:

- Individuals who are addicted to opioids may not have transportation, or a place to live and, therefore, to expect them make a scheduled appointment is unrealistic.
- Due to the rigidity of appointment structure, individuals are likely missing their appointments, resulting in wasted time for the service providers and a reluctance to reschedule the individuals.
- Some service providers have an informal policy of following up with an individual three times by phone. Lack of response results in the individual being placed at the bottom of the waiting list. Again, for individuals with complexities and vulnerabilities, they may or may not be reached by phone and/or notice calls and messages.

Comments included:

*We expect people who are pre-occupied and fixated on their next fix to show up on Tuesday morning for an appointment? This is not going to work for those whose lives are in chaos. They can't get*

*themselves to appointments Monday to Friday 8 to 4. If they miss an appointment, they are labeled as “unmotivated”. Case management pieces are missing.*

*The response for this population in particular is a need to get immediate assistance, as opposed to “we will prioritize you and you will go through central intake and maybe in six months to a year we’ll get you in. We will send you a letter to an address where you don’t live – you don’t answer and then have to go back to doctor and start again.”*

*In the moment, many say they want to access counselling, but then they do not follow through. The result is that counsellors close them out, either because they are no-shows or they come once or twice and then are no-shows.*

*Can’t assume people have a telephone or that they are at the same address; can’t assume literacy. Those who do not show up are not just sitting back saying, “I do not want to go.” [Serious] implications for those who cannot get to an appointment and then are kicked off when they think they are on a list. The “system” has decided they did not show up and so they are not serious about the response.*

Some of the focus group participants and a few of the informants provided suggestions for alternative approaches to working with individuals who have an opioid dependency.

- They cited the need for more flexible opening hours, e.g., noon to 10 p.m. and weekends, and enhanced access to drop-in clinics without a need for specific appointment times. It also was stated that such drop-in clinics should be based in the community as well as out of government offices/centres as some individuals might not approach what they consider a “formal” site. As commented by one health care provider informant,

*We only have enough resources for clinics to open 8:30 – 4:30 Monday to Friday. We need evening and weekends to respond to needs. We need additional resources to increase time available.*

- Another critical component would be enhanced outreach services to those who can’t or won’t come, wherein staff could meet the individuals out in the community.

It was suggested that outreach workers should be in emergency rooms and the Waterford, for example, and be linked with those presenting with opioid addiction. This could begin a coordinated process of effectively connecting them to the larger system. As stated by health care provider informants,

*Now, our clients come to meet with us; we don’t go to them. They would be better served if we had the ability to meet them where they are instead of them being responsible for coming to us.*

*We would like to start doing more outreach, being more flexible. Our office hours are 8:30-4:30. Maybe we should spend more time going into community organizations where clients go. That way they don’t have to come to our offices.*

*We look at the population and realize we have to do something different. We need the ability to go to the client. They don't want to come to us if they feel we're above them, e.g., the way we dress. We need more flexibility to go to them, to help them, to take away the isolation...If they're on the ground, I want to sit on the ground with them. I don't want to put myself at risk but...we're missing the boat. We have made things so complicated.*

A related initiative would be implementing patient navigators to guide those who are seeking access to treatment for ODT (or any addiction) to connect to and move through relevant systems and access needed psychosocial supports, in particular housing. It was suggested that this resource could be modeled after the patient navigation offered through the Cancer Care program of Eastern Health<sup>xxvi</sup>. As described on their website,

Through the Cancer Care program of Eastern Health, specially trained oncology (cancer) nurses act as compassionate and effective guides. The patient navigator offers practical help to bridge the gap and assist patients, families and caregivers understand and work through the series of treatments, services and challenges encountered on their cancer journey.

Cancer patient navigators are highly resourceful. They can help problem solve, assist with counseling, and coordinate support care services through referrals. Navigators are trained to anticipate, address and overcome barriers to care and help with timely access to services.

Having mental health and addictions counsellors and/or social workers located in community organizations several hours per week can be very beneficial for clients who, for example, do not interact well with formal systems/authorities and/or who have been barred from government offices.

- Case management supports modeled on the existing case management approaches for individuals with complex mental health issues and/or those who are homeless (e.g., Front Step Program in St. John's) would be a critical resource for the target population. These staff would build relationships and trust with the individuals, go to where they are, support them with appointments, document their activities and facilitate connections to relevant providers.

## **10.1 Perspectives of the survey respondents on access to resources**

All of the non-methadone survey respondents said they had tried to get off drugs in the past, with 96% saying they had tried to get clean on their own. In addition, 89% of these respondents said they had tried to find a program or service to help them get off drugs/get clean.

Just over half (54%) of the methadone survey respondents have accessed another form of treatment or service at some point in their addiction journey besides the methadone program.

The respondents from both survey groups referenced accessing resources such as Front Step, Stella's Circle, John Howard Society, U-Turn, Narcotics and/or Alcoholics Anonymous, residential treatment programs and/or counselling from an RHA.

### 10.1.1 ***Past barriers to accessing programs and services***

The survey respondents identified a range of barriers they faced in the past when trying to access programs and services to help them get off drugs/get clean. The barriers most often cited included waitlists, transportation to a service and program, and programs and services not available when they are ready for access. Fifty percent or more of the non-methadone survey respondents also said that stigma and the location of the services/programs were barriers. For those who cited “other” barriers, these included fear and anxiety about trying to access services, loss of their ID to get blood work and/or financial challenges.

On average, the non-methadone survey respondents faced five barriers to accessing other programs and services; the methadone survey respondents faced two barriers.

Table 15: Barriers faced survey respondents in the **past** when trying to get clean

<b>Barrier faced in the <u>past</u></b>	Non-methadone survey respondents (N=29) %	Methadone survey respondents (N= 30) %
Waitlist	88%	50%
Transportation to get to the service/program	67%	40%
Programs/Services not available when I was ready	63%	30%
Stigma	54%	20%
Location of service/program	50%	27%
There is no program in my town/region	29%	10%
Only short-term help available; I need long-term program/service	25%	27%
Having to take time off work	21%	27%
Other*	21%	3%
No one provides this type of help, service or program	17%	3%
I don't meet the program criteria	13%	3%
I did not have any barriers	13%	27%
Child-care	8%	10%

### 10.1.2 ***Current barriers to accessing programs***

The non-methadone survey respondents also were asked where they would go for help if they wanted to get off drugs at the time of the survey. They referenced several community-based services (e.g., Stella's Circle, U-Turn, Choices for Youth, and Thrive-Community Youth Network), as well as their parents, physicians, and more formal services such as counselling and the Recovery Centre.

These respondents once again cited the following barriers to accessing services: waitlists, transportation to and/or location of a service and program, and stigma. On average, the non-methadone survey respondents faced five barriers to accessing other programs and services.

## **11.0 Community capacity**

Community-based groups/organizations often lack the needed human and financial resources to provide ODT and related services. This deficiency is even more apparent in rural and remote locations of the province where organizations often have one or no staff person and rely heavily on volunteers.

It was felt by a small number of focus group participants that there should be more resources allocated for self-help activities, innovative approaches, and peer support.

## **12.0 Naloxone kits**

While the availability of naloxone kits was considered an important step in prevention of overdoses in this province, some concerns were expressed in relation to their availability and usage. A few of the informants and focus group participants felt that naloxone kits should be more widely available through, for example, community groups and pharmacies, in particular to facilitate a wider geographical distribution to those who might need access to same.

A few of the informants and focus group participants expressed concern that the Government of NL does not have a Good Samaritan Law or legislation. It was felt that this would impede the program from reaching its full potential because individuals would hesitate to administer the naloxone or monitor the person following the injection, if they thought they could be held liable for any deleterious effects.

Of note, however, is that the Province does have legislation which appears to provide the same protections to an individual helping another in the case of overdose: Emergency Medical Aid Act (Amended 1997 c23 s13). As per this legislation:

Protection of certain persons from action

**3.** Where, in respect of a person who is ill, injured or unconscious as the result of an accident or other emergency,

- (a) a physician or registered nurse, voluntarily and without expectation of compensation or reward, renders emergency medical services or first aid assistance, and the services or assistance are not rendered at a hospital or other place having adequate medical facilities and equipment; or
- (b) a person other than a person mentioned in paragraph (a) voluntarily renders emergency first aid assistance, and that assistance is rendered at the immediate scene of the accident or emergency,

the physician, registered nurse or other person is not liable for damages for injuries to or the death of that person alleged to have been caused by an act or omission on his or her part in rendering the medical services or first aid assistance, unless it is established that the injury or death was caused by gross negligence on his or her part.<sup>xxvii</sup>

## 13.0 Harm reduction

Harm reduction is a public health approach with a priority to decrease the negative consequences of drug use. This approach tries to reduce problems associated with drug use and recognizes that abstinence is not the only acceptable or important goal. It aims to provide or enhance the skills, knowledge, resources, and support that people who use drugs need to be safer and healthier.

Harm reduction is based on the belief that moral condemnation of groups at-risk will lead to less contact with health services, and that the majority of people who use drugs are willing and able to change behaviour if the right conditions apply.<sup>xxviii</sup> The harm reduction philosophy:

- Considers risk-taking behaviour as a natural part of our world and suggests that work should be focused on minimizing the harmful effects of these behaviours rather than focusing on the stopping the behaviour;
- Supports the involvement of individuals in the creation and/or delivery of programs and services that are designed to serve them; these programs and services should be offered in a non-judgmental and non-coercive manner;
- Recognizes the impact of issues such as poverty, classism, racism, homophobia, social isolation, past trauma, and other social inequities on both people's vulnerability to, and capacity for, effectively dealing with risk-taking behaviour.<sup>xxix</sup>

A few of the informants and focus group participants specifically raised the concerns that many existing ODT programs and services are high barrier i.e., individuals must be clean, dry or sober to access or be maintained in a program. It was felt that the likelihood is low that individuals who have addictions, including opioid dependence, can be abstinent to access a program and be maintained in a program without a relapse or “falling off the wagon”. The informants and focus group participants stated that ODT programs and services should be operating within a harm reduction framework, which would allow people to “slip” without losing access to their program while simultaneously trying to address the issues that caused this slip.

While it was noted that abstinence should be on the recovery continuum, it cannot be the primary entry criteria nor the only outcome.

*It makes no sense to have a program where they have to stop using a substance which they might be addicted to, prior to getting services, e.g., someone comes in and smells of alcohol or had some coke and is not inebriated, but a lack of harm reduction [approach] and the worker says, “come back when you are sober”.*

*All aspects of the continuum must embrace and practice harm reduction. A significant attitude change is needed particularly for people working long-term in government and community.*

Programs which could provide some learning in relation to employing harm reduction include SWAP, the Front Step program (which is founded on Housing First and operates within a harm reduction framework) and The Works in Toronto – a harm reduction-based clinic that provides its clients with methadone and buprenorphine/naloxone in addition to harm reduction supplies, counseling, support, and referrals to housing and other community services. The clinic states that it is “a self-directed, client-centred program that does not require abstinence” and only administers single dose treatments.<sup>xxx</sup>

### **13.1 Lack of respect for individuals accessing ODT**

Many focus group participants raised a concern about the lack of professionalism, confidentiality and/or respect displayed by some health care providers when interacting with individuals who have addictions. It was stated that when individuals who have addictions try to access Emergency Rooms, they are barred because they have addictions; disparaging comments are made about them; and/or their physical complaints and ailments are not treated as they are viewed as “an addict” and their medical issues are ignored.

Some of the focus group participants cited sexual harassment and abusive attitudes from some methadone-prescribing physicians. Examples included physicians who say to their patients:

*If you continue that kind of use, you will be in a body bag.*

*You are a sex worker and you have no STIs – how does that happen?*

*You messed up three times before and now you are back.*

A few of the informants spoke to concerns that inmates who have addictions often are viewed even more negatively than individuals who have addictions living in the broader community. They felt that efforts must be made to ensure they are provided adequate, appropriate and respectful treatment.

It was felt by a few of the focus group participants that if harm reduction approaches were employed within systems, these judgmental attitudes and comments would be mitigated.

