



Canadian Executive Council on Addictions
Conseil exécutif canadien sur les toxicomanies

Cross-Canada MMT Policy Scan

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Agenda

- Brief overview of the report
- Highlights and updates from findings
- Main messages
- Recommendations
- Progress on Recommendations



Questions

The goal of this project was to assess the content of existing federal, provincial and territorial system reviews of methadone maintenance treatment and opioid dependence treatment in order to answer the following questions:

1. What is the most effective – and cost-effective way – of meeting increased demand for opioid dependence therapy?
2. What is the model for service delivery that increases access to treatment quickly, retains people in treatment as appropriate, and offers the best hope of long-term efficacy?
3. Are there alternatives to MMT that should be actively pursued by jurisdictions with responsibility for addiction services?



Methods

- Document reviews
 - System reviews
 - Best practices and guidelines

- Informant interviews
 - Key informants
 - Other informants

- Scientific literature review



Highlights from provincial summaries

- All provinces offer MMT in government funded clinics and through individual and/or group physician-led practices.
- There is no MMT available in Northwest Territories or Nunavut.
- There is only minimal service in Whitehorse, Yukon.
- MMT is not provided through the National Native Alcohol and Drug Abuse Program (NNADAP).
- Opioid dependence treatment (methadone and buprenorphine) is offered at all federal penitentiaries.
- Québec provides more system supports (guidelines, data analysis) than other provinces.



Highlights from findings

- Access to services
 - Informants all reported a “dramatic” increase in demand for MMT.
 - Demand has been largely met with increase in private individual or group practices.
 - Some increases in funding/resources of provincially funded clinics.
 - Adjustments to the model of service.



Highlights from findings continued

- Buprenorphine
 - Very low utilization across the country
 - Not covered by most drug benefit plans
 - No guidelines (except Québec)
 - Described as a “lost opportunity”



Highlights from findings continued

- A methadone system?
 - Provincial methadone provision essentially through two distinct systems: addiction treatment and fee-for-service physician practices.
 - Little or no connection between them.
 - Usually funded through different departments within Ministry of Health.
 - Saskatchewan – interesting exception.
 - Jurisdictional issues in provision of service for First Nation communities.



Highlights from findings continued

- Impact on quality assurance
 - Level of quality assurance across the country varies significantly.
 - Availability of guidelines, patient registry, required training for prescribers also vary.
 - Some concerns raised that fee-for-service physician practices not following best practices for MMT.



Highlights from findings continued

- System supports
 - Lack of prescribers, counsellors
 - Lack of supports for prescribers/dispensers
 - Lack of specialist advice available for consultation



Highlights from findings continued

■ Funding

- Payment scheme described as confusing and lacking in clarity and transparency.
- Funding comes from multiple sources within ministry of health and from other ministries.
- Lack of consistent funding for psychosocial supports.
- Financial incentives that become perverse incentives.



Highlights from findings continued

- Models of MMT
 - Health Canada Best Practices in MMT (2002) foundation upon which most provincially funded and CSC MMT clinics are based.
 - Provinces beginning to adjust model to address changing client base in MMT.
 - Struggle with maintaining fidelity to the model and improving access to services.
 - Need for different models for different levels of intensity of service.



Updates 2010-2011

- Alberta - continues to experience service caps and significant wait lists.
- Saskatchewan - slight increase in number of prescribing physicians and number of patients on MMT.
- Manitoba - reduction of waitlist at m.i.n.e. program, increased number of prescribers, increasing numbers of clients on suboxone, training sessions for pharmacists.
- Ontario - new provincial *Narcotics Strategy* including prescription monitoring program, revised provincial MMT guidelines published.



Updates Continued

Nova Scotia – overdoses of prescription opioids a particular concern, struck a provincial working group, looking at adopting Ontario methadone prescribing guidelines, program in Sydney closed waitlist and is revising referral process.

Newfoundland and Labrador - waitlist in St. John's is still a concern although they now have an additional physician providing service at the clinic, otherwise physician recruitment still problematic, looking at Telehealth option in western area, provincial guidelines being revised.



Main Messages

1. A continuum of MMT service delivery (low threshold, intensive and primary care) is needed to serve an increasingly diverse population struggling with opioid dependence.
2. A coordinated MMT system is needed to ensure that clients are matched with the appropriate intensity of treatment.
3. A consistent, transparent funding system for all elements of MMT including prescribing, dispensing, drug costs, travel costs, and funding for psychosocial supports and case management is necessary.
4. The lack of availability of buprenorphine is a 'lost opportunity' to provide an alternative to methadone for patients.
5. The stigma of addiction is still very prevalent and affects every level of the addiction treatment system.



Main Messages

- A continuum of MMT
 - MMT system has changed significantly since 2002.
 - Current best practice model not able to meet demands for treatment.
 - Need different models to address changing needs of patients.



Main Messages

- System coordination
 - Different models won't address changing needs of clients unless there is some coordination within the system to ensure patients are provided the level of service they need.
 - Requires coordination between departments within the ministry of health and with colleges and between addiction treatment system and fee-for-service physician practices.



Main Messages

- Coordinated payment system
 - Clear and transparent payment systems are necessary.
 - Need to balance providing financial incentives for physicians and pharmacists and monitoring for quality assurance.
 - Costs to the patient should be minimized.



Main Messages

- Buprenorphine
 - Very little use of buprenorphine for treatment of opioid dependence – “lost opportunity”.
 - Not covered by provincial drug benefit formularies.
 - Restrictions on prescribing.
 - Used successfully in other countries to expand the reach of opioid dependence treatment.



Main Messages

- Stigma
 - MMT judged to be less effective than abstinence-based treatments.
 - Stigma of addiction and injection drug use.
 - Affects physicians, pharmacists, clients, policy makers.
 - Education and awareness should focus the clinical effectiveness of MMT.



Recommendations

1. CECA could play a role in advocating for policy changes that would facilitate the increased uptake of buprenorphine for the treatment of opioid dependence.
2. CECA could work with Health Canada and other national partners to update and expand the Best Practice document to include other models of MMT (e.g., low threshold and primary care) as well as best practices for buprenorphine.
3. CECA could convene a national MMT conference bringing together regulatory colleges, government ministries, regional health authorities, private providers, clients and addiction providers.



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Examples of innovative practices

- Use of nurse practitioners
- 2nd level prescribers
- Telemedicine
- Part-time prescribers
- Improve prevention and pain management
- Physician access to addiction medicine consults



Progress on Recommendations

- Distributed the report to networks throughout the provinces.
- Utilized the report to move issues forward within jurisdictions.
- Sent a copy to Health Canada requesting further discussion.
- Presented the report findings to FPT committee.
- Presentations at CSAM and IOS.



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Questions/discussion