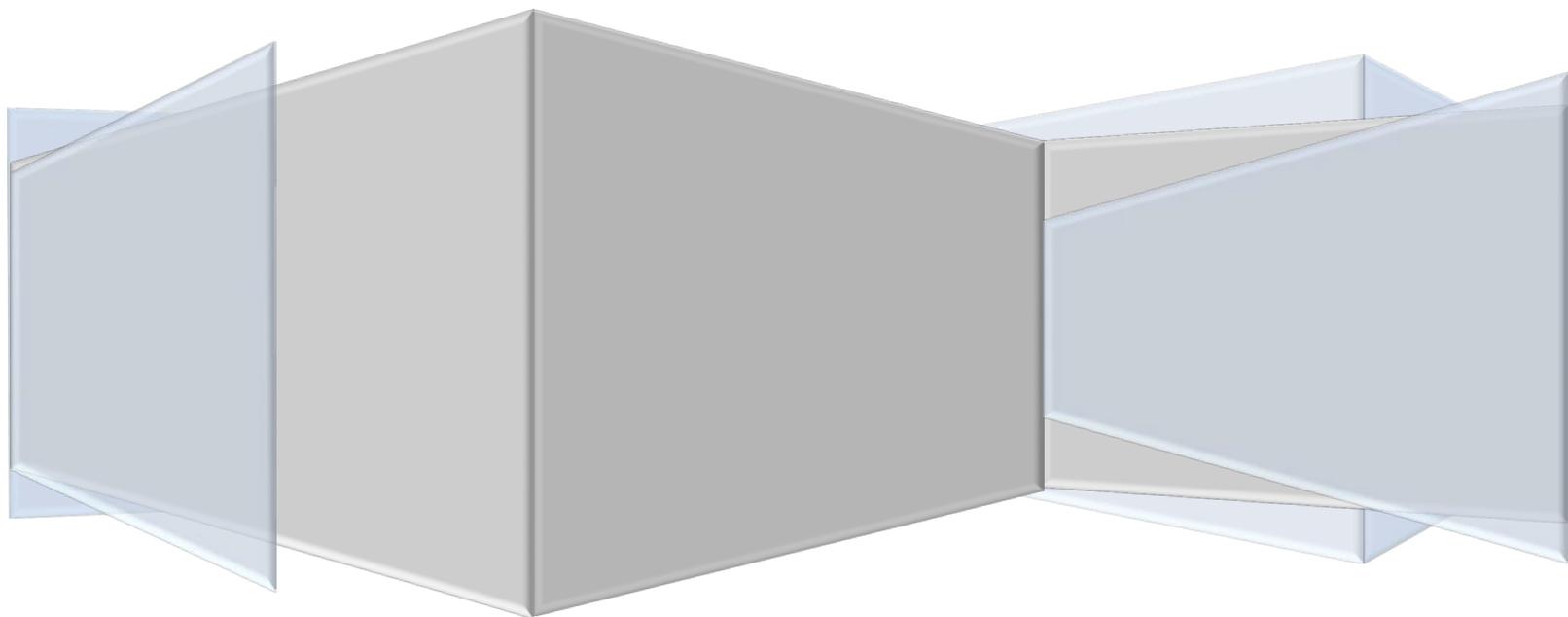


# **Methadone Treatment and Services Advisory Committee**

**Final Report**

June 9, 2016



# LETTER FROM THE CO-CHAIR

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On behalf of my colleagues on the Methadone Treatment and Services Advisory Committee, we are pleased to submit this report of final key recommendations to the Minister of Health and Long-Term Care.

We have done our best, under the challenging time constraints given, to bring the concerns of a variety of stakeholders to the table, understanding that the existing issues with the current system of opioid agonist therapy and services in Ontario are multi-faceted, incredibly complex, and impact each stakeholder differently. Recognizing this, the conversations hosted by the Advisory Committee and the topics of in-depth discussion focused on putting patients at the centre of care plans to ensure that they receive the appropriate treatments and supports they desperately require.

It is our hope that through the implementation of these recommendations, treatment and quality of life for those facing opioid use disorders will be greatly improved.

The recommendations included in this report are based on the best available evidence and the diverse expertise of the Advisory Committee members.

Thank you for the opportunity to provide advice on this important issue.

Sincerely,

Dr. Meldon Kahan  
Co-Chair, Methadone Treatment and Services Advisory Committee

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## Acknowledgements

Over the course of our time-limited Advisory Committee work, we heard many diverse views and perspectives on the necessary changes that are required to improve the way that opioid agonist therapy is currently delivered in Ontario. We observed a tremendous generosity of knowledge and a willingness to engage, understand diverse perspectives, and find common ground on contentious issues.

The process of generating the following recommendations was a highly collaborative and rich experience. We would especially like to thank the secretariat provided to us by the Ontario Ministry of Health and Long-Term Care (Ministry). This team of individuals worked long hours, evenings and weekends to coordinate, research, strategize, and keep us to deadline.

The Advisory Committee wishes to thank those who presented and provided valuable feedback (for a full list see pages 12 and 13). These unique perspectives were integral to informing the final recommendations found in this report. Specifically, the Advisory Committee would like to thank Ontario Regional Chief Isadore Day, Wiindawtegowinini, for speaking to the Advisory Committee about the importance of appropriately addressing the unique needs of Indigenous people and communities.

We would also like to thank Dr. Carol Strike for sharing the viewpoints of people with lived experience. Dr. Strike provided the invaluable results of her research on a comprehensive study on patient involvement with opioid agonist therapy programs in Ontario. Her work grounded the conversations, ensuring that quality care and access to essential treatments and services lie at the heart of the recommendations.