## **14.0 Lack of an effective awareness campaign**

A few of the informants spoke to the need for a provincial awareness campaign focused on addiction and prevention. While they noted that celebration of National Addictions Awareness Week across the province is a good initiative, it was felt there should be more consistent messages from the health sector across the province. Again, it was stated by a few of the informants that while the province has done good work in relation to raising awareness of mental health and providing services, there is less focus on addiction.

Overall, it was noted by some of the focus group participants and informants that there is a need for service providers and the public to better understand the continuum of those who can experience addiction, how addiction “happens”; the impacts on the individuals, their family, and communities; and the treatment and supports available. If individuals who have experienced addiction are included in such a campaign, they would have to represent the continuum and be from all sectors of society. Comments included,

*When we have consumers speaking out, we need to have consumers from all walks of life. The impression is that addiction is only for the poor and marginalized street people. it is our mothers our fathers. Nobody is exempt from addiction.*

## 15.0 Overprescribing

A few informants felt that over-prescribing of opioids was an ongoing concern and one which contributed to the prevalence of addiction. Reasons suggested for overprescribing were many and varied, including:

- Physicians, their patients and the public lack information and education on the need to use narcotics wisely and sparingly, recognizing that in the past opioids were touted as being a safe treatment with little information provided about the potential risks;
- Lack of a provincial addiction medicine specialist who could be accessed for training and effective practice;
- Physicians do not have sufficient expertise in managing benign pain;
- Patients' expectations for pain medication together with some physicians who take the quick "path of least resistance", rather than taking time to counsel or outline options;
- Individuals who are drug seeking can be challenging. Some physicians give into them rather than fight with them;
- Physicians want to prescribe alternative treatments (e.g., massage, acupuncture, physiotherapy) but patients' insurance and/or Income Support does not always cover these treatments; and
- The fee-for-service system does not encourage physicians to spend time counselling patients in relation to their pain/alternative treatments.

Comments included:

*For both treatment and prevention, physicians need to be re-educated in relation to their prescribing habits. Why give Atasol 30 or Percocet for a toothache?*

*Does a patient need Percocet for a week for an abscess on their tooth?*

*We need better options for treating pain. For the size of our population, the amount of drugs prescribed is out of control.*

Conversely, it was stated by a few informants that some physicians won't prescribe narcotics because they are afraid to encourage addiction. They felt that physicians do not have sufficient expertise in managing benign pain.

## **15.1 Improving physicians' prescribing practices**

It was stated that individuals with chronic pain and an opioid addiction needed to have both their pain and addictions addressed. A few of the informants identified the need for enhanced pain management services through a province-wide chronic pain program founded on province-wide standards and delivered through and with support from the RHAs. This program should have a significant focus on educating physicians on effective prescribing habits for chronic pain and alternative treatments. As well, it was stated that a review will be needed of the coverage for these alternative treatments under the province's NLPDP.

Of note, all physicians must be registered with either the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians Canada (certifying bodies) to be licensed by the CPSNL. In every renewal cycle, the licensed physicians are required to undertake mandatory CME from these national bodies. As well, during peer review, the CPSNL also reviews physicians' prescribing practices - e.g., how are they treating chronic non-cancer pain?

In addition, and as referenced in section 2.0, in partnership with MUN, the CPSNL is developing a new online safe prescribing course, which physicians will have to complete six months before they get a license.

### ***15.1.1 Resources which could provide learnings to support safe prescribing habits***

→ Canadian Guidelines for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain<sup>xxxi</sup>

In response to physician and other stakeholder's request for guidance on safe and effective use of opioids, the National Opioid Use Guideline Group with support from provincial and territorial medical regulatory bodies, released a national guideline for opioid prescription in 2010. This guideline was released in two sections, with the first section providing an executive summary and background information of the present research. The second section contains recommendations for practice including monitoring long-term opioid treatment and suggestions for dealing with opioid misuse and addiction. For example, this document presents several recommendations for physicians in advance of initiating opioid therapy including to ensure comprehensive documentation of the patient's pain condition, general medical condition and psychosocial history, psychiatric status, and substance use history; consider using a screening tool to determine the patient's risk for opioid addiction; consider the evidence related to effectiveness in patients with chronic non-cancer pain; and ensure informed consent by explaining potential benefits, adverse effects, complications and risks. A treatment agreement also may be helpful, particularly for patients not well known to the physician or at higher risk for opioid misuse.

→ Ontario Pharmacists Association<sup>xxxii</sup>

### *Methadone discussion forum*

The Ontario Pharmacists Association's methadone discussion forum is designed to give methadone practitioners a place where they can share best practices, discuss tough practice questions, and interact with other pharmacists and physicians who prescribe or dispense methadone. Registration is free and the forum is open to all methadone dispensers and prescribers. Members can log on to the forum to interact with subject matter experts in areas including (but not limited to) the administration of methadone maintenance therapy in pregnancy and lactation, concurrent psychiatric illness, and handling difficult situations.

### *Methadone drug information line for professionals*

This service is free for all healthcare professionals who prescribe or dispense methadone — including pharmacists, physicians, and nurses — and who have clinical or therapeutic questions about the use of MMT in the treatment of addictions.

Calls are answered by the Association's Drug Information and Resource Centre pharmacists who are specifically trained in the use of methadone in opioid withdrawal and have access to various references. They can provide support on a wide range of issues related specifically to methadone use to treat addiction, including questions about side effects, the use of methadone during pregnancy, and drug interactions, to clarifications about policy and reimbursement.

### Medical Mentoring for Addictions and Pain Network<sup>xxxiii</sup>

The Ontario College of Family Physicians and the College of Physicians and Surgeons of Ontario partnered to develop a shared-care model in the fields of addictions, pain management, and methadone prescribing. Patients presenting with the complications of opioid addiction and chronic pain are difficult to manage in the context of a family practice. Physicians who have focused practices in pain management or mental health and addictions, especially those skilled in methadone prescribing, are often isolated from family physicians and unable to share their expertise with them.

Modeled after the College of Family Physicians' Collaborative Mental Healthcare Network, the Medical Mentoring for Addictions and Pain (MMAP) initiative is intended to support physicians with expertise in pain management and addictions including methadone prescribers to mentor family physicians interested in chronic pain and or addictions.

The MMAP network connects family doctor mentees to mentors in psychiatrist and Family Practice-focused practice in pain and addictions through telephone, email, and fax. Matched based on clinical interest and geographical location, mentees may contact their mentors on an informal basis for guidance and support in the areas of diagnosis, psychotherapy, and pharmacology. Formal continuing professional development workshops, small group teleconferences and sessions take place regularly to foster group cohesion. These tools help to support and augment the case-by-case mentoring program.

As well, and of note, in the Methadone Treatment and Services Advisory Committee - Final Report, Recommendation 26 states:

The Ministry of Health and Long-Term Care should provide sustainable funding to expand existing programs such as the Medical Mentoring in Addiction and Pain Network, and establish new programs if necessary, to facilitate long distance clinical support and mentorship programs to assist in the safe prescribing and dispensing of opioids and in the management of opioid use disorders.

## **16.0 Pharmacy network**

The Pharmacy Network is a province-wide, real time system that feeds all prescriptions filled in the province to a central database. When a patient presents to a connected pharmacy, their prescription is added to their network profile (a compilation of all prescriptions they have had filled in the province), and any messages resulting from the drug utilization review are returned to the pharmacy. These messages include, but are not limited to, duplication of therapy, duplicate drugs, and drug interactions. If double-doctoring or polypharmacy is detected, the pharmacist can refuse to fill the prescription. In addition, physicians have access to these medication profiles so they can check to see what the patient has had filled before they even write the prescription. Such a system should address double/poly-doctoring.

The deadline for connection was January 1, but pharmacies that were unable to meet the connection deadline were eligible to apply for conditional licensing to extend their compliance deadline. A January 25, 2017 news article in The Telegram<sup>xxxiv</sup> indicated that 81% per cent of all licensed community pharmacies in the province are now connected to the Pharmacy Network with the remaining 19% to connect by March 2017.

## **17.0 Policy Concerns**

### **17.1 Advanced Education, Skills and Labour**

Some of the focus group participants asked, “How much more of a story do they need?”, in reference to their interactions with some AESL staff. It was reported that these staff are asking, for example, how people with addictions acquire money to buy drugs and how much sex workers charge. It was felt that these departmental staff are not respecting individuals’ privacy and are going beyond what policy dictates they need for decision-making.

A related issue was raised by a few of the methadone-prescribing physician informants who stated that AESL is requesting information in relation to their methadone patients which they feel is confidential. As stated by one of these informants:

*AES has requested to see proof that I am treating a patient, the appointment dates, and a copy of the patient agreement. I am reluctant to give them the agreement as I feel this is a breach of confidentiality. The policy should be changed.*

## **17.2 The Newfoundland and Labrador Prescription Drug Program**

A few of the methadone-prescribing physician informants also raised concerns about information requests from the NLPDP that were considered unnecessary for securing confirmation that an individual could receive methadone or suboxone. Comments included:

*Why does the [NLPDP] need to know extraneous information about a patient when a physician is applying for methadone for this patient? Why should they want to know if someone has tried detox or what drugs they are on? They only need to know that the individual has a substance use disorder; after all the physician already has their exemption from Health Canada.*

*The only identified challenge is NLPDP who requests information about the patient's history including number of times they have tried detoxing, whether they took the drug orally or through IV. I do not understand why this information is required, as it does not impact the level of treatment.*

## **17.3 Lack of timeliness in approving individuals for MMT**

A few of the informants spoke to policy concerns surrounding delays in funding for individuals entering the MMT. They reported on individuals who have been taken off the program/had to leave the program because the approval for their prescription coverage was delayed, and they could not afford the prescription in the interim. It was felt this was a lack of coordinated efforts between and among relevant providers that could be remedied by creation of a fast-track policy.

## **17.4 Methadone patients entering/exiting hospital**

One of the pharmacists spoke to what they describe as a recent policy lapse in relation to methadone patients who enter/exit a hospital setting. They said there used to be a policy in place which detailed a protocol to follow should a methadone patient enter the hospital. The pharmacy which is supplying the patient's methadone is to call the hospital to verify dose and when the individual is leaving the hospital, staff are supposed to let the pharmacist know the individual is being discharged and will, once again be coming for their medications.

As of late, this pharmacist described a change, noting that when the methadone patient leaves the hospital, they are doing so without a prescription. The individual comes to the pharmacy expecting to continue their treatment, but they cannot access their methadone without the prescription. It was stated that both the individual's physician and pharmacist need to be notified prior to the individual's release and the individual should have a prescription provided as they leave the hospital.

## 18.0 Factors That Impact Individuals' Access to and/or Success in ODT

In identifying the factors that impact individuals access to and/or success in ODT, it is important to reiterate that the MMT Standards and Guidelines state that methadone alone does not constitute effective treatment of opioid dependency. Effective MMT services would ideally comprise several components as previously described in section 4.1.1 and repeated here for ease of reference:

- An appropriate methadone dose;
- Routine medical care;
- Treatment for other substance dependence;
- Counseling and support;
- Mental health services;
- Health promotion, disease prevention and education;
- Linkages to other community-based services; and
- Outreach and advocacy.

### 18.1 Transportation

Chapter 7 of the Income and Employment Support Policy and Procedure Manual<sup>xxxv</sup>, Transportation Benefits (ii) Medical Transportation identifies factors which need to be considered in order to determine eligibility for medical transportation and the circumstances warranting approval:

*Overview:* (if applicable)

Income Support recipients may require financial assistance in attending medical appointments or treatment facilities. This service may be provided by a physician, psychiatrist, or by other professionals such as social workers, psychologists and nurses employed under the RHAs or non-profit agencies.

*Policy:* (a) Eligibility Criteria

In determining eligibility for medical transportation, staff must assess the need based on the distance that the client must travel to receive the treatment, the frequency of the required travel and the most cost effective means of transportation.

Eligibility Criteria

- 1) The medical treatment must be beyond 60 km round trip (as determined by Google maps). If clients living within a 60 km return trip of their medical appointment demonstrate a need for

- frequent trips (a minimum of 8 return trips in a 30-day period) for medical treatment is required.
- 2) The individual must visit the nearest (from the client's residence) doctor, medical clinic, optometrists, dentist or hospital. They are only able to visit a different provider in extenuating circumstances as approved by a manager.
  - 3) Where possible, a client should arrange transportation through their own vehicle, family or friend, who will be reimbursed at \$0.30 per km.
  - 4) Public transportation may be the recommended form of travel as the most economic mode of transportation is used.
  - 5) Clients must obtain prior approval from the department.
  - 6) If an escort is required, proof of medical need (not just emotional support) is required.
  - 7) Waiting times for taxis should be kept at a minimum.
  - 8) If a patient moves farther away than they originally were from their treatment center, they will only be funded the original amount.

