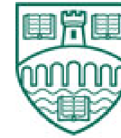

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DEPARTMENT OF
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Methadone maintenance treatment (MMT) in British Columbia, Canada: Lessons for health care system change and research practice

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The value of Methadone treatment

- There are currently over half a million people in receipt of Methadone Maintenance Treatment (MMT) around the world, and it is estimated that this figure will double in the next decade. The reasons for this are two-fold:
  - The value of methadone treatment in reducing the incidence and spread of HIV infection amongst injecting drug users (IDU's).
  - The value of methadone as a treatment that stabilises the changes in brain function that propels dependent opiate use.

  This does not mean that non prescribing treatments like CBT and psychotherapy are not valuable as well.

Methadone and IDU's

- Methadone treatment has been accepted by most UN agencies – WHO, UNAIDS, UNODC, UNICEF, World Bank.
- Also by Red Cross/Red Crescent.
- Accepted by many countries in Europe, Asia, North America and growing number of former Communist countries.
- Disliked by the INCB, and a few other countries – for example Russia – who are shrinking in number.

Methadone Maintenance Therapy/ Treatment

- Several Cochrane reviews have concluded that **methadone treatment is effective in treating addiction to heroin and other opioids** (Faggiano, et al, 2003: Mattick et al, 2003)
- MMT has been implemented as a **means of addressing a range of health, social harms** associated with opiate addiction, including costs related to these harms (i.e. health and criminal justice)
- MMT is, however, just **one of a number of opioid substitution therapies now available globally (e.g. Buprenorphine)**
- **BC remains somewhat confused about buprenorphine (Suboxone)**

Factors associated with better outcomes

- Reducing barriers to entry.
- Optimal daily dose.
- Flexibility of take-home doses.
- High quality medical and psychosocial services..
- Help with social rehabilitation.
- Sufficient duration of treatment.
- Detoxification only of willing, well stabilised patients
- Validation of maintenance treatment.

Note: programme variables far more significant than patient variables.

Background to the 2010 BC study

- **BC has had nearly 50 years of involvement with MMT** initiating an expansion of MMT from the mid 1990's to address major public health problems – esp. Downtown Eastside (DTES)
- Rapid expansion of MMT in the past two decades in BC, from approximately **1200 clients in 1991 to over 12,000 in 2010**
- While MMT has validity as a treatment for opioid dependence, less is known about the challenges faced by policy makers and practitioners in **creating and maintaining high quality programmes**
- **Aims of review:** commissioned by Ministry of Healthy Living and Sport to address access, retention, effectiveness, quality and equality of MMT in BC and produce recommendations for systems change
- This presentation describes the strengths and weaknesses of MMT in BC **according to people providing and using these services**

Review Activities

- **Qualitative, multi-phase and multi-method review**
  - Stakeholder province-wide approach
  - 13 face to face feedback sessions with the aim of ensuring validity of findings and recommendations
  - Documentary analysis throughout - Canadian and international
- **Data collected Jan 2008 – March 2009**
  - 136 data events involving **309 people**
    Approx. 30% data from clients (inc. 9 focus groups BC wide)

Table 1: Stakeholder Groups

Client Populations	Service Providers	Service Settings
Aboriginal and First Nations peoples	Counsellors	Corrections settings
Men on MMT	Nurses	HIV treatment/Public Health
Women on MMT	Pharmacists (dispensing)	Non-profit agencies
Family members	Physicians (prescribing)	Northern, rural and remote
Self advocacy groups	Physicians (non-prescribing)	Outreach services
System managers	Physicians (pain specialists)	Private sector
Health authorities	Social workers	Residential treatment programs
Provincial and federal government ministries	**Other**	Downtown Eastside in Vancouver
Provincial Health Officer	Educators	Youth Services
Provincial Harm Reduction Committee	International experts	
Provincial Mental Health and Addictions Planning Council	Municipality representatives	
Regulatory and professional bodies	Researchers	

Background: Methadone Clients

- Many clients have **combined mental health, physical health, substance use problems,** HIV/Hep C, long term conditions including chronic pain
- Generally, but not exclusively, **a marginalized group,** lack of social/economic power & “voice”, stigma, chaotic lifestyles
- **Many social problems:** poverty, unemployment, homelessness/poor housing, dislocation from families/other community supports, involvement with criminal justice system
- Other **prescription/non-pres. drug use very common**
- Prevalence of **trauma histories**
- **Varying needs and levels of stability**

What is working, according to clients?