## Executive Summary

The system of prescribing opioids and treating Opioid Use Disorder (OUD) in Ontario needs to be transformed. Canada is the largest per capita consumer of prescription opioids in the world and now the additional threat of illicit opioids is causing further harm to our communities and our families. Of all the provinces and territories, Ontario has the highest rates of opioid prescription, and rates of addiction and overdose deaths continue to increase.<sup>1</sup>

Deaths from opioid overdoses have hit crisis proportions, but access to addiction treatment and long-term management with Opioid Agonist Therapy (OAT) remains limited, especially in remote and rural areas, and uneven in terms of quality.

While the College of Physicians and Surgeons of Ontario (CPSO) has standards and guidelines in place to guide the delivery of methadone maintenance treatment (MMT), a significant minority of methadone clinics insist on imposing burdensome requirements, such as weekly clinic visits, that are not required by the standards and guidelines. Twice weekly urine drug screenings can severely restrict a patient's ability to conduct daily living activities, such as their ability to work, travel, and participate in social activities. There are many physicians and other health care providers across the province dedicated to caring for

patients with OUD, but too many systemic barriers and inappropriate incentives remain in the way of quality patient-centred care.

Developmental and bio-psychosocial determinants of health play a significant role in OUDs and contribute to the variety of services required to support patient-centred care. There are treatment options that can save lives. However, in order to be effective, treatment needs to be accessible, available, and consider the individual needs of a person’s full health care requirements.

The recommendations of this Advisory Committee intend to transform how OUDs are managed, and how patients are treated. It rests on a model of inclusiveness, where patients are treated for all of their health care needs and receive accessible services, quality supervision, and holistic health care.

The members of the Advisory Committee recognize that improving the treatment pathway for OUD will not be sufficient on its own. Important upstream improvements need to be made to ensure that opioids are appropriately prescribed and monitored from when patients first seek treatment for acute and chronic pain, as well as expansion of harm reduction initiatives to reduce injury and death from opioid overdose. As a result, some of the recommendations provided by the Advisory Committee go beyond the scope of OUD treatment and services.

## List of Recommendations

PHARMACOLOGY	
Recommendation 1	Providers should present benefits, side effects and risks of opioid agonist therapy (buprenorphine/naloxone and methadone) to all patients with an opioid use disorder. Given its better safety profile and accessibility in Ontario, providers should recommend buprenorphine/naloxone as the first-line medication for most patients. The selection of medication should be a shared decision-making process, with the patient making the final choice about their treatment.
ACCESS	
Recommendation 2	The Ministry of Health and Long-Term Care should facilitate moving buprenorphine/naloxone combinations from Limited Use status to a General Benefit on the Ontario Drug Benefit Formulary.
Recommendation 3	The Ministry of Health and Long-Term Care support amendments to provincial regulations that would enable nurse practitioners, with appropriate training, to prescribe and administer buprenorphine/naloxone and methadone for opioid use disorder.
STANDARDS OF PRACTICE	
Recommendation 4	Health Quality Ontario, with the participation of regulatory colleges and professional organizations, as appropriate, should develop clear Quality Standards and guidelines for opioid use disorder, including opioid agonist

	therapy, by the end of 2017.
Recommendation 5	Health Quality Ontario, in collaboration with the Ministry of Health and Long-Term Care, College of Physicians and Surgeons of Ontario (CPSO), and other professional organizations and regulators, as appropriate, should develop standards on opioid prescribing. The CPSO and other professional organizations should provide appropriate oversight to ensure adherence to these guidelines. The CPSO should focus its regulatory oversight on all opioids, not just methadone.
<b>HEALTH CARE DELIVERY</b>	
Recommendation 6	<p>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.</p> <p>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.</p>
Recommendation 7	The Ministry of Health and Long-Term Care and Local Health Integration Networks should ensure that models, pathways, and funding support Health Service Providers to develop appropriate transition plans tailored to the specialized needs of the patient to support continuity of care.
Recommendation 8	The Ministry of Health and Long-Term Care and Local Health Integration Networks should prioritize opioid agonist therapy patients for attachment to primary care, particularly those models associated with interprofessional primary care teams. Family Health Teams and Community Health Centres should be contractually obligated to accept a specific number of patients who have a diagnosis of opioid dependence per year and provide opioid agonist therapy.
Recommendation 9	Opioid agonist therapy and addiction treatment, with the appropriate regulatory oversight, should be fully integrated into the usual breadth of primary care services. Until such integration can be achieved, opioid agonist therapy prescribers and focused clinics should be required to try to attach patients to primary care providers and engage in regular bilateral ongoing communications; opioid agonist therapy prescribers and focused clinics should integrate the full scope of mental health and addiction services into their practice.
Recommendation 10	The Ministry of Health and Long-Term Care should ensure all health care providers who regularly prescribe opioids should be provided with assessment and feedback reports on their opioid prescribing.
Recommendation 11	The Ministry of Health and Long-Term Care should work with service providers in both public and private institutions where opioid agonist therapy patients reside (e.g., residential treatment programs, long-term care homes,