Annual Limit:

- Effective July 1, 2016, an annual limit of \$3,000 will be applied to the approval of medical transportation.
- In cases when that budget is surpassed, the Income Support Division can be consulted to determine if an exception should be made for that case.

A recurring issue identified by most informants and focus group participants was the 2016 change to AESL's Medical Transportation policy, in particular as it was said to impact program participants' access to their methadone treatment. A small number of pharmacist and physician informants felt that the changes in the policy were appropriate and not impacting people's access.

Concerns arise in relation to the few transportation options available to individuals needing same in small and rural communities. As well, while in St. John's bus travel is the lowest-cost option, it can be problematic for some, in particular those travelling with small children/infants.

It was stated that methadone patients often are travelling to other communities to access their dose. This is not only problematic from a cost perspective, but also because it impacts patients' quality of life and functionality, as they spend so much of their day in transit. One example was provided of a private provider in one community that has offered a transportation service for methadone patients to go to a nearby community to access their methadone. The service leaves around noon/early afternoon and returns late afternoon.

A few of the focus group participants said they are getting regular calls from individuals who cannot get to appointments with one noting that AESL is saying you should be "budgeting" – to get to medical appointments. It was also stated that there can be waitlists for methadone services in a region, but because this service exists in that region, AESL will not pay for clients to access available service in another region.

It also was reported that AESL will cover the cost of transportation to a treatment centre one time, but will not cover if the person wants to re-admit themselves into the program.

Comments included:

*One of the pharmacies in [our community] refuses to service methadone as, [many] years ago, [they had an issue] and now they refuse to provide the service. Therefore, whenever a participant wants to enter the program, we ask the patient to state what pharmacy they would use and then ask the pharmacy if it is possible. We have had patients who would rather use opiates than have to travel long distances.*

*Parents who are accessing public transportation, trying to get their children to school or day care and then to a pharmacy or clinic on time, it can be stressful and problematic.*

*One of the barriers for patients is the lack of services in proximity to the patients. I see only people living on the Avalon. Transportation is more of a barrier in the last six months due to the limit on the transportation stipend. Many have missed appointments with physicians and pharmacies due to transportation difficulties. People outside the city only have \$3000/year for transportation. They need a urine sample two times a week, to get to pharmacies daily and their physician weekly. There was definitely abuse when transportation funding was available, but everyone used to get there. Now six to eight clients don't show for all their appointments... Bus schedules are inflexible and don't run on weekends.*

While informants and focus group participants cited the Income Support Medical Transportation policy as being a significant barrier, representatives of AESL stated that the policy always should have been based on the least cost option, but, in the past, regions were interpreting the policy differently, e.g., some were focused on distance of travel and some on the frequency of travel. As a component of the last provincial budget, and to try to limit the growing expenditures on medical transportation, a cap of \$3000 was imposed. It was noted that departmental staff contacted clients and explained the change and that to the point of the writing of this report, they have not had to enforce the cap, i.e., no one has been cut off. However, it was stated that this measure has helped bring the cost to a more reasonable expenditure.

Of note, the Provincial Government's document, "The Way Forward: A Vision of Sustainability for Newfoundland and Labrador"<sup>xxxvi</sup>, references the following initiative in terms of medical transportation in the province:

Focus Area - A More Efficient Public Sector: Transportation Policy: "Implement a Single Entry Medical Transportation Assistance Program (Action 1.4, Pg. 12)

The government will launch a single provincial medical transportation finance assistance program that will combine existing resources into a single program. Over a six-month period, the government will plan this approach with selected clients and looking to implement it fully in 2017.

## 18.2 Fear of Child Protection Services

A few of the informants expressed that people living in poverty are often already challenged to be considered “good” parents. They stated, for example, that this challenge is magnified when addictions are present. It was said, for example, that parents who have addictions often do not seek help for fear a service provider will report them to Child Protection Services and/or might remove the children from the home.

## 18.3 Lack of access to child care

Lack of access to child care also was cited as a barrier to accessing addictions services, including methadone and suboxone. As an example, it was noted that single parents do not want to bring their children with them when they are going for their methadone as they do not want their children to see them taking their dose; yet, they often lack funding for child care.

## 18.4 Lack of access to psychosocial supports/resources

The majority of the informants and focus group participants spoke to the need for access to psychosocial supports, as fundamental for addressing addictions. It was stated by a few informants that individuals can be well-supported in programs and/or residential treatment programs but when they leave they are provided little or no after care, and are left to fend for themselves in terms of getting the supports they need while endeavouring to continue in their recovery.

Primarily, individuals need access to low barrier housing/Housing First approaches as it is recognized they cannot achieve stability if they do not have safe, affordable, and appropriate housing. In addition, safeguards must be put in place to ensure that individuals do not lose access to their housing or other needed supports when they enter residential treatment programs, so that on completion, these supports are still in place.

Other critical supports include access to transitional housing, vocational supports, transportation, adequate income (without having to struggle each day), childcare (as needed), family support, peer support and planned opportunities for community engagement.

Comments included:

*One of the main gaps we see, when discharging clients [from a treatment centre] is time is up and they are ready to go out, but psychosocial supports are lacking. We know if people are going back to a boarding home with no vocational and family supports, they are not able to maintain their sobriety or to maintain their status. When you move beyond St. John's, there is no emergency housing here. This is a real challenge when planning after care and support to people...we are sending them back out after treatment in their most at-risk time. Yes, they cannot stay inside a treatment centre. Having access to some kind of transitional housing to bridge the move from the centre would be helpful from a treatment [perspective].*

*Housing is another issue, and we don't have resources on site to connect clients with a new place to live. We rely on them to make changes. Clients voluntarily come in and complete the program. Then it is their own responsibility to ensure recovery continues.*

*The clients are largely people who for most of their lives, focused on getting and using drugs. It is a big shift trying to develop a fresh start, if psychosocial supports aren't in place.*

A small number of informants did state that individuals experiencing and/or recovering from addictions need access to activities which support their capacity to cope physically and emotionally– e.g., exercise, meditation, acupuncture, physiotherapy, and chiropractic services. These resources need to not only be accessible, but also affordable, in particular such restorative services should be covered by those in receipt of Income Support.

It also was noted by a few focus group participants and informants that there are many community-based organizations which need their funding increased or maintained as many provide housing and access to other psychosocial supports, that are critical at every step in the addiction continuum.

#### *18.4.1 Perspectives of the survey respondents on their challenges in addition to addictions*

The need for psychosocial supports is evidenced by the numerous challenges faced by both groups of survey respondents.

Almost all of the methadone survey respondents cited having challenges in their lives in addition to addictions. The most often cited challenges included those related to relationships, mental health, childhood abuse and trauma, unemployment, and other health issues. A lack of transportation and a decreased self-esteem were stated by respondents as “other challenges” to addiction. On average, the respondents cited at least three challenges.

**Table 16: Methadone survey respondents' challenges in addition to addiction (N=39)**

<b>Challenges in addition to addiction</b>	<b>%</b>
Relationship challenges	54%
Mental health issues	51%
Childhood trauma/abuse	33%
Unemployment	33%
Other health issues	33%
Lack of support	31%
Involvement with the legal system	28%
Poverty	28%
Lack of education	18%
Housing/homelessness	15%
Other addictions	10%
No challenges	8%
Other*	8%

Almost all of the non-methadone survey respondents also cited having challenges in their lives in addition to addictions. The most often cited issues included those referenced for the methadone survey respondents, i.e., unemployment and mental health issues. The non-methadone survey respondents also often cited lack of education, poverty, criminality and housing/homelessness as challenges. On average the respondents cited at least five challenges.

Table 17: Non-methadone survey respondents’ challenges in addition to addiction (N= 28)

<b>Challenges in addition to addiction</b>	<b>%</b>
Unemployment	71%
Mental health issues	64%
Other addictions	61%
Lack of education	57%
Poverty	54%
Involvement with the legal system	54%
Housing/homelessness	50%
Relationship challenges	46%
Lack of support	46%
Childhood trauma/abuse	25%
Other health issues	21%
Other*	7%
I have no challenges	4%

**18.5 Accessing employment**

Some of the focus group participants and informants felt that random urine checks and daily trips to the pharmacist as well as histories of addiction, constrain people’s ability to get and keep a job and/or continue with their education. Finding employers who will employ someone with an addictions history and/or on methadone, or who will be flexible and supportive of an employee having to get to a pharmacy or a clinic during working hours was considered to be difficult.

It was felt that those who are unable to have carries due to their instability and/or experience, are severely negatively impacted in relation to efforts to attach to the labour force. Yet, individuals struggle to return to their regular lives when they are unable to accept a job.

One of the methadone-prescribing physician informants recounted an anecdote of one of their patients who had to decline employment because they did not have sufficient time in the program to access carries and lived too far from the pharmacy to access their methadone during lunch. He stated that some of those receiving methadone referred to it as the “liquid handcuff”.

Another of the methadone-prescribing physicians spoke to the constraints of carries for those working in rural and remote regions of the province, asking how, for example, individuals working in remote areas of Labrador or out to sea fishing access their methadone without carries. He stated that he has had to give more

carries than allowed under the program to ensure individuals can access their medication, maintain their stability and their employment.

## **18.6 Rural and regional disparity**

It also was recognized across all of the informants and the focus group participants that there is disparity in the level and scope of resources across rural areas and regions, which can be challenging to service due to their vast geography. For example, one of the physicians cited the pockets of opioid dependency in regions of the west coast with few or no services to support their recovery (Port aux Port, Deer Lake, Hampton).

As previously referenced, there are significantly more MMT physicians and pharmacists in the Avalon region, and a well-developed transportation system in the St. John's Metro Region resulting in improved access. In addition, this region has the most well-established community-based organizations which have long histories of working with individuals (adults and youth) with mental illness and addictions, including, for example, Choices for Youth, Thrive-Community Youth Network, Stella's Circle, John Howard Society, ACNL-SWAP, and the Canadian Mental Health Association's Justice Program. Newer initiatives which also have this focus include Front Step, NAVNET and U-Turn.

## **19.0 Addressing the Continuum of Treatment Needs**

There is a continuum of individuals who are opioid dependent – e.g., varying in age, gender, sexual orientation, ethnicity, economic status, marital status, and criminal involvement. As well, there are different categories of opioid dependent patients – i.e., those who are narcotic naïve (e.g., who might become addicted because of medication taken for chronic pain or due to what they thought would only be occasional/recreational use); those with predisposition to addiction; those who already experiencing addiction – some for the long-term; and/or those with mental illness. Given the variability in who can experience addiction, the treatment approaches and options cannot be unilinear.

During the consultations, the informants and focus group participants were asked what, if any, are the key considerations for designing and implementing ODT services for specific populations. The following sections provide a summary of their perspectives in relation to a diverse target group.

### **19.1 New Canadians**

Access to health care is often a challenge for New Canadians who may not know what is available or why it is needed. Services must be culturally relevant and sensitive. It was felt that health care providers must have time to gather knowledge about the individuals' cultures and backgrounds, as trauma-informed care might be necessary depending on their home country experience.

Information on health care services, including ODT, must be in multiple languages and interpretation services must be available. One health care provider informant referenced using "CanTalk" which is described as providing access to high quality, immediate language services (interpretation – verbal, and translation – written) such as onsite interpretation; in-language voice mail box; language testing; translation,

as well as e-mail translation and transcription over-the-phone interpretation.<sup>xxxvii</sup> This informant stated that a phone-based translation service is a useful resource for working with New Canadians, citing that such a service avoids the fear associated with using a translator from their local community and their addictions becoming known.

## **19.2 Persons with disabilities**

Providers should ensure that services for persons with disabilities are fully accessible – e.g., physical access, sign language, information available in plain language and alternative format. Assumptions about disability must be discarded and the focus must be on determining what is needed.