- **Methadone can and does "turn lives around"**
- **Lives saved***: "it's a life saver plain and simple", "I'd probably be dead if I didn't get on the program"*
- **Can help reduce drug use** *"I haven't touched heroin since"*
- **Can create more safety and reduce range of harms related to IDU:** *"got me off the needle",* less at risk of blood-borne viruses
- **Methadone decreased women's need to engage in sex work,** no longer were *"a slave to that corner"*
- **Reduces need for crime activity***: "Keeps me from having to run and rob somebody"*

Turning lives around

"For me it saved my life. I work every day. I live a normal life whereas I was getting to the point where I just wanted to die. Where I thought I couldn't do anything in my life ever again without being sick, or having to use a few times a day to make it through a day. It was destroying my life. Methadone has helped me to respect myself, know that it's okay to be on it. I can do stuff every day in society now. I am accepted in society."

Relationships with providers

- **Kindness, compassion and respect** were highlighted again and again as vital components of good MMT care, as was **open-minded and non-judgmental care:**

  "Me and him have a really good relationship and he's really happy with the accomplishments that I've been doing with myself. He is one of the nicest doctors I've had."

Problems, according to clients

- **Methadone as a "full time job"** – practices that interfere with the ability to live a "normal" life, straitjacket, ball and chain
- **Punitive, shame-based, controlling practices** that reinforce negative self-perceptions and stigma for clients
- **Low expectations** of people on MMT
- **Poor pain management**, people accused of drug seeking
- Lack of **psycho-social supports**
- Lack of **information** about methadone
- **Stigma and discrimination**
- **Physical effects of methadone**
- Lack of **alternatives** to methadone
- **User fees**
- **Profit making activities of professionals and "unethical practices"-** an unhealthy system with a lack of regulation and accountability
- **Having to travel long distances to access MMT** – not only rural/remote, due to lack of physicians mainly
- **Continuity problems between corrections and community**

“I’ve been told that I’m already an addict and that the recovery rate is low and that I’m not going to work hard enough”.

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

Challenged care relationships

- While empowerment and positive transformations are possible in the context of authentic, non-judgemental, compassionate support…the opposite also seems to be true…

  …in the context of care relationships that are devoid of these characteristics, and especially those based on punitive and shame based practices, ***increased isolation, stigma and discrimination, and increased substance use is a danger***

Role of nurses

- Nurses can be complicit in perpetuating stigmatising and punitive responses
- They can also effectively challenge and transform practices towards a more empowering, relational model of care
  - e.g. nurses have a strong role in normalising MMT and helping to integrate MMT care into care of other health problems through specialist services for HIV & Hep C
- There is great potential for non-medical prescribing to address many of the current system problems

Summary of findings

- Methadone has **positively impacted on and saved lives,** reduces many harms associated with drug use
- Problem areas in “the system” are **many and varied**
- Clients identified some similar problems, strengths and solutions as professionals but placed **an emphasis on the negative impact of MMT on ordinary life,** once life has become stabilised
- **Lack of accountability and standards** leads to many **poor outcomes for clients**
- **Best practice is out there** but not visible or celebrated
- **Multi-level, creative, multi-disciplinary solutions are needed** to create health systems change that can benefit clients

The Response of the BC Gov't

- Improving the health of vulnerable, opioid-dependent British Columbians by including MMT as a key strategy for reducing risky patterns of substance use in the model core public health program, *Prevention of Harms Associated with Substance Use*;

- Improving the care that vulnerable British Columbians receive through improved knowledge and practices of health care professionals involved in MMT

The Response of the BC Gov’t

- Improving the care that vulnerable British Columbians receive from their MMT physicians, with a revised edition of the College of Physicians and Surgeons of BC’s *Methadone Maintenance Handbook*

- Improving the care that vulnerable British Columbians receive from their methadone-dispensing pharmacists, with updated policies and guidelines on MMT from the College of Pharmacists of BC;

The Response of the BC Gov't

- Reducing the costs to British Columbians of one aspect of the MMT program, through a Frequency of Dispensing policy implemented by Pharmacare in 2009. Under the policy, Pharmacare limits the number of fees it pays to pharmacies that dispense medication, including methadone, to patients on a daily basis to three dispensing fees per patient per day
- Improving the care that vulnerable British Columbians receive from their MMT physicians and reducing one associated cost, through the introduction of point-of-care urine screening.