	<p>hospitals, corrections facilities) to ensure that:</p> <ul style="list-style-type: none"> <li>a) patients on opioid agonist therapy are able to continue treatment in an uninterrupted fashion when admitted; and</li> <li>b) they provide rapid access to opioid agonist therapy, when clinically indicated or if requested by the patient at any point during their treatment.</li> </ul> <p>The Ministry of Health and Long-Term Care should provide assistance in implementing these policies as requested.</p>
<b>YOUTH</b>	
Recommendation 12	Youth should have access to services specific to their developmental needs. Buprenorphine/naloxone should be the first-line opioid agonist therapy and should be the only treatment for youth that live in, or travel frequently to, communities where methadone is not available, in particular First Nations communities. Opioid agonist therapy clinicians and clinic staff should have access to education and connection to other supports as needed in providing youth specific services.
Recommendation 13	The Ministry of Health and Long-Term Care should support a pilot for a youth-specific opioid agonist therapy/addiction treatment program that will measure treatment outcomes of opioid substitution therapy, including optimal support for tapering down and off of opioid agonist therapy.
<b>INDIGENOUS PEOPLE AND COMMUNITIES</b>	
Recommendation 14	The Ministry of Health and Long-Term Care, in collaboration with Health Canada, First Nations leadership and Indigenous partners, should allocate sustainable funding for Prescription Drug Abuse programs that are based in community, land, and culture. The programs should include treatment with buprenorphine/naloxone, as well as addictions recovery and relapse prevention counselling.
Recommendation 15	The Ministry of Health and Long-Term Care, the College of Physicians and Surgeons of Ontario, and other regulatory and professional regulatory bodies, should encourage all opioid agonist therapy providers to support transition from methadone to buprenorphine/naloxone when clinically or geographically indicated for First Nations patients and other patients.
Recommendation 16	<p>The Ministry of Health and Long-Term Care, in collaboration with Indigenous partners and Health Canada, should provide funding for training and programs that support recovery from Intergenerational/Historical Trauma and Post Traumatic Stress Disorder. Funding should provide support for:</p> <ul style="list-style-type: none"> <li>• wellness retreats for Chief and Council leadership;</li> <li>• training of Prescription Drug Abuse program workers in Trauma Informed Care; and</li> <li>• culturally appropriate aftercare programs that support individual, family and community healing from Post-Traumatic Stress Disorder and Historical Trauma Transmission.</li> </ul>

PREGNANT / POST-NATAL	
Recommendation 17	<p>The Ministry of Health and Long-Term Care should provide additional supports to pregnant and post-natal women with opioid use disorder through the removal of barriers to treatment access, support for breast feeding and nutritional supplements, child care, and improved training and education on substance use disorders for:</p> <ul style="list-style-type: none"> <li>• child protection workers;</li> <li>• child protection services lawyers; and</li> <li>• judges and jury members.</li> </ul>
Recommendation 18	<p>Buprenorphine should be prescribed to pregnant women who live in or travel to communities where methadone is not available, especially First Nations' women. Opioid agonist therapy should be consistently maintained during pregnancy, labour, and post-natal care.</p>
PHYSICIAN INCENTIVES / FUNDING	
Recommendation 19	<p>The 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.</p>
HARM REDUCTION / OVERDOSE PREVENTION	
Recommendation 20	<p>The Ministry of Health and Long-Term Care should quickly follow-through on its commitment to ensure naloxone is broadly and immediately available to all those who can benefit from it.</p>
Recommendation 21	<p>The Ministry of Health and Long-Term Care should revise coverage of opioids under the Ontario Drug Benefit Formulary to:</p> <ul style="list-style-type: none"> <li>• place limits on reimbursement of high total daily doses of opioids; and</li> <li>• delist unnecessarily high dose formulations of potent opioids.</li> </ul>
Recommendation 22	<p>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.</p>
SOCIAL DETERMINANTS OF HEALTH	
Recommendation 23	<p>The provincial government should allocate funding to promote and support a range of supportive housing, including the Housing First approach for people with opioid use disorder.</p>
EDUCATIONAL SUPPORTS	
Recommendation 24	<p>The Ministry of Health and Long-Term Care should work with appropriate regulatory colleges, professional associations and organizations, and educational institutions to develop curriculum updates and align educational</p>

	initiatives and standards on safe opioid prescribing by Ontario’s physicians and nurse practitioners, and safe opioid dispensing by nurses and pharmacists.
Recommendation 25	The Ministry of Health and Long-Term Care should mandate hospitals and interprofessional primary care clinics (including Family Health Teams, Community Health Centres, and Aboriginal Health Access Centres) to develop programs to support the initiation of opioid agonist therapy in patients presenting with opioid overdose or opioid use disorder, based on best practice treatment guidelines.
Recommendation 26	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.
Recommendation 27	The Ministry of Health and Long-Term Care should develop, in collaboration with other organizations (e.g., Health Quality Ontario, Centre for Addiction and Mental Health), a comprehensive education package, including patient rights and standardized patient information package, for patients who are currently receiving opioids for pain management and considering and/or beginning opioid agonist therapy. This education package should be developed in consultation with: physicians with training in the treatment of opioid use disorder and pain/pain management, specialists in medical ethics, pharmacists, and people with lived experience with opioid use disorder.
<b>TECHNOLOGY</b>	
Recommendation 28	The Ministry of Health and Long-Term Care should champion the use of electronic tools for the documentation of care plans and capturing and sharing of health information. This will avoid duplication, promote file sharing between care providers, and improve patient experience transitioning through the system.
Recommendation 29	The Ministry of Health and Long-Term Care should develop information systems that proactively identify providers with potentially dangerous opioid prescribing practices. The Ministry of Health and Long-Term Care and the College of Physicians and Surgeons of Ontario should work together to address dangerous prescribing practices. All clinicians should have access to the Narcotics Monitoring System.
<b>RESEARCH</b>	
Recommendation 30	The Ministry of Health and Long-Term Care should invest in research on the opioid crisis and opioid addiction treatment to address questions that impact clinical practice, community-based services and supports, and public policy.

# INTRODUCTION

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Canada is now the highest per capita consumer of opioids in the world,<sup>2</sup> and Ontario has the highest rate of prescription opioid use in the country.<sup>3</sup> Approximately one of every 170 deaths in Ontario is now related to opioid use.<sup>4</sup> Among young adults aged 25 to 34, one of every eight deaths is related to opioids, making it the leading cause of death among young adults in Ontario.<sup>5</sup>

Years of liberal prescribing practices have inappropriately exposed a broad range of people to potent opioids for all types of pain management. This has caused a dramatic increase in rates of prescription opioid addiction and has also created a large market for the diversion of licit opioids and the influx of illicit variations. Opioids are often illicitly used as a form of self-medication for physical pain and untreated mental health conditions. Social determinants of health – for example, the lasting effects of intergenerational trauma in many Indigenous communities – have made already marginalized individuals and communities vulnerable to the risks of opioid addiction and overdose.