## **19.3 Individuals who have mental illness**

Individuals with mental illness have many and wide-ranging barriers, including experiencing and address their addictions. It was stated, for example, that if individuals with mental illness in the Metro Region try to access emergency services for an issue emanating from their addictions, they can be told to go to the Waterford Hospital; once at the Waterford, they can be refused admittance because they are under the influence of drugs.

For individuals who have mental illness and addictions issues, there is a need for an integrated approach to treatment, i.e., it is of little benefit to address the addictions issue if the individual is not supported to stabilize their mental illness and get well. This integrated approach should include ready access to psychiatrists and case managers.

## **19.4 Aboriginal people**

In working with Aboriginal people, it was highlighted that responses must include empowering communities to support their residents and build their own self-efficacy. In relation to Aboriginal youth who have addictions, suggestions included that there be a focus on re-connecting with their families and the community, as well as allowing for intergenerational, cultural and land connections.

Service providers must work with Aboriginal groups and populations, and their leaders, including the Chiefs and Elders, to design services that are culturally sensitive, relevant, and respectful of their traditions and ways of healing. Resulting programs must provide holistic treatment and acknowledge the potential physical and emotional harm Aboriginal people may have experienced.

As an example, in Northern Ontario, a community-developed opioid treatment program was implemented that combined the strength of Western and traditional medicine.<sup>xxxviii</sup> In the first 28 days of the program, community and mental health workers provide patients with buprenorphine. At the same time, community leaders and healers deliver group and individual sessions on addiction recovery, relapse prevention, understanding early-life trauma, grief counseling and traditional health techniques to assist the patient through their addictions. A year follow up saw a decrease in criminal charges by 61.1%, and an increase in school attendance (33.3%) and sales at the local store (20%).

Non-aboriginal practitioners need to participate in culturally relevant sensitivity training and ensure that the information and services provided also are culturally responsive. A small number of informants felt that emphasis should be placed on employing Aboriginal staff as possible.

## **19.5 Women**

There should be more female-only programming (including female service providers and physicians) to increase women's comfort level and, thereby increase the likelihood women will engage in addictions programming. It was stated that programs and services must be sensitive to the fact that women may be victims of violence, sexual abuse and/or engaged in the sex trade.

Pregnant and post-natal women should be a priority. They should have access to non-judgmental, quality pre- and post-natal care and clinics. As well, women who have addictions should have increased opportunities for education on safe sex and birth control, and be informed about the likelihood of their babies being born addicted to opioids and the ramifications of same.

There must be efforts made to support women who have children to maintain the children in a safe and protective environment. It was noted that some women's "*biggest fear about accessing treatment is they will lose their children*" and some are "*terrified to state that they have children when getting service as they will be viewed as unfit parents*".

To support women with children to engage in programs and services, they must have access to child-care as needed. As well, there must be a focus on women moving forward with their lives and engaging in education, training and/or the workforce.

## **19.6 Seniors**

Seniors were identified as a population with emerging addictions concerns. It was stated for example, that like any other population, seniors are at risk of becoming addicted to opioids prescribed for chronic pain. This population needs to be educated on opioids, the risks associated with prescription and illicit opioids, as well as available resources to support them should they become addicted and how to access these resources.

## **19.7 Recreational users**

Another population which must be considered when designing and developing ODT programs and services is recreational users. As commented by one health care professional, "*It is important to remember that not everyone who is using opioids would consider themselves users or addicts, but rather as recreational users. This population [also] can be at risk – e.g., of ingesting fentanyl that is cut into other drugs.*"

It was stated that there is a need to include and reach out to this population in any media and/or public awareness campaigns to address the harms/risks they face in their recreational use.

## 19.8 Youth

Perhaps the most critical message in designing services for youth who have addictions is “access in the moment”, i.e., when youth identify the need, even waiting a short period can impede their resolve to get help. It was suggested, for example, that harm reduction services should be onsite where other supports are available to this population (e.g., at community-based organizations where this population are known to be).

ODT for youth must be founded on relationship-building; youth must feel a connection and a sense of trust to engage in programming. They may not be willing at the outset to give up drugs and so there must be a focus on harm reduction to support them on a path to being drug-free.

A Review of Youth Substance Use Services in B.C.<sup>xxxix</sup> found that the most effective programs provide youth with one stop shopping, do not require sobriety and have flexible operating hours beyond 9 to 5, with access on weekends being critical. Additionally, flexible referral pathways resulted in a greater number of youth entering the program. In terms of areas of improvements, programs need to be aware of the challenges faced by transgender youth and the different requirements of males and females. Community programs need to collaborate with health practitioners and each other to be able to provide holistic treatment to youth.

A few informants commented on the availability of methadone and suboxone for youth, with differing opinions as to the degree of access this population should have to these treatments. Some felt that methadone and suboxone should not necessarily be the first option or avenue for treatment for youth, as it can set them on a life-long path of dependence to these drugs. Some felt that with good screening and assessment and well-managed medical withdrawal through methadone or suboxone, youth can be directed to more appropriate treatment options.

Comments included:

*A lot of newer patients are very young. If you are addicted to Oxy and Percocet and placed on a methadone program right away, are there not other alternatives? [Methadone was intended] for hard core opioid dependent addicts. When you are 17 or 18, and [for example,] addicted to morphine and Percocet – can they not do medical withdrawal. Why set them on this path?*

*When you have youth 16 years of age who want methadone, there are life-long impacts...For young people, this should not be first line of treatment.*

*I see a number of people who are using a bunch of drugs. It is beyond me why someone in their late teens or early 20s is on methadone...Are we utilizing harm reduction enough?*

A small number of health care providers felt that the requirements for methadone treatment should allow for some flexibility, especially in relation to the removal of an age requirement. They felt that there is a need to provide methadone to youth to safely address the intense cravings associated with opioid addictions and the difficult withdrawal process. It was reported that while youth in withdrawal can be provided clonidine in addition to gravel, and trazadone, this works for about 80% of the population; and clonidine can lower blood

pressure which can be risky for youth who enter a treatment program and have not eaten for days. Further, it was highlighted that on leaving a treatment program or centre, some youth still need support for a period of time to address their cravings, and that methadone would be the most effective prevention for relapse.

### *Prevention and early intervention*

Education on drugs and addiction and related consequences should be undertaken early in a child's school life. As well, there should be a focus on social and emotional learning, which can equip children and youth with the skills and coping strategies needed to address the issues which often precipitate drug use (e.g., negative peer pressure, poor impulse control).

There also is a need to provide parents and caregivers with education on drugs/addictions and how to best support their children to develop these coping skills. Case managers also should have ease of access youth in schools, as it is unlikely that youth will source out a treatment program.

Educators within the school system need to be able to recognize the signs of drug use and abuse and how to engage/support and/or refer youth appropriately. Suspension and expulsion should not be only solutions to youth who are using/selling drugs in school or on-school property.

*We want to do more around prevention. We focus on being reactionary. We need to start focusing on prevention. The best thing is to focus on children's mental health to build resiliency in children and community. We want to educate parents on supports and coping skills. We tend to look to the schools, but parents need work too. We need to work with the education system on how to integrate into the curriculum so there is a consistent message going out.*

## **19.9 Gender and sexual orientation<sup>x1</sup>**

The LGBTQ community is comprised of gay, lesbian, bisexual, transgender, and questioning individuals. Each of these subgroups has a unique set of needs, mental health disorders, and social problems that require specific treatments. A few of the focus group participants highlighted that assumptions are sometimes made about patients' sexual orientation and gender identity, which can result in lack of consideration of these issues in their treatment plans and inadequate and inappropriate referrals.

Most alcohol and drug treatment facilities do not have designated LGBT treatment programs, nor are they prepared to handle the types of physical, psychological, or psychiatric problems that confront these patients. As a result, many LGBT patients are more likely to remain silent about physical problems for example, because of fear of stigmatization and/or fear of substandard care in the face of staff bias.

Providers need to be aware that because LGBTQ patients often have a reluctance to receive medical treatment, they may have incomplete medical history. Having LGBT staff can support deeper understand of the unique challenges this population faces and ensure more responsive services. For example, there could be a focus on teaching participants how to address job discrimination or healthy ways to deal with discrimination from family members. Programs additionally can support individuals as they accept their sexual orientation or gender identity.

Further information on considerations when designing and developing LGBTQ addiction treatment is available from the following:

- Recovery Connection: “What to look for when seeking LGBT-friendly addiction treatment”. 2011. Available from <http://www.recoveryconnection.com/wp-content/uploads/2016/04/what-to-look-for-when-seeking-lgbt-friendly-addiction-treatment.pdf>; and
- Rehabs.com: “LGBTQ Addiction Rehab Programs”. 2017. Available from <http://www.rehabs.com/about/gay-lesbian-bisexual-transgender-rehab/>.

## **19.10 Individuals in correctional facilities**

As expressed by a small number of the informants, individuals with addictions who are incarcerated have a longer period to address their issues than in any of the existing provincial residential treatment centres. There are no barriers to accessing service (e.g., transportation, funding, and child care are not barriers) and so a continuum of services should be available and delivered respectfully.

It was stated that the norm across the country for access to methadone while incarcerated is often similar to that in NL. If an individual is receiving methadone prior to entering the system, they can remain on methadone; if not, they do not get access to methadone while incarcerated. A few of the informants considered this a gap given the need within the provincial correctional facilities for access to this treatment, along with counseling to support inmates to develop coping strategies to offset relapse, and 12-step programs and education. They felt methadone should be accessible to those in prison as needed. As well, MMT delivered in correctional facilities should be responsive to the realities and needs of those participating in treatment.

A few informants felt that there should be enhanced connections between the correctional facilities and the RHAs, noting that the RHAs should have significant in-reach to the inmates and provide services as they do to any other population out in the community. Such an approach would allow for more continuity of service in exiting the facilities, as the inmates would already be involved in programming and not have to be waitlisted for service. Psychosocial supports also must be in place prior to an individual leaving their correctional facility.

*We need to be able to have services available during incarceration. While they are there, there is hope they can be sober. We need to ask how we can help them prepare for release, to provide them with the appropriate tools. People should be supported with methadone treatment on release instead of having to start over.*

Many of these sentiments were echoed those found in two reports undertaken in the last ten years which have reviewed and/or commented on operational aspects of Adult Corrections in the province.

The 2008 report “Decades of Darkness – Moving Towards the Light: A Review of the Prison System in Newfoundland and Labrador”<sup>xli</sup> spoke to the need for broad scale MMT in correctional institutions in the province:

MMT has been used for more than a decade in the federal prison system and a team, including a nurse, has been in place to incorporate MMT into the inmate’s correctional plan. Consideration should be given to expanding the program to include new methadone recipients subject to the capacity to offer quality care, support, and monitoring of each inmate. The service should include those who are assessed as needing MMT, but who are not receiving it upon arrival; and mechanisms should be put in place to ensure that there is a continuity of service between the prison and community methadone treatment program.

It is recommended that consideration be given to expanding the current Methadone Maintenance Program to include those who are assessed as needing MMT, but who are not receiving treatment upon arrival at Her Majesty’s Penitentiary and the Newfoundland and Labrador Correctional Centre for Women; and that further consideration be given to expanding the program to other correctional institutions in the province. (Pg. 110)

Speaking to the challenges inmates face upon discharge, the report also recommended:

...that all provincial prisons partner with community stakeholders and service providers to ensure that offenders generally, and mentally ill offenders in particular, are provided with a continuity of care and continue to receive support to address housing, employment, addictions and mental health needs in the community. (Pg. 125)

In the more recent 2011 report, “Citizens’ Representative Investigation of Psychiatric Services in Provincial Correctional Facilities”,<sup>xlii</sup> it was stated that,

Inmates should have the reasonable expectation that they will receive the same type and level of medical care which is available to all citizens. (Pg. 21)

The Canadian Centre on Substance Abuse provided a list of best practices for substance abuse programs in prisons. Their key three principles are:<sup>xliii</sup>

1. Individuals at high risk of reoffending should receive more intensive programming;
2. Treatment should target criminogenic factors or needs that are predictive of criminal behaviour; and
3. Treatment should be customized to the person, with further attention placed on multiple factors including their orientation, and cognitive and learning style.