The Response of the BC Gov't

- Improving access to evidence-based treatments to vulnerable British Columbians living in isolated rural parts of the province, by authorizing billing for MMT care via tele-health
- The MHSD will participate in conversations with the MoHS and MHLS focused on ensuring that our mutual clients have access to appropriate supports for addictions treatment

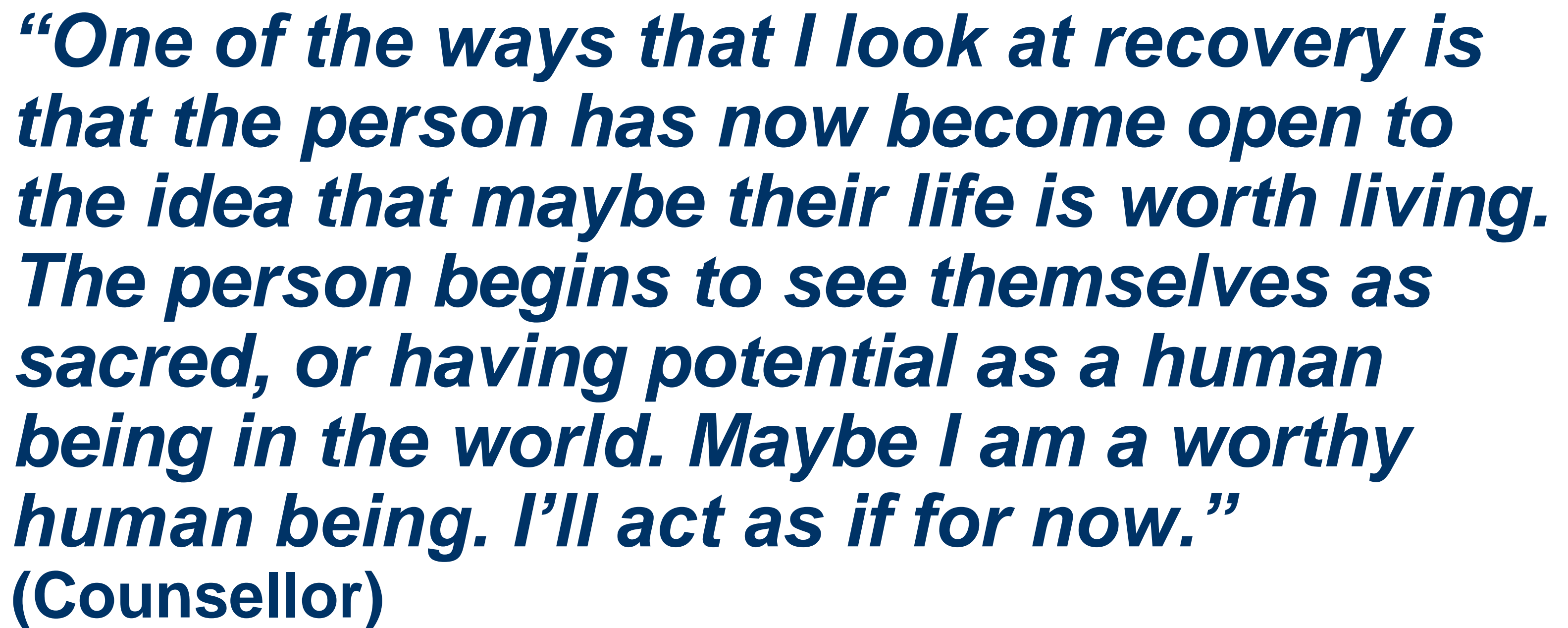
The Response of the BC Gov’t

- The MoHS will take the lead for consideration of a coordinated approach to MMT delivery in BC. Within the priorities established and resources available, the approach will explore means to address gaps related to responsibility and accountability across components of the system

- The MHLS thanks CARBC for its work on the MMT review and looks forward to working with other government ministries, health authorities, and other health system partners

Some lessons for health care systems change

- When we place client views at the centre of our analysis of service “systems” new explanations of service use can emerge
- Services and systems are not necessarily experienced in the ways they are intended
- People find a way to make services fit their needs or they leave – *“go back under the table”* – many risks if we don’t make our services friendly, accessible and relevant to each individual’s recovery process


"One of the ways that I look at recovery is that the person has now become open to the idea that maybe their life is worth living. The person begins to see themselves as sacred, or having potential as a human being in the world. Maybe I am a worthy human being. I'll act as if for now."
(Counsellor)

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