The current opioid crisis is having devastating consequences on individuals, families, and entire communities across the province, as the prevalence of addiction, and the incidence of injuries and deaths associated with opioids, have increased dramatically in recent years.<sup>6 7</sup>

Opioid Agonist Therapy (OAT) refers to the long-term treatment of opioid addiction with methadone or buprenorphine/naloxone (also known as “Suboxone”, or from this point forward in the report, “buprenorphine”), two long-acting opioids which relieve opioid withdrawal symptoms and reduce drug cravings for up to 24 hours. Both medications have a slow onset of action, so they do not cause intoxication or euphoria when taken at the appropriate dose.

OAT typically has three components: frequent dispensing of these medications under the observation of a pharmacist (including supervised on site consumption), with the gradual introduction of short-term take-home doses; ongoing monitoring of substance use with urine drug screens and office visits; and the provision of counselling and medical care. Numerous controlled trials and long-term cohort studies have demonstrated that OAT is the most effective long-term strategy for reducing illicit opioid use, retaining patients in treatment, preventing overdose, and restoring function. However, some patients are successfully able to taper and discontinue the maintenance prescriptions with significant support from their treatment providers and community-based services.

Opioid Use Disorder (OUD) is a complex health issue that requires holistic, patient-centred care that is often not available or accessible when and where patients need it most. Currently, the most common treatment is methadone maintenance treatment (MMT) provided in stand-alone fee for service clinics, academic centres, Community Health Centres (CHCs), and community clinics. Some of these clinics, in addition to their appointments, require patients to attend the clinic weekly to provide a urine drug screen and receive a prescription from the physician, regardless of the state of recovery achieved by the patient. These time-consuming, obligatory visits limit patients’ autonomy and interfere with their ability to participate in work, travel, enjoy time with friends and family, and other activities of daily living.

The work of this Advisory Committee builds on the foundational work of the 2007 Methadone Maintenance Treatment Practices Task Force, and reflects issues that have emerged since then, such as a dramatic increase in opioid overdose fatalities. The Advisory Committee considered several aspects of OUD treatment: access to OAT; safety and appropriateness of the medications used in OAT impact of OAT on quality of life and treatment retention; provision of primary care and mental health care; and specific treatment needs of youth, pregnant women, and Indigenous populations.

The Advisory Committee also considered strategies to reduce rates of overdose and addiction, through provision of take-home naloxone and promotion of safe opioid prescribing practices.

## Current Methadone Practices

In Ontario, Ontario Health Insurance Plan (OHIP)-funded stand-alone clinics, often referred to as methadone clinics, provide the large majority of OAT.

Since methadone became more available as an addiction treatment option in 1996, methadone maintenance has been a very effective treatment modality, associated with marked reductions in illicit opioid use, improved mood and function, and decreased health care utilization and mortality. However, reform is needed to better meet the needs of all patients with OUD. A number of serious systematic issues are severely impairing treatment access and quality. These include:

- **Exemption from the Federal Government:** Physicians are required to obtain an exemption from the Federal Controlled Drugs and Substances Act, facilitated through the CPSO, to prescribe methadone. This stipulation effectively deters many primary care physicians from prescribing methadone in their family practices.
- **Lack of access to OAT clinics:** There is concern that there are insufficient numbers of clinics to meet patient needs. Over 40,000 patients are currently on methadone maintenance treatment, yet many communities have limited or no access to OAT, especially Northern, rural, and remote

The CPSO was asked by the Ministry to operate a methadone program in Ontario with the goal of increasing the availability of prescribers in Ontario as there was limited access at the time. The College established a Methadone Committee in by-law in 1999 to provide oversight and undertook to do the following:

- (i) Ensure there were programs in place to provide educational training for physicians before they prescribe methadone;
- (ii) Facilitate the development of MMT guidelines and standards with key Ontario addiction experts on the safe management of opioid dependence;
- (iii) Develop a rigorous program to assess methadone prescribing physicians to ensure they are practicing safely and effectively; and
- (iv) Decide whether to issue, refuse to issue, or withdraw a permit for a physician to administer, prescribe or otherwise furnish methadone for the management of opioid dependence.

The involvement of the CSPO has increased access for patients while supporting physicians (e.g., through help with acquiring an exemption to prescribe methadone from the federal government, guidelines to help with safe provision of MMT, an annual conference, practice feedback/education through the practice assessment).

communities. Access to treatment is extremely limited for Indigenous people and communities. In addition, stigma and discrimination further reduces access for some groups more than others, e.g., language barriers and ethnic minorities.

- **Lack of access to comprehensive care in stand-alone fee for service clinics:** Many of these clinics provide little more than urine drug screening and methadone prescribing and dispensing, leaving patients without access to primary care, mental health and addiction screening, brief intervention or counselling, and management of acute and chronic illnesses.
- **Variation in the quality of clinical services:** Some clinics require frequent attendance for urine drug screening and a brief office visit regardless of the state of recovery demonstrated by the patient. This is wasteful and can be harmful to patients' recovery as attendance can be inconvenient and at times very challenging, particularly for those in rural and geographically isolated areas.
- **Lack of access to other treatment options,** such as naltrexone and abstinence-based treatment.