The report further identifies techniques that have been shown to reduce post-treatment substance use including:

- Social skills training;
- Problem-solving skills;
- Coping skills training;

- High risk identification skills;
- Structured relapse prevention;
- Goal-setting in treatment;
- Motivational Interviewing/Enhancement techniques;
- Employment skills;
- Behavioural marital training;
- Stress management training;
- Maintenance, monitoring, and aftercare; and
- Community reinforcement techniques.

## 20.0 Overall Considerations

Opioid dependence is an ongoing and growing concern. It is critical that services and resources be developed for the continuum of individuals who experience opioid dependence with specific initiatives undertaken for vulnerable, marginalized populations. There must be sufficient resources to systematically support this growing demographic at every step on the continuum. These resources should be available in rural and urban regions of the province.

The following sections provide key considerations for HCS as they move forward on developing their policy on opioid dependence treatment, arising from the findings of the gaps analysis. In summary, the critical areas of focus are designed to build capacity within systems to enable the target population to have increased access to and success in opioid dependence treatment. Considerations include:

- Increasing the number of physicians and pharmacists, as well as other health care professionals, who participate in MMT;
- Increased accountability for physicians in relation to their prescribing habits and/or participation in MMT;
- Enhanced education for the continuum of health care service providers on opioids and ODT related topics;
- Development of multi-disciplinary, harm reduction ODT sites across the province;
- Increased access to psychosocial supports for individuals who have addictions and/or who are in recovery; and,
- Enhanced collaboration between and among community and government service providers.

### 20.1 Governmental initiatives

Initiatives detailed in the “The Way Forward: A vision for sustainability and growth in Newfoundland and Labrador” should support improvements in the delivery of ODT in the province. Examples include:

### Adopt a Health-in-All-Policies Approach (Action 1.29)

Government will build health impact considerations into all policy decisions, from infrastructure planning to labour market support. The goal is to create a healthy environment needed to support and promote not only healthy people, but also a healthy economy.

### Response to Recommendations from the All-Party Committee on Mental Health and Addictions (Action 1.30)

The government pledges to transform the way mental health and addiction services are delivered, with a promise to enhance access to community-based services and improving access to acute care services, where and when they are required across the province. They are presently preparing to address gaps in their system, strengthen existing programs and services, break down barriers of stigma and provide timely access.

### Implement an Individualized Funding Model (Action 2.11)

In this new model, individuals will participate in developing their support plan and will have control over an individualized amount of funding for personalized supports that are applicable to their identified need. This allows patients to tailor their funding based on the supports they require to aid in the development of daily living skills; improved care of self and home, find or maintain suitable housing; support access to recreation and other community resources; and, increase their capacity to undertake paid or volunteer work.

## **20.2 Enhanced education and training for health care service providers**

Many of the informants felt that there needs to be additional education and training on pain management, addictions, new and emerging opioids, and ODT and related resources (government- and community-based) for both pharmacists and physicians in-training and practicing. Others felt this training should be more inclusive across the continuum of health care providers and include RNs, occupational therapists, and physiotherapists. Further, it was felt that this training should include front-line experience with and exposure to individuals who have addictions and/or who are receiving suboxone or methadone. As previously referenced, in partnership with MUN, the CPSNL is developing a new online program which physicians will have to complete six months before they get a license.

A few of the focus group participants stated that administrative staff in government offices also should have additional training in how to address an aggressive person, particularly what the potential risks are and how to mitigate them, while still affording the person respect. Similarly, a few informants and focus group participants also felt that all service providers should be mandated to complete cultural and gender sensitivity training, which should support working with the continuum of groups that experience addiction. As commented by one informant, *“Moving forward, cultural competency is fundamental as it is important to learn the cultural context of a group, [thus] fostering open dialogue.”*

## 20.3 Accountability and oversight

### 20.3.1 Physicians role in MMT

Some of the methadone-prescribing and non-prescribing physician informants highlighted the need for more accountability in relation to the physicians' role in MMT.

It was highlighted that the majority of these prescribers are primary care providers. It was stated that some of the physicians might not recognize their gaps in knowledge, and not seek a tertiary consult when it is required. It was suggested that it would be of benefit to have overarching expertise available to the MMT. This resource could be available (e.g., a consultant) at the provincial government level to coordinate and oversee MMT throughout the province.

### 20.3.2 Physicians prescribing opioids

Some of the physician and pharmacist informants highlighted the need for more accountability in relation to the physicians' role in prescribing opioids.

Peer to peer reporting was considered an option for monitoring physicians' prescription habits. They could review their prescribing patterns in comparison to the average of their peers regionally, provincially, and nationally. If discrepancies were found, then the contributing factors could be identified (e.g., high number of cancer patients) and mitigative actions taken as necessary.

In tandem with this increased accountability in relation to prescribing opioids is the need for enhanced and provincial chronic pain management services, including a focus on alternative treatments (e.g., massage, acupuncture, physiotherapy).

## 20.4 Multi-disciplinary sites

There was wide-spread support across informants and focus group participants for provincially run, community-based, multi-disciplinary, harm reduction ODT sites in urban and rural areas of the province. These sites, which would be delivered through the RHAs, should have sufficient and appropriate funding, human resources, and infrastructure; operate within a set of consistent standards and approaches; and facilitate access to a continuum of health and psychosocial supports. This would include, for example, physicians who can prescribe and pharmacists who can dispense methadone, as well as other health care professionals who could administer methadone, Income Support staff and SWAP. These ODT sites should result in quicker access to programs and services for the target population and would allow for case management and planning.

*There need to be provincial clinics around the island with salaried physicians who are not worried about numbers and who can take the time to work with patients and support and/or refer them. Multi-disciplinary, well-resourced, harm reduction practices where individuals can be sent down the hall to social workers, addictions specialists, etc. [It would be staffed by] professionals sensitive to the individuals' realities.*

*It would be awesome to have a true methadone clinic where clients can come for one-stop shopping, e.g. physicians, counselling, access to supplies, and the ability to utilize a harm reduction approach treatment.*

It was suggested that these sites could be modeled on the OTC.

Of note, given the large geographical area of the province, it was recognized that these clinics would not replace the need for a continuum of physicians to prescribe methadone, particularly in rural and remote areas.

This direction of wraparound supports and multi-disciplinary harm reduction clinics is similar in intent to that identified in the 2016 Methadone Treatment and Services Advisory Committee - Final Report out of Ontario:

Recommendation 6: The Ministry of Health and Long-Term Care should allocate funding to develop rapid access treatment clinics/services for those seeking immediate help for opioid use disorder. In addition to medical treatment, clinics/services must include and provide access to a broad range of health care services and supports, including mental health and addictions counselling, and have plans, protocols, and timelines in place for transferring stable patients to appropriate care for ongoing management

Recommendation 22: The Ministry of Health and Long-Term Care should support and fund evidence-based practice to include harm reduction programming, including but not limited to: access to safer injecting and smoking supplies, and supervised drug consumption.

#### **20.4.1 Mobile ODT services**

It also was suggested that to supplement these sites, there should be investments in mobile ODT services which could provide a level of multi-disciplinary outreach. It was felt that this approach would be beneficial to more rural and remote areas, in particular for individuals who are receiving methadone. A model which could be reviewed to inform the development of mobile ODT services in the province is the 180 Bailey Bus - a program of Direction 180, a community-based methadone clinic located in the North End of Halifax.<sup>xliv</sup>

The 180 Bailey Bus is an interim, wait-list management program that provides methadone treatment to individuals with opioid dependency while awaiting admission into a comprehensive methadone maintenance program. The 180 Bailey Bus is a mobile service that broadens access to methadone treatment in various communities throughout the city. They currently have four sites including Halifax, Dartmouth, Fairview, and Spryfield. This is a daily witnessed ingestion program in which all clients receive their medication daily, administered by a registered nurse, on board the mobile unit. Client admission, treatment, and progress is conducted and monitored on board the mobile unit by the prescribing physician, nursing staff, intake coordinator, and case manager. The goal of the program is to reduce the risks and harms associated with ongoing intravenous drug use while awaiting entry into a treatment program.

### **20.4.2 Increased use of technology and telehealth**

The benefits of using telehealth to access patients is evidenced in MMT, given that such technology provides methadone patients on the West Coast access to a methadone-prescribing physician. This helps to fill a gap in MMT services on this part of the island and offsets the patients having to potentially travel long distances (if they can afford such travel) to access these services elsewhere.

It is suggested that opportunities for increasing access to ODT using technology and telehealth be a specific focus of HCS and the RHAs, with pilot projects implemented (and evaluated) as possible.

Examples which could provide some learnings in this regard include the following:

- Based on youth's comfort utilizing technology Inner Change<sup>xlv</sup>, a British Columbia addictions program, provides their clients access to E-Health. The platform is designed to educate and support youth in addition to help them build social connections with peers in five geographical hubs (Island, Fraser, Northern, Interior, Vancouver).
- iRecover Alberta, a residential treatment centre, provides all clients with a tablet equipped with educational materials, workbooks, and videos to better customize their treatment<sup>xlvi</sup>. Upon leaving the program, participants can contact their counselor at any time through technology.

## **20.5 Increase access to psychosocial supports**

Medications are useful in the treatment of opioid dependence. However, providing medications without offering any psychosocial assistance fails to recognize the complex nature of opioid dependence, loses the opportunity to provide optimal interventions and requires treatment staff to go against their clinical inclination to respond to the holistic needs of their patients. At a minimum, services should attempt to assess the psychosocial needs of patients, provide whatever support they can, and refer to outside agencies for additional support where necessary.<sup>xlvii</sup>

This need for psychosocial interventions to support those with opioid dependence is evidenced by the survey respondents who spoke to their many and varied challenges, in addition to their addictions. The most often cited issues included relationships, mental health, childhood abuse and trauma, unemployment, lack of education, poverty, and housing/homelessness. The provision of required psychosocial interventions is integral to the recovery of those who have opioid dependence.

To address both an individual's opioid dependence, as well as their psychosocial support needs, there must be emphasis placed on developing continuums of care for the target population. It is suggested that clinicians and administrators "*envision admitting the client into the continuum through their program rather than admitting the client to their program.*" This early focus on moving the client along the continuum also prompts clinicians to look ahead to the next step in a client's treatment. This, in turn, helps clinicians engage in the treatment planning that is integral not only to the client's ongoing care but also to the transition from one level of treatment to the next.<sup>xlviii</sup>

### ***20.5.1 Develop an employment strategy for those in MMT***

As referenced previously, methadone patients are often challenged to engage in education and/or employment due, for example, to the time spent travelling each day to access their methadone, the random nature of the witness urine checks and/or the instability of their lives. It was felt that there should be an employment strategy in place to support the methadone patients in attaching to the labour force and thus improving their capacity to be contributing members of society and as well to have an enhanced quality of life.

This employment strategy should be developed by relevant departments of the provincial government, including AESL, the Department of Education and Early Childhood Development and HCS, together with community-based organizations which have both a focus on addressing addictions and employment barriers for the target populations.

### ***20.5.2 Address transportation concerns***

HCS and AESL should collaborate to address transportation concerns faced by those accessing MMT, while ensuring cost-control measure to offset additional growth in the program budget.

## **20.6 Enhanced collaborative activity across service providers**

Approaching treatment through a continuum of care will demand enhanced collaborative activity between and among government and community-based service providers. It will be imperative that those involved in the continuum of care know who the various providers are, have clarity on each other's roles and be focused firmly on the effective use of resources to address the needs of a shared target group.

## **20.7 Informing HCS's ODT policy development process**

In relation to HCS's policy development process, the following considerations emerged during the consultations:

- HCS must have a vision for ODT services in the province – one founded on collaboration and coordination of service, with clearly defined outcomes;
- There should be ongoing collaborative consultations across provincial government departments as HCS is developing their ODT policy. Community and individuals with lived experience also should be included because they can provide on-the-ground feedback on whether policies can translate into effective and realistic protocols for service;
- The policy must be client-focused and responsive across the continuum of potential users. It should be built around the needs of the target population, not around the needs of the departments. Meeting basic needs must be fundamental to this policy;
- Any future initiatives must respond to the realities of rural and remote areas across the province. The focus cannot be solely in urban and urbanized areas. Further these initiatives must allow for numerous entry points; and

→ It must be recognized that new initiatives likely will not be cost-neutral, but should be cost-effective in the long-run. HCS should consider implementing and evaluating pilot projects.

### ***20.7.1 Perspectives of the survey respondents on critical elements of an effective ODT program***

In terms of the critical elements of an effective ODT program, survey respondents highlighted the following:

- Medical staff who are supportive and positive;
- Flexible programming to respond to individuals' needs and lives;
- Access to a methadone program with mandated one-on-one counselling that would address coping strategies, mental health issues, relapse prevention, and provide further knowledge about methadone;
- Psycho-social supports, e.g., access to transition support and after care, with a focus on finances, life skills/strategies to avoid relapse, housing/rent control, transportation, employment, and access to activities/hobbies;
- Access to one-on-one counselling, (including drop-in centres);
- Access to an in-patient rehabilitation treatment centres with sufficient length of stay and after-care;
- Access to non-traditional treatment programs, e.g., massage, acupuncture, and those which take individuals out in the country to live off the land; and
- Peer support/Access to group counselling facilitated by individuals with experience of opioid dependence.

## **20.8 Evaluation and data collection**

A few of the informants spoke to the need for ongoing data collection and evaluation in relation to ODT programs and services. Evaluation activity should include opportunities for client feedback – e.g., surveys. It was stated that outcomes should be clearly outlined, and data should be used to identify which programs and services are most beneficial to the target group, highlight effective practices and assess achievement of outcomes and cost-effectiveness.

However, it was stated by a few informants that given the population and their complexities, and the long-term nature of recovery, effective programs should not be discontinued because of low numbers of positive outcomes.

## 20.9 The World Health Organization

The recommendations and directions provided herein mirror some of those detailed by the World Health Organization in its January 2014 publication – "How to improve Opioid Substitution Therapy Implementation"<sup>xlix</sup>. It highlights that to increase access to OST and make it more universal, interventions should be:

- Physically accessible – there should be a broad geographical distribution, e.g., OST should not only be available in the major cities or unavailable in hard-to-reach locations such as prisons;
- Equitable and non-discriminatory – there should be no exclusion criteria except medical ones, e.g., OST should not be limited to those over a certain age or only available to those opioid dependent individuals who are HIV infected or who have “failed” other drug dependence treatments; and
- Non-rationed– the supply of OST should be determined by need and not limited by costs or other considerations; ideally there should be no waiting lists.

Further, it discusses a series of actions for ensuring the quality of OST programs including:

- Implementing a multidisciplinary approach and coordination of multidisciplinary staff, e.g., through a case manager;
- Developing a system of referrals to external medical, social and legal services and collaborating with them (general practitioners, infectious disease specialists, hospitals, social care services, shelters, probation, child protection agencies, etc.);
- Implementing a system of continuous external and on-site training for professionals;
- Maintaining an adequate and, as much as possible, user-friendly environment at the OST sites; and
- Asking OST clients regularly (including anonymous client satisfaction surveys) about their opinion of the services and whether their needs are addressed.

## **APPENDIX “A”: List of primary documents and websites reviewed**

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# **APPENDIX “B”: Sample interview guides and the focus group guide**

## Gaps analysis for ODT in NL

**Key informant guide** – Physicians with an exemption to prescribe methadone for opioid dependence (one-on-one interview)

### **Background**

1. How long have you been a practicing physician? What, if any, is your particular area of focus or specialty?
2. How long have you been prescribing methadone?
  - 2.1 What does the service entail (e.g., goal of the service, assessment, intake) and why did you decide to provide this service?
3. What, if any, challenges/barriers did you experience to **acquiring and/or maintaining** your exemption to prescribe methadone? (*Prompt for any issues pertaining to the standards and/or regulatory regime.*)
4. Why do you think so few physicians decide to seek an exemption to deliver a methadone program? (*Prompt for issues related to the exemption and the delivery.*)
5. What, if any, other ODT services (e.g., counselling) do you deliver?  
[If delivering other services, ask:]
  - 5.1 How long have you been providing these services/programs? (Prompt for any challenges to delivery and potential solutions.)
6. What, if any, innovative techniques and/or technology do you employ to deliver your methadone program and/or any other ODT?  
 Yes  No

If yes, what? \_\_\_\_\_

### **Demographics of those receiving methadone**

7. About how many people are currently participating in your methadone program? What is the maximum number you can accommodate? (*If there is a difference in the numbers, please ask for the reason.*)
  - 7.1 Is there a waiting list? If yes, on average how long would people be on the list before participating in the program?
8. How would you describe the demographics of the individuals in your methadone program - e.g., age, gender, employment, education?
  - 8.1 Have you seen a change in this demographic over time (e.g., is there a predominant demographic)?  
 Yes  No

If yes, please explain.

### **Experience delivering methadone program**

9. What, if any, challenges do you face in delivering the methadone program? Prompt for (and ask for specific examples, as available):

- Instability in the patients' lives -e.g., difficulty getting to appts, transportation
- take-home doses
- Diversion
- Time and resources constraints – e.g., no consistent client evaluation process; lack of time to provide counselling
- Lack of communication with pharmacists
- Lack of connection to other needed agencies/organizations
- Existing government policies
- Policy gaps
- Other?

***For each of the identified challenges***, ask, “What if anything can be done to address these challenges?”

10. What factors positively or negatively impact clients' access to and/or their ongoing participation and success in the methadone program?

Prompt for (and ask for specific examples, as available):

- Transportation
- Child-care
- Employment-related
- Stigma
- Lack of available psycho-social supports
- Existing policies
- Policy gaps
- Other?

***For each of the identified factors***, ask, “What if anything can be done to address these factors?”

11. What percentage of your clients have finished the methadone program and stayed clean? What might have contributed to their success?

## **Broader ODT services**

12. What other ODT options (e.g., resources, programs and services) are available in the region/the province to support individuals struggling with opioid dependency? (Prompt for regional variations.)

*12.1* Which would you describe as the critical resources, programs and services and why?

13. What are the existing and/or emerging gaps in ODT resources, programs and services in your region/the province - e.g., recruitment/retention of physicians to deliver MMT, lack of/limited psycho-social interventions, lack of residential services, regional disparity? (Prompt, in particular, for policy gaps.)

*13.1* What is needed to address these gaps (e.g., specific policy changes and/or development) and who should take the lead?

14. What, if anything, is needed to ensure better coordination and/or complementarity of ODT resources, programs and services to support both clients and service providers?

*14.1* What factors positively or negatively impact clients' access to, ongoing participation and success in ODT services? (Prompt for whether or not the issues are the same as noted in Q#10. Record any additional factors/solutions.)

15. What, if any, are the key considerations for designing and implementing ODT services for specific populations (e.g., Aboriginal people, new Canadians, persons with disabilities, people in correctional facilities, youth)?

16. What are critical considerations for HCS as they are developing the provincial ODT policy?

17. Do you have any additional comments?

## **Gaps analysis for ODT in NL**

**Interview guide** – RHAs, Treatment Centres (Humberwood, Opioid, Grace and Hope Valley), Labrador Friendship Centre and NLHHN

### **Background**

1. What is the mandate of your centre/division?

*1.1* What is your role within the RHA/Centre/organization? In particular, what, if any, is your role in relation to the development, delivery and/or oversight of ODT programs/services regionally and/or provincially (including policy development/delivery that impacts ODT programs and services)?

### **[If providing ODT:]**

2. Do you have any challenges in relation to the development and/or delivery of ODT?

*2.1* If yes, what and what are potential solutions to these challenges?

**Can you please complete the attached template if your division/centre provides ODT programs and services. If you are responsible for several programs, please provide information on one or two main programs, and provide links to descriptions of the other programs, as possible.**

### **Provincial/Regional ODT service**

3. In addition to any programs/services your division/centre/organization might provide, what other ODT options (e.g., community-based and government resources, programs and services) are available in the province to support individuals struggling with opioid dependency? (Prompt for regional variation.)

*3.1* Which of these ODT programs/services would you describe as the critical services and why?

4. What are the existing and/or emerging gaps in ODT resources, programs and services in the province (e.g., recruitment/retention of physicians to deliver MMT, lack of/limited psycho-social interventions, lack of residential services, regional disparity, policy gaps)?

*4.1* What is needed to address these gaps (e.g., specific policy changes and/or development) and who should take the lead?

5. What, if anything, is needed to ensure better coordination and/or complementarity of ODT resources, programs and services to support both clients and service providers?

6. What factors positively or negatively impact clients' access to, and/or their ongoing participation and success in ODT services?

Prompt for (and ask for specific examples, as available):

- Transportation
- Child-care

- Employment-related
- Stigma
- Lack of available psycho-social supports
- Existing policies
- Policy gaps
- Other?

What can be done to address these factors and who should take the lead?

7. What, if any, are the key considerations for designing and implementing ODT services for specific populations (e.g., Aboriginal people, new Canadians, persons with disabilities, people in correctional facilities, youth)?
8. What are critical considerations for HCS as they are developing the provincial ODT policy?
9. Do you have any additional comments?

## **Gaps analysis for ODT in NL – Focus group guide**

### **Background**

1. Please briefly provide your role in your organization. In particular, do you/does your organization have a role in relation to the development, delivery and/or oversight of ODT programs/services regionally and/or provincially (including policy development/delivery that impacts ODT programs and services; supporting clients)?
2. What, if anything, might challenge your efforts in relation to ODT? Solutions to these challenges?

**Can you please complete the attached template if your organization does provide ODT programs and services. If you are responsible for several programs, please provide information on one or two main programs, and provide links to descriptions of the other programs, as possible.**

### **Provincial/Regional ODT service**

3. What would you identify as the critical ODT resources, programs and/or services in the region/the province to support individuals struggling with opioid dependency? Are there regional variations?
  - 3.1 *Why did you choose these resources, programs and services?*
4. Can you identify on any innovative techniques or technology being used to deliver ODT services and/or support clients receiving ODT? If yes, what?
5. What are the existing and/or emerging gaps in ODT resources, programs and services in the province (e.g., recruitment/retention of physicians to deliver MMT, lack of/limited psycho-social interventions, lack of residential services, regional disparity, policy gaps)?
  - 5.1 *What is needed to address these gaps (e.g., specific policy changes and/or development) and who should take the lead?*
6. What, if anything, is needed to ensure better coordination and/or complementarity of ODT resources, programs and services to support both clients and service providers?
7. What factors positively or negatively impact clients' access to, and/or their ongoing participation and success in ODT services?

**Check all that apply and please provide examples and potential solutions as possible to the issues.**

- Transportation
- Child-care
- Take-home doses
- Employment-related
- Stigma
- Lack of available psycho-social supports

- Existing policies
- Policy gaps
- Other?

8. What, if any, are the key considerations for designing and implementing ODT services for specific populations:

- a. Aboriginal
- b. New Canadians
- c. Persons with disabilities
- d. People with mental illness
- e. People in correctional facilities
- f. Youth
- g. Women
- h. Other (Please list the groups)

9. What are critical considerations for HCS as they are developing the provincial ODT policy?

10. Do you have any additional comments?

# APPENDIX “C”: Models of Service template

<p><b>1. Name of service provider/organization/department:</b></p>
<p><b>2. Name of program:</b> <i>What is the name of your opioid dependence treatment program/service?</i></p> <p>a. <i>How long has this program/service been operating?</i></p>
<p><b>3. Source of program/service funding:</b> <i>How is your program/service funded? (As possible, for external funding sources, please identify the funding stream/program.)</i></p>
<p><b>4. Goal/Focus:</b> <i>What is the goal and/or primary focus of the program/service?</i></p>
<p><b>5. Target group:</b> <i>Who is the <b>target group</b> for your program/service (e.g., youth, seniors, age group, all ages...)?</i></p> <p>a. <i>What, if any, are the eligibility criteria for access to the program/service?</i></p> <p>b. <i>Is participation</i>     <input type="checkbox"/> <i>mandatory</i>     <input type="checkbox"/> <i>voluntary</i></p> <p>c. <i>What is the maximum number of people who can access your program/service at any one time?</i></p> <p><i>Have you reached capacity?</i>     <input type="checkbox"/> <i>Yes</i>     <input type="checkbox"/> <i>No</i></p> <p>d. <i>What, if any turnover, do you have in your program/service: each month? Each year? (i.e. do people move on from your program or do they need ongoing support from your service/program)?</i></p> <p>e. <i>What if any are the main considerations for designing and implementing ODT services for your target population?</i></p>
<p><b>6. Location:</b> <i>Is your program/service:</i></p> <p><input type="checkbox"/> <i>Local</i>                                     <input type="checkbox"/> <i>Regional</i>                                     <input type="checkbox"/> <i>Provincial</i></p> <p>a. <i>If local or region, what geographic area is serviced?</i></p>
<p><b>7. Referral:</b> <i>Who refers to your program/service and how (e.g., external providers, formal/informal referrals, self-referral)?</i></p>

**8. Assessment:** Describe your assessment process (e.g., formal/standardized or informal, tool/s used, who conducts the assessment).