## Advisory Committee

### Mandate

The Ministry of Health and Long-Term Care (Ministry) established the Methadone Treatment and Services Advisory Committee with a mandate to:

- review current jurisdictional best practices against more recent evidence and new expert reports; and
- provide evidence-based, tangible, targeted recommendations – for both the short and long-term – on implementation of OUD treatment that integrates primary care and connects patients to primary health care supports and community services.

Objectives to be addressed by these recommendations include:

- enhanced care pathways for patients that integrates methadone treatment into primary care;
- identification of appropriate alternative treatment options (buprenorphine);
- enhanced clinical support and training about opioid prescribing and addiction for health care providers and their patients (with emphasis on addictions and mental health support); and,
- improved treatment and supports in high-risk areas (Northern, rural, and remote communities, particularly for Indigenous people and communities).

The expert advice of the Advisory Committee members was sought to ensure the proposed province-wide plan considers the best evidence from both population health and systems-based perspectives.

## Composition

The Advisory Committee members hold a variety of positions related to addictions and opioid use, and bring a range of professional expertise on key issues pertaining to the opioid crisis. The Advisory Committee was chaired by Dr. Meldon Kahan, Medical Director, Substance Use Service at Women’s College Hospital, and includes the following members (see Appendix 1 for full biographies):

Dr. Philip Berger	Dr. Mike Franklyn	Dr. Ken Lee
Mr. Rob Boyd	Ms. Tara Gomes	Dr. Bernard Le Foll
Dr. Claudette Chase	Dr. Doris Grinspun	Ms. Sabrina Merali
Dr. Sharon Cirone	Mr. Wade Hillier	Dr. Peter Selby
Dr. Robert Cooper	Ms. Carol Hopkins	Dr. Sheryl Spithoff
Ms. Gail Czukar	Ms. Mae Katt	
Dr. Irfan Dhalla	Dr. Tara Kiran	

## Process

The Advisory Committee conducted its work from February to May 2016. Thorough discussions led to the expert recommendations in this report, outlining how to design and implement a strategy for the delivery of OAT that encompasses additional services required to provide quality, holistic, and patient-centred care.

Comprehensive academic research, published evidence from the field, clinical guidelines, and best practices from other jurisdictions supported the Advisory Committee members’ unique viewpoints, advice, and cumulative experience, driving the process and the development of their key recommendations.

This report outlines recommendations to improve the current system of service delivery for patients faced with OUD and to provide them with the best possible care and quality of life, creating an OAT system that truly puts patients first.

The majority of the advice and recommendations in this report were achieved by consensus.

## Background Presentations

The Advisory Committee received background presentations from the following:

- A panel of community services providers on their experience providing community-based OAT and wrap-around supports. The panel was comprised of: Penny Marrett, Executive Director, Addiction Services York Region; Dennis Long, Executive Director, Breakaway Services in Toronto;

Robin Griller, Executive Director, St. Michael's Homes, Toronto; and Nancy Black, Director, St. Joseph's Care Group, Thunder Bay.

- Ministry of Community Safety and Correctional Services on the challenges faced in corrections facilities.
- Ministry of Health and Long-Term Care on the status and forward plans for the Comprehensive Drug Profile Repository.
- Wade Hillier, from the CPSO, and Advisory Committee member, on CPSO guidelines for methadone treatment programs.
- Tara Gomes, Advisory Committee member and Principal Investigator at the Ontario Drug Policy Research Network on emerging research on opioid agonist therapy options.
- Dr. Carol Strike, a health services researcher with the Dalla Lana School of Public Health at the University of Toronto, on people's lived experience with receiving OAT.
- Ontario Regional Chief Isadore Day, Wiindawtegowinini, on the experience of Indigenous people with OUD.

## Patient Engagement Considerations

Transformational change, which puts the person at the centre of the care plan, requires input from patients themselves. The Advisory Committee took Dr. Carol Strike's excellent work on patient experience within the opioid agonist system in Ontario into consideration throughout the development of the report. However, the Advisory Committee recognizes that more patient engagement is required.

In Recommendation 4, the Advisory Committee is proposing that Health Quality Ontario (HQO) engage a diverse patient population as they develop a Quality Standard for the treatment of OUD. This will ensure that the patient's needs are fully considered when developing specific guidelines for service standards and treatment options, as well as implementation.

Given that HQO has significant expertise in safe and meaningful patient engagement processes, and will be developing the Quality Standard, the Advisory Committee feels as though patient engagement would have a greater overall impact on service delivery during this stage of the work.

## Statement of Principles and Values

A key component of the Advisory Committee's mandate was to consider the patient as being at the center of a transformed system. As a result, in developing the recommendations, the Advisory Committee relied on the guiding principles from the Ministry of Health and Long-Term Care's *Patients First: Action Plan for Health Care*:

- Focusing on the person, not solely on the addiction.
- Providing care that is coordinated and integrated, so a patient can get the right care from the right providers.
- Helping patients understand how the system works, and where to access care, so they can find the care they need when and where they need it.

- Making decisions that are informed by patients, and ensuring patient engagement in affecting system change.
- Considering the impacts of long-term treatment on daily living.
- Being more transparent in health care, so Ontarians can make informed choices.<sup>8</sup>

# RECOMMENDATIONS

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## Pharmacology

***Recommendation 1: Providers should present benefits, side effects, and risks of opioid agonist therapy (buprenorphine/naloxone and methadone) to all patients with an opioid use disorder (OUD). Given its better safety profile and accessibility in Ontario, providers should recommend buprenorphine/naloxone as the first-line medication for most patients. The selection of medication should be a shared decision-making process, with the patient making the final choice about their treatment.***

Like all health care treatments, people with OUD who wish to initiate OAT need to be made aware of all the treatment options available to them and of the benefits and risks, both in the short- and long-term, of each option. People initiating OAT require sufficient and objective support in order to make informed decisions about their care plans, as for many, their initial treatment choice will affect their long-term quality of life. Shared decision-making is a collaborative process that allows patients and their providers to make health care decisions together, with the patient making the final choice about their treatment. The process takes into account the best clinical evidence available, as well as the patient's values and preferences.