**9. Intake:** Describe your intake process (e.g., formal/informal; time between intake and assessment).

a. Is there a waiting list for your program/service?  Yes  No

b. If yes, about how many people are on the list?

c. What is the average wait time to access the program/service (# of weeks or # months)?

**10. Program overview:** Please describe the key aspects of your program/service (e.g., services provided, schedule of service, any cap on services- i.e., maximum time for participation, maintenance phase/ongoing treatment/service, potential for re-entry to program...).

a. Do you work with other providers to support your clients/patients?  Yes  No

If yes, who and what do they provide?

**11. Innovation:** Would you describe any aspect of your program/service as innovative?  Yes  No  
If so, please explain.

**12. Technology:** Do you use technology to deliver any aspect of your program/service?  Yes  No

a. If yes, please explain how technology is used.

**13. Future:** Do you have any plans to expand/reduce your program in the next year?  Yes  No

a. If yes, what are you planning to do and why?

**14. Policies:**

a. Are there policies **within** your organization/department that restrict or facilitate the target group's access to/engagement in your program/service?  Yes  No

*If yes, please identify the policies and explain how they impact the target group.*

b. *Are there policies in **other** organizations/government departments that restrict or facilitate the target group's access to/engagement in your program/service?  Yes  No*

*If yes, please identify the policies and explain how they impact the target group.*

**Other comments:**

# APPENDIX “D”: Methadone Users’ Survey

**METHADONE USERS' SURVEY**

Physician's/Pharmacist's name: \_\_\_\_\_

Survey Number   xx  

**Introduction / Consent to be interviewed**

The provincial Department of Health and Community Services would like to hear about your experiences in getting help for your addiction/drug dependency. They are hoping you might be able complete this survey to tell them about:

- Your experience in the methadone program, and
- What other services are needed to help people with their addictions.

You can complete the survey yourself or you can call **Genie** toll free at 1- 855-805-2065 and she will do the survey over the phone with you. Genie works for Goss Gilroy (not for government) and we are helping the Department with this survey.

**IF YOU CHOOSE TO DO THE SURVEY:**

- Your answers will be kept **confidential** and your name will not appear on this survey or any report coming out of the survey information.
- If there are any questions that you do not want to answer, that is okay!
- This survey will take about 15 minutes.

**You will receive \$10 for helping us by doing the survey. Please write your address on the bottom of this page and we will send you the money in the mail.**

If you would **like to participate**, please complete the attached survey **or** call Genie.

(Leave a message if she is not there and she will call you back.)

If you **do not want to participate**, please give the survey back to your physician/pharmacist.

Thanks very much.

Marie Ryan, Project Manager

Goss Gilroy

**Your mailing address:** \_\_\_\_\_

**When you have finished, please put your survey in the envelope provided and mail it. We will send the \$10.00 to the address you provided.**

1. Gender? \_\_\_\_\_
2. What year were you born? \_\_\_\_\_
3. What region of the province **OR** which town/city do you live in? \_\_\_\_\_
4. How long have you been in the methadone program? # months \_\_\_\_\_ OR # years \_\_\_\_\_
5. How long were you taking drugs before you started taking methadone?  
# months \_\_\_\_\_ OR # years \_\_\_\_\_
6. Did you have any challenges **getting into** a methadone program: (Check  $\checkmark$  all that apply to you.)
  - Lack of information on the program
  - Wait list to get into the program
  - Criteria to get into the program
  - Finding a physician/pharmacist to dispense the methadone
  - No methadone program in my area
  - Transportation costs
  - No outreach into the community
  - I worried that someone would find out I am in the program
  - Having to leave work to access my methadone
  - My employer is not supportive of me leaving to get methadone
  - Other \_\_\_\_\_
  - I did not have any challenges
7. Do you get your methadone from: (Check  $\checkmark$  all that apply to you.)
 

<input type="checkbox"/> Your doctor	<input type="checkbox"/> At the hospital
<input type="checkbox"/> Your pharmacist	<input type="checkbox"/> At HMP
<input type="checkbox"/> A nurse	<input type="checkbox"/> Take-home doses
<input type="checkbox"/> Staff at a clinic	<input type="checkbox"/> Other _____
8. Do you have any challenges **now that you are in the program?** (Check  $\checkmark$  all that apply to you.)
  - Transportation
  - No outreach into the community
  - No funds for child care
  - The hours for the methadone clinic do not work well for me
  - Lack of counselling in the program
  - I worry that someone will find out I am in the program
  - Lack of privacy when I get my methadone
  - Having to leave work to access my methadone
  - My employer is not supportive of me leaving to get methadone
  - Other \_\_\_\_\_
  - I do not have any challenges

9. On a scale of 1 – 10 where 1 = not very helpful at all and 10 = very helpful, how helpful has the methadone program been in your life? *(Please circle your rating.)*

Not very helpful = 1 2 3 4 5 6 7 8 9 10 = very helpful

Please explain why you gave this rating:

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10. Do you think the methadone program will help you **stay off drugs/stay clean**?

Yes  No      If **no**, why not?

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11. Do you think you will reach a point when you can **stop using methadone** and stay off drugs/stay clean?

Yes  No      If **no**, why not?

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**Other services**

12. Have you gotten any other help for your addiction, **besides** methadone?  Yes  No (Go to Q#13)

If **YES**, what organization or individual helped you and what did they help you with? *(E.g. one on one support; help get you into a program)*

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13. Do you need other services or programs to help you get off and stay off drugs?

Yes  No (go to Q#14)      If **yes**, what do you need?

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13.1 What, if any, barriers are there to accessing any of the programs or services you listed above? (Check  $\checkmark$  all that apply to you.)

- I don't meet the program criteria (e.g., age range; being clean)
- Waitlists
- Programs/Services not available when I was ready
- There is no program in my town/region
- No one provides this type of help, service or program
- Only short-term help available; I need long-term program/service

- Transportation to get to the service/program
- Location of service/program
- Child-care
- Stigma (someone might see me going to the program/service)
- Having to take time off work
- Other (please list) \_\_\_\_\_
- I did not have any barriers

14. If you could create your own program to help people get off drugs – what services and resources would it include?

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**Personal - Profile**

15. What is your marital status?

- Single
- Married
- Separated/divorced
- Common-law/living together
- Other (please specify: \_\_\_\_\_)

16. What is the highest level of education you completed?

- No formal schooling
- Some schooling
- Completed high school
- Some post-secondary
- Completed post-secondary (college)
- Completed post-secondary (university)

17. What is your main source of income? (e.g. income support, work, pension, Worker’s Compensation)

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18. Do you have other significant challenges in your life? (Check  $\surd$  all that apply to you.)

- Relationship challenges
- Housing/homelessness
- Poverty
- Other addictions
- Mental health issues
- Other health issues
- Involvement with the legal system
- Childhood trauma/abuse
- Lack of support
- Unemployment
- Lack of education
- Other (please list) \_\_\_\_\_
- I have no other challenges

19. Do you have anything else you would like to say?

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# APPENDIX “E”: Non-Methadone Users’ Survey

Organization distributing survey \_\_\_\_\_

Survey Number   xx  

### **Introduction / Consent to be interviewed**

The provincial Department of Health and Community Services would like to hear about any experiences you might have had in trying to get help for your drug addiction/drug dependency. They are hoping you might be able complete this survey and:

- Tell them about your efforts to try to get help and/or get into a program, and
- Tell them what services you think are needed to help people with their addictions.

You can complete the survey yourself or you can call **Genie** toll free at 1- 855 805-2065 and she will do the survey over the phone with you. Genie works for Goss Gilroy (not for government) and we are helping the Department with this survey.

### **IF YOU CHOOSE TO DO THE SURVEY:**

- Your answers will be kept **confidential** and your name will not appear on this survey or any report coming out of the survey information.
- If there are any questions that you do not want to answer, that is okay!
- This survey will take about 15 minutes.
- You will receive \$10 for doing the survey and helping us. Please write your address on the bottom of this page and we will send you the money in the mail.

If you would **like to participate**, please complete the attached survey **or** call Genie.  
(Leave a message if she is not there and she will call you back.)

If you **do not want to participate**, please give the survey back to [name or organization].

Thanks very much.

Marie Ryan, Project Manager  
Goss Gilroy

**Your address:** \_\_\_\_\_

**Demographics**

- 1. Gender: \_\_\_\_\_
- 2. What year were you born? \_\_\_\_\_
- 3. What region of the province **OR** which town/city do you live in?  
\_\_\_\_\_

**Your experience with drug dependency/addiction**

- 4. About how old were you when you first used drugs? \_\_\_\_\_ years of age
- 5. Have you had times when you were off drugs?     Yes  No
- 6. What drugs, if any, are you using now? Please list:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Access to other services**

- 7. In the past, have you tried to get off drugs/get clean?     Yes  No (Go to question #11)  
  - 7.1 If **yes**, did you try on your own to get off drugs/get clean?     Yes  No
- 8. Did you find a program or service to help you get off drugs/get clean?     Yes  No (Go to Q#9)

If **yes**, what program, service, organization or individual (e.g., a community group, methadone program...) helped you and what did they help you with? (*E.g. one on one support; help get you into a program*)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 9. Did you need any other services or programs to help you get off drugs/get clean?  Yes  No (Go to Q#10)

If **yes**, what did you need and were you able to access these other programs and services?

\_\_\_\_\_  
\_\_\_\_\_

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10. What, if any, barriers did you face **in the past** when trying to access programs and services to help you get off drugs/get clean? (Check  $\checkmark$  all that apply to you.)

- I don't meet the program criteria (e.g., age range; being clean)
- Waitlists
- Programs/Services not available when I was ready
- There is no program in my town/region
- No one provides this type of help, service or program
- Only short-term help available; I need long-term program/service
- Transportation to get to the service/program
- Location of service/program
- Child-care
- Stigma (someone might see me going to the program/service)
- Having to take time off work
- Other (please list) \_\_\_\_\_
- I did not have any barriers

11. If you wanted to get off drugs **right now**, where would you go for help? (*E.g. is there a person/an organization and/or a government agency, program/service which could help you?*)

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11.1 What, if any, barriers are there to accessing any of these programs or services?  
(Check  $\checkmark$  all that apply to you.)

- I don't meet the program criteria (e.g., age range; being clean)
- Waitlists
- Programs/Services not available when I was ready
- There is no program in my town/region
- No one provides this type of help, service or program
- Only short-term help available; I need long-term program/service
- Transportation to get to the service/program
- Location of service/program
- Child-care
- Stigma (someone might see me going to the program/service)
- Having to take time off work
- Other (please list) \_\_\_\_\_
- I do not have any barriers

12. If you could create your own program to help people get off drugs – what services would it include?

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**Personal - Profile**

13. What is your marital status?

- Single
- Married
- Separated/divorced
- Common-law/living together
- Other (please specify: \_\_\_\_\_)

14. What is the highest level of education you have completed?

- No formal schooling
- Some schooling
- Completed high school
- Some post-secondary
- Completed post-secondary (college)
- Completed post-secondary (university)

15. What is your main source of income (e.g. income support, work, pension, E.I., Worker's Compensation)?

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16. Do you have other significant challenges in your life? (Check  all that apply to you.)