A variety of factors may influence the decision to begin treatment using one drug therapy over another. Particularly, it is important to recognize that many First Nations communities have self-determined a community-wide preference for buprenorphine over methadone due to reported issues with the diversion of methadone, methadone side effects and risks (sedation and overdose), the inability to have on-site methadone treatment because of lack of resources, and problems associated with off-site methadone programs (e.g., long travel distances, lack of counselling and support). For these reasons, buprenorphine treatment is often preferred by Band Leaders, counsellors, and physicians within First Nations communities, as the treatment regimen allows for culturally appropriate services and communal healing.

Buprenorphine is a "partial opioid agonist" with only limited activity on the part of the brain that controls breathing. Methadone is a full agonist with the ability to suppress the brain's respiratory center, which can cause the patient to stop breathing. As a result, methadone has a far greater risk of overdose death than buprenorphine. The overdose rate for those prescribed methadone is four times higher than for those prescribed buprenorphine.<sup>9</sup> The overdose risk for those using diverted methadone is six times higher than for those using diverted buprenorphine.<sup>10</sup>

A single day's dose of methadone can be lethal to non-tolerant individuals, leaving patients at a high risk of overdose within the first two weeks of treatment. Moreover, the *Vancouver Coastal Health Guideline for the Clinical Management of Opioid Addiction (Vancouver Coastal Health Guideline)* reported that

methadone was involved in approximately 25% of all prescription opioid-related deaths in British Columbia.<sup>11</sup>

Methadone has other risks. It prolongs the QT interval, which is a measure of the time between the start of the Q wave and the end of the T wave in the heart's electrical cycle, and it interacts with many medications.<sup>12</sup> Buprenorphine has fewer interactions with other medications and does not appear to affect the QT interval. Both methadone and buprenorphine can cause sedation, tooth decay,<sup>13</sup> reduced libido, sweating, and weight gain; however, these effects are much less pronounced with buprenorphine.

Buprenorphine also appears to lead to better neonatal outcomes relative to methadone. Buprenorphine (without naloxone) is associated with less neonatal withdrawal, less severity and shorter lengths of stay in neonatal intensive care. Given the 400% increase in Neonatal Abstinence Syndrome (NAS) in Ontario since the prescription opioid epidemic, this is another important consideration.

Buprenorphine and methadone appear to have comparable clinical efficacy in terms of suppressing illicit opioid use. Controlled trials have shown that methadone has a somewhat higher treatment retention rate than buprenorphine.<sup>14</sup> However, patients who have not responded to buprenorphine can be easily switched to methadone,<sup>15</sup> whereas it is clinically more complicated to switch from methadone to buprenorphine.

Based on clinical evidence and best practice guidelines in other jurisdictions, notably the *Vancouver Coastal Health Guideline*, and the expert opinions of the Advisory Committee members, it is recommended that buprenorphine be classified as the appropriate first-line treatment for individuals presenting with OUD, in most cases.

Because of its safety profile, physicians do not require an exemption from Health Canada in order to prescribe buprenorphine. This may encourage more primary care physicians to start prescribing buprenorphine, especially if they have access to appropriate education and mentoring. This could help expand the use of OAT beyond methadone clinics and into primary care settings, reaching many more patients. Studies consistently show that patients do well when they receive OAT in primary care settings, both from an addiction<sup>16 17 18 19 20 21</sup> and quality of care perspective.<sup>22 23</sup> Observational studies have shown that patients receiving buprenorphine treatment in primary care settings are more likely to receive screening and preventive services, diagnoses of medical and psychiatric illnesses, and chronic disease management than patients being treated in specialized settings. In a study of buprenorphine patients in Connecticut, patients who received buprenorphine in a primary care clinic were more likely to receive preventive services (screening for cancer, hypertension and cholesterol, HIV and Hepatitis C) than patients receiving buprenorphine from a specialist with training in OUD.<sup>24</sup> In a study of 168 patients started on buprenorphine in a primary care setting (most of whom previously did not have a primary care provider), a new chronic medical condition was diagnosed and treated in 47 patients (28%), and 68% had known chronic conditions which were not being treated (with treatment initiated for half of these conditions).<sup>25</sup>

In a qualitative study of long-term methadone patients in Ontario,<sup>26</sup> one prominent theme was that as patients aged, they developed multiple health issues, and their participation in the methadone program made it difficult for them to receive adequate primary care. This sometimes led to long delays in diagnosis and treatment of chronic illnesses.

Furthermore, evidence suggests that many opioid users prefer primary care settings to private methadone clinics. Bartoszko and Strike (2012) reported, “Frequent mandatory attendance at the MMT practices lead to frequent exposure to the drug scene; [and] many patients want an inconspicuous family doctor’s office to avoid triggers for relapse and to avoid the stigma of being labelled as someone on methadone.”<sup>27</sup> In a qualitative study of opioid addicted patients with HIV, participants strongly preferred receiving buprenorphine in a primary care setting, because it was more convenient and efficient, and the primary care setting provided better team support.<sup>28</sup>

Some addiction physicians have expressed concern about family physicians’ prescribing of buprenorphine, pointing to the experience in France. Buprenorphine misuse and diversion is common, which may reflect suboptimal prescribing practices, such as prescribing of take-home doses among French general practitioners. However, French general practitioners began prescribing buprenorphine in 1995, with little education or clinical support from addiction physicians.<sup>29</sup> In Australia, buprenorphine was introduced to physicians through clinical guidelines, training programs, patient materials, and integrated care pathways were developed between addiction medicine and primary care.<sup>30</sup>

Methadone treatment has short-term benefits in that it can be administered immediately without requiring the patient to experience symptoms of withdrawal, whereas buprenorphine will precipitate withdrawal if administered while a patient still has other opioids in his or her system. On the other hand, the buprenorphine dose can be increased much more rapidly than methadone doses, allowing for earlier cessation of opioid use.

## Access

To improve access to buprenorphine as a first-line treatment for most patients, the following actions are recommended.

***Recommendation 2: The Ministry of Health and Long-Term Care should facilitate moving buprenorphine/naloxone combinations from Limited Use status to a General Benefit on the Ontario Drug Benefit Formulary.***

Economic evaluations suggest that costs for patients treated with buprenorphine are similar to costs for patients treated with methadone. Ontario-specific cost-data is pending.

In Ontario, methadone is listed as a General Benefit on the Ontario Drug Benefit Formulary, whereas buprenorphine is currently classified as a Limited Use product. This may suggest to some prescribers that buprenorphine should be considered as a second-line medication.

The formulary states that buprenorphine should only be used if the patient is at high risk for methadone toxicity, has a contra-indication to methadone, has failed methadone, or if methadone is not available in the patient's community. To further support Recommendation 1, it is imperative that buprenorphine be listed as a General Benefit on the Ontario Drug Benefit Formulary. This will further encourage physicians to prescribe buprenorphine as the first-line treatment for OUDs.

As reviewed in the section above, buprenorphine and methadone have similar clinical efficacy,<sup>31</sup> buprenorphine is far safer than methadone<sup>32</sup> and has fewer side effects and drug interactions. Buprenorphine will be able to achieve a higher overall population level impact if the Ministry lists it as a General Benefit.

***Recommendation 3: The Ministry of Health and Long-Term Care support amendments to provincial regulations that would enable nurse practitioners, with appropriate training, to prescribe and administer buprenorphine/naloxone and methadone for opioid use disorder.***

Prescribing controlled substances to treat patients with OUD will allow nurse practitioners (NPs) to provide a comprehensive treatment approach in providing chronic disease management, including addiction. It will expand the authority of NPs to use their competencies, knowledge, and skills to benefit patients through increased access to medication, which will have a positive impact on the patient experience and the health system.

Currently, NPs may work in isolated rural and Northern communities with very high rates of addiction and limited access to primary care physicians and physicians with training in the treatment of OUD. Permitting NPs to prescribe buprenorphine and/or methadone will significantly enhance access and treatment capacity in Northern, rural and remote communities. To provide broader access to smaller rural and remote First Nations (and non-First Nations) communities, a compensation model needs to be considered. Because many NPs are full-time residents of these communities, there is an opportunity to provide these communities with greater access to treatment.

## Standards of Practice

The CPSO's *Methadone Maintenance Treatment Program Standards and Clinical Guidelines* (Feb 2011) focuses primarily on methadone dosing, urine drug screening, and take-home schedules. The document does not adequately address other aspects of comprehensive care.

The quality of care provided by OAT programs can have a major impact on patient outcomes. Continuous retention in treatment for 365 days or more is associated with significantly better outcomes, including reduced substance use.<sup>33</sup> Long-term continuous treatment (two years or more) is associated with excellent outcomes, including successful tapering and abstinence.<sup>34</sup> As one author said, "*Improving retention in methadone treatment is quite important, as it has been shown that longer retention in treatment is associated with better patient outcomes and that the first year of treatment is critical.*"<sup>35</sup> Observational studies have demonstrated that patients are at high risk of death when they drop out of

methadone treatment.<sup>36</sup> Once they re-enter treatment, it can take weeks to titrate to the optimal methadone dose, during which time the patient remains at risk for relapse, overdose and drop-out.

The overall treatment retention rate among patients treated with methadone in Ontario is estimated at 56%.<sup>37</sup> In an analysis of treatment retention and mortality for different regions in Ontario, the one-year continuous treatment rate varied between 39% and 49%.<sup>38</sup> These treatment retention rates compare unfavourably to those reported in the literature. The two-year treatment retention rates at the Centre for Addiction and Mental Health (CAMH) comprehensive methadone program ranged from 67% to 73%.<sup>39</sup> The low-threshold methadone program in Saint John, New Brunswick, which offers minimal counselling, has a one-year treatment retention rate of 95%.<sup>40</sup> In the North American Opiate Medication Initiative Trial (NAOMI), which compared heroin to methadone, methadone had a retention rate of 57.1%, even though the subjects were heroin users who had repeatedly failed previous methadone treatment.<sup>41</sup> In a systematic review of 58 program evaluations involving 27,000 patients in middle and low-income countries, the average retention rate for buprenorphine programs was 48%, while the average for methadone programs was 56%.<sup>42</sup> Individual methadone programs in Stockholm, Tel Aviv and Boston had 1-year retention rates of 84%, 74% and 62%, respectively.<sup>43 44</sup>

Patients who drop out of treatment often will often re-enter it weeks or months later. In a study of the Ontario Addiction Treatment Centers, the average number of days in treatment per patient was 678, with 119 days in between treatment episodes.<sup>45</sup> This suggests that cycling in and out of treatment is common. Cycling is associated with worse outcomes than continuous treatment.<sup>46</sup>

Treatment retention rates are affected by several factors. Patients who use oral prescription opioids have higher retention rates than injection heroin users.<sup>47</sup> Data suggests that most patients with OUD in Ontario are addicted to prescription opioids.<sup>48</sup> Low doses of methadone or buprenorphine can cause treatment drop-out.<sup>49</sup> However, this is probably not a significant factor in Ontario, as physicians are generally compliant with the recommendations of the CPSO's guidelines,<sup>50</sup> which contain a detailed dose titration protocol. The impact of counselling on treatment retention is uncertain.<sup>51 52 53</sup>

The Ontario Drug Policy Research Network (ODPRN) recently analyzed the clinical services provided by Ontario methadone physicians using data housed in the Institute for Clinical Evaluative Sciences (ICES).<sup>54</sup> They classified OAT physicians as high, medium, and low prescribers, according to the number of methadone and buprenorphine prescriptions they wrote in a year. Over 50% of the patients on OAT were receiving their medication from a high prescriber. The high methadone prescribers had an average of 435 methadone patients each and saw an average of 97 patients per day (of which 71 were methadone patients with public drug coverage). On average, each patient provided one urine drug test and attended one clinic visit every four to five days.