- Relationship challenges
- Childhood trauma/abuse
- Housing/homelessness
- Poverty
- Other addictions
- Mental health issues
- Other health issues
- Involvement with the legal system
- Lack of support
- Unemployment
- Lack of education
- Other (please list) \_\_\_\_\_
- I have no other challenges

17. Do you have anything else you would like to say?

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**THANK YOU VERY MUCH!**

**Please put your survey in the envelope provided and mail it.**  
**We will send the \$10.00 to the address you wrote on the first page of the survey.**

## **APPENDIX “F”: Addictions Programming at HMP**

**1. Addictions Awareness Program**

Facilitated by the HMP Addictions Counselor, this eight-session structured program is designed to help participants become more aware of the impact that substance use has had on their life, explore the stages of change, and introduce options for recovery. Through motivational interviewing techniques and a stages of change model, inmates who are in the pre-contemplative or contemplative stages of change are educated about the addictions programs available to them within the institution, as well as community organizations that may be able to provide service to them upon release. This is achieved through a psycho-educational and therapeutic approach.

**2. MIMOSA- Moderate Intensity Management of Offender Substance Abuse**

MIMOSA is a continuous intake, moderate-intensity substance abuse program for participants with moderate to high level of alcohol or drug dependency, or gambling addiction. Done through a partnership with HMP and the John Howard Society of NL, the seven-week program aids inmates as they complete a detailed, individualized relapse prevention plan. Utilizing a number of techniques, including psycho-education, values clarification, goal setting, and cognitive and social skills training, two counsellors from Howard House facilitate all twenty-one sessions. Based on the design of the program, participants are required to be assessed by the HMP Addictions Coordinator, to ensure that the program will best meet their needs.

**3. Addictions Recovery Program**

This is a group for any inmate who has successfully completed a program such as MIMOSA while in custody, or a community-based program or counselling prior to incarceration. Facilitated by the HMP Addictions Coordinator and an Addictions Counsellor from Eastern Health, the group meets once a week for open dialogue and sharing through a process-oriented and therapeutic approach. The group is open to all qualifying inmates with the primary goals to reinforce positive changes that participants have made while in prior programs or counseling, and provide participants with ongoing support and encouragement in their own individual recovery.

**4. Healthy Minds Program**

This eighteen-session structured program is designed for inmates who have concurrent disorders (people who experience both addiction and other mental health problems or diagnosed illness). Facilitated by the HMP Addictions Coordinator and a social worker from the Canadian Mental Health Association's Justice Program, participants create a recovery plan by reflect on their individual recovery and then work on the life skills needed now and upon release

**5. Methadone Maintenance Program**

The Methadone Maintenance Program is a mandatory group for any inmate who is receiving methadone as a treatment for addiction at HMP. This weekly group is open, offering continuous intake to inmates. Facilitated by the HMP Addictions Coordinator, the group provides inmates

the opportunity to customize the weekly topics with common examples including experiences of methadone maintenance treatment, cycle of addiction, relationships in recovery, cravings and triggers, stages of change and motivation in recovery. The group is both psycho-educational and therapeutic in nature

#### **6. Peer Support Group**

The Peer Support Group at HMP meets once a week to discuss issues related to recovery from substance abuse and/or other mental health issues. Inmates facilitate the group with no staff person/professional in attendance. The emphasis is placed on peer support through common lived experiences with the participants selected by the inmates in consultation with the HMP Addictions Coordinator.

#### **7. Guided Meditation Classes**

Guided meditation classes take place once a week for 30 minutes. In the class, the HMP Addictions Coordinator guides the participants through a meditation that focuses on breathing and self-awareness (awareness of thoughts, feelings, and body sensations) with the use of aromatherapy and music. The meditation is used as a tool in recovery to cope with difficult feelings and encourage relaxation.

#### **8. Individual Addictions Counselling**

Prior to starting any of the above-noted programs, the HMP Addictions Coordinator meets with inmates individually to complete an assessment and make appropriate referrals. The Addictions Coordinator also provides the individual with addictions counselling for those who are unable to access group programs and/or to inmates who may need extra support while attending groups and serving their sentence.

#### **9. Additional Supports provided by Community Services Providers in partnership with HMP:**

- Weekly AA meetings on Monday nights;
- Weekly ACOA (Adult Children of Alcoholics) meetings on Wednesday afternoons;
- Monthly Harm Reduction Workshops offered by the AIDS Committee of NL (SWAP Program for safer needle use);
- Weekly Yoga Classes for inmates who are in recovery from addiction and/or other mental health problems;
- Faith-based recovery programs including Celebrate Recovery and Life's Healing Choices programs offered through Pastoral Care;
- Impaired Driving workshops for inmates convicted of this offence, facilitated by Classification Officers; and

- Periodic workshops and projects offered through various partnerships with the community. Examples in the past have included “Healthy Eating in Recovery” workshop with a dietician from Eastern Health and Horticultural Therapy/Mindfulness with MUN Botanical Gardens.

**Updated on December 22, 2016**

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<sup>ii</sup> World Health Organization – Management of substance abuse. 2017 Available from [http://www.who.int/substance\\_abuse/en/](http://www.who.int/substance_abuse/en/).

<sup>iii</sup> Health Canada. Best Practices – Methadone Maintenance Treatment. 2002. Available from <http://www.hc-sc.gc.ca/hc-ps/pubs/adp-apd/methadone-bp-mp/index-eng.php>.

<sup>iv</sup> Martin, Garth; Brands, Bruna; Marsh, David C. Methadone Maintenance: A Counsellor’s Guide to Treatment. Chapter 9. 2003. Available from <https://www.porticonetwork.ca/documents/489955/0/Action+and+maintenance+phase+-+9+Methadone+Maintenance+-+Counsellor%27s+Guide/b736f7c8-0807-4558-b30a-03c5b8ebbf72>.

<sup>v</sup> United Nations Office on Drugs and Crime (UNODC). Methadone Maintenance Treatment Intervention Toolkit. 2012. Available from [https://www.unodc.org/documents/southasia/Trainingmanuals/Methadone\\_Low\\_res\\_09-06-12.pdf](https://www.unodc.org/documents/southasia/Trainingmanuals/Methadone_Low_res_09-06-12.pdf).

<sup>vi</sup> European Monitoring Centre for Drugs and Drug Addiction. Drug Treatment Overview for Netherlands. 2015 Available from <http://www.emcdda.europa.eu/data/treatment-overviews/Netherlands>.

<sup>vii</sup> The Globe and Mail. Canada lags behind in adopting safer drug for opioid addiction treatment. August 2016. Available from <http://www.theglobeandmail.com/news/national/canada-lags-behind-in-adopting-safer-drug-for-opioid-addiction-treatment/article31526916/>.

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<sup>ix</sup> The Globe and Mail. Canada lags behind in adopting safer drug for opioid addiction treatment. August 2016. Available from <http://www.theglobeandmail.com/news/national/canada-lags-behind-in-adopting-safer-drug-for-opioid-addiction-treatment/article31526916/>.

<sup>x</sup> CTV. Health. Ontario expands use of Suboxone as part of new provincial opioid strategy. October 2016. Available from <http://www.ctvnews.ca/health/ontario-expands-use-of-suboxone-as-part-of-new-provincial-opioid-strategy-1.3112291>.

<sup>xi</sup> Information on naloxone in Canada was garnered from the following sites: Canadian Centre on Substance Abuse. The Availability of Take-Home Naloxone in Canada. Available from <http://www.ccsa.ca/Resource%20Library/CCSA-CCENDU-Take-Home-Naloxone-Canada-2016-en.pdf>; and Toward the Heart (BC). Available from <http://towardtheheart.com/naloxone/>.

<sup>xii</sup> Government of NL. Press Releases. Naloxone Kits to be Available this Fall in Newfoundland and Labrador. August 31, 2016. Available from <http://www.releases.gov.nl.ca/releases/2016/health/0831n01.aspx>.

<sup>xiii</sup> Mental health and addictions. Our Services. Available from <http://www.easternhealth.ca/WebInWeb.aspx?d=1&id=2106&p=74>; and Thrive - Community Youth Network. Addictions Services - Eastern Health. Available from <http://www.thrivecyn.ca/directory-of-services/health/addictions-services-eastern-health/>.

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<sup>xiv</sup> Welcome to Front Step: New Program Will Help to End Homelessness in St. John's. Available from <http://www.nlhhn.org/PDF/Release-Front-Step.pdf>.

<sup>xv</sup> Buprenorphine is an opioid partial agonist. This means that, although Buprenorphine is an opioid, and thus can produce typical opioid effects and side effects such as euphoria and respiratory depression, its maximal effects are less than those of full agonists like heroin and methadone. Further information is available from [https://www.google.com/search?sourceid=ie7&q=dr+syeda+rizvi&rls=com.microsoft:en-CA:IE-Address&ie=UTF-8&oe=UTF-8&rlz=117LENP&gws\\_rd=ssl#q=mu+agonist](https://www.google.com/search?sourceid=ie7&q=dr+syeda+rizvi&rls=com.microsoft:en-CA:IE-Address&ie=UTF-8&oe=UTF-8&rlz=117LENP&gws_rd=ssl#q=mu+agonist).

<sup>xvi</sup> Mental Health Daily. Methadone vs. Suboxone. Comparison. 2013-2016. Available from <http://mentalhealthdaily.com/2015/06/10/methadone-vs-suboxone-comparison/>.

<sup>xvii</sup> ACNL. SWAP. Available from <https://acnl.net/swap>.

<sup>xviii</sup> Government of Newfoundland and Labrador. Press Releases. Naloxone Kits to be Available this Fall in Newfoundland and Labrador. August 31, 2016. Available from <http://www.releases.gov.nl.ca/releases/2016/health/0831n01.aspx>.

<sup>xix</sup> Information on the Atlantic Mentorship Network was garnered from <http://www.atlanticmentorship.com/>.

<sup>xx</sup> Government of Canada. Correctional Service Canada. Integrated Correctional Program Model. 2014. Available from <http://www.csc-scc.gc.ca/correctional-process/002001-2011-eng.shtml>.

<sup>xxi</sup> Government of Newfoundland and Labrador. Press release. Minister Announces Latest Initiative under Provincial Opioid Action Plan. December 6, 2016. Available from <http://www.releases.gov.nl.ca/releases/2016/health/1206n01.aspx>.

<sup>xxii</sup> Centre for Addiction and Mental Health (CAMH). Methadone Maintenance Treatment: A Community Planning Guide. 2009. Available from [https://www.porticonetwork.ca/documents/77404/475940/mmt\\_community\\_guide.pdf/7848440b-634b-499c-bff0-ec3548c2c23f?intcid=search-results](https://www.porticonetwork.ca/documents/77404/475940/mmt_community_guide.pdf/7848440b-634b-499c-bff0-ec3548c2c23f?intcid=search-results).

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<sup>xxiv</sup> Government of Ontario. Ministry of Health and Long-Term Care. Methadone Treatment and Services Advisory Committee - Final Report. 2016. Available from [http://health.gov.on.ca/en/public/programs/drugs/ons/docs/methadone\\_advisory\\_committee\\_report.pdf](http://health.gov.on.ca/en/public/programs/drugs/ons/docs/methadone_advisory_committee_report.pdf).

<sup>xxv</sup> The National Native Alcohol and Drug Abuse Program (NNADAP) helps set up and operate addiction programs to reduce and prevent alcohol, drug and solvent abuse in Aboriginal communities. The program's goal is to help fund First Nations and Inuit-run initiatives. Further information is available from <https://www.canada.ca/en/health-canada/campaigns/national-anti-drug-strategy/funding-programs/national-native-alcohol-drug-abuse-program.html>.

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<sup>xxvii</sup> Government of NL. Emergency Medical Aid Act. 1971. Available from <http://assembly.nl.ca/Legislation/sr/statutes/e09.htm>.

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<sup>xxxiii</sup> Ontario College of Family Physicians. Medical Mentoring for Addictions and Pain. 2016. Available from

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<sup>xxxvi</sup> The Way Forward: A Vision of Sustainability for Newfoundland and Labrador is available from

[http://www.gov.nl.ca/pdf/the\\_way\\_forward.pdf](http://www.gov.nl.ca/pdf/the_way_forward.pdf).

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<sup>xxxviii</sup> Kanate, D., Foldk, D., Cirone, S., Gordon, J., Kirlew, M., Vaele. . . . Community-wide measure of wellness in a remote First Nations community experiencing opioid dependence. February 2015. Available from

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<sup>xxxix</sup> Representative for Children and Youth. A Review of Youth Substance Use Services in B.C. May 26, 2016.

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