Surveys and qualitative studies suggest that treatment retention is affected by patient satisfaction with the program, and the patient's perception that the program supports and cares about them.<sup>55 56 57 58 59 60</sup>

In a qualitative study of long-term methadone patients in Ontario,<sup>61</sup> patients identified frequent office visits and long wait times as a major barrier to remaining in methadone treatment. Patients typically spend several hours travelling to their clinic, providing a urine sample and then waiting to see the physician.

Other reports have also expressed concern that frequent clinical services adversely affect treatment retention. A cross-Canada scan of methadone practices and policies observed the following:

The Methadone Maintenance Treatment

Practices Task Force 2007 reported that some

physicians preferred to do at least two urine tests per week, and sometimes more. This practice was justified by physicians for a number of reasons: it provided income for the service provider and it was also intended to provide motivation for the patient to not use other drugs. However, much of the urine screening did not follow best practice recommendations and patients found too frequent urine screens intrusive. The task force observed that the focus on the urine screening could stand in the way of an effective therapeutic relationship between patient and physician. Following the report's release, Ontario changed the policy for point of care tests, placing a cap on the number of tests that can be performed.

*"The patient sees his methadone physician once every 2 weeks and is quite stable. His visits often take in excess of 3 hours due to the long wait time at the clinic, but he only actually speaks to his doctor for 5 minutes or less. One subject said, "I've seen a lot of people go back on pills, because they have to keep their job...I've been clean for a long time and I couldn't go get a job that was from eight to four thirty. I wouldn't be able to see a doctor or get my methadone...And one doctor, [their] response to that is "Well, you need to find an employer that will work around your methadone." Well, that's not the first thing you want to say when you go for an interview." (Bartoszko and Strike 2012)*

There is evidence to support frequent urine drug screens (UDS) in the first few months of treatment. Short term studies and controlled trials have demonstrated the effectiveness of contingency management, i.e., giving take-home doses for UDS that are negative for illicit drugs.<sup>62 63 64</sup> One study found that in the first 30 days of methadone treatment, frequent UDS and frequent office visits were associated with a lower risk of dying from a methadone overdose,<sup>65</sup> although an Ontario study found no such association.<sup>66</sup>

Even after the first few months, periodic UDS should be performed in all patients to detect relapses and monitor compliance with OAT; however, the Advisory Committee could find no evidence that frequent ongoing urine drug screening improves clinical outcomes. In one controlled trial, 430 methadone patients were randomly assigned to receive either no UDS or regular weekly UDS. After one year, no differences were observed between the monitored and unmonitored group in prevalence of illicit drug use as measured by UDS.<sup>67</sup>

Furthermore, the main purpose of UDS is to enable early counselling interventions to reduce illicit drug use. Illicit drug use is often due to untreated mental illness, interpersonal conflicts, social isolation and

many other problems. OAT patients who continue to use illicit substances need short term counselling and referral for more intensive counselling, but clinics that see an average of 97 patients a day are unlikely to provide even brief counselling interventions.

The Advisory Committee recommends that the CPSO closely examine the evidence for frequent UDS and clinic visits, given the lack of evidence that these practices improve clinical outcomes, and their negative impact on patients' quality of life and treatment retention.

***Recommendation 4: Health Quality Ontario, with the participation of regulatory colleges and professional organizations, as appropriate, should develop clear Quality Standards and guidelines for opioid use disorder, including opioid agonist therapy, by the end of 2017.***

The CPSO's Methadone Maintenance Treatment Program Standards and Clinical Guidelines (Toronto 2011) is an evidence-based document developed with careful consideration; however, it focuses primarily on methadone dosing, UDS, and take-home schedules. The guideline does not address the role of buprenorphine in OAT, nor does it address quality of care (for example, identification and management of mental health and substance use disorders). Thus, some high volume prescribers are able to pass their CPSO methadone assessments despite providing suboptimal patient-centred care.

HQO involvement in standards and guidelines for treatment of OUD will address buprenorphine prescribing, frequency of office visits and UDS, and other essential components of OAT treatment. The collaboration and endorsement of the CPSO will ensure compliance with the new standards and guidelines.

Alternatively, the CPSO could delegate responsibility to an independent body to develop harmonized evidence-based standards and guidelines for OAT and thereby separate the regulator from the standards of practice. Standards and guidelines from an independent medical organization could allow for continued oversight by the CPSO as a regulator.

Quality Standards are concise statements designed to help clinicians easily and quickly know what type of care they should be providing, based on the latest and best evidence. They also are designed to help patients and families know what to expect in their care. To ensure the delivery of quality and comprehensive care, the standards and guidelines should contain:

- alternatives to OAT, including naltrexone, structured opioid therapy, and abstinence; and
- explicit standards for OAT prescribing, including:
  - indications for prescribing methadone versus buprenorphine;
  - criteria for transferring patients from methadone to buprenorphine, and vice versa;

The process to develop a Quality Standard is:

1. **Scoping** – Determine what will be included in the Quality Standard (e.g., populations, care settings, treatment pathways)
2. **Advisory Committee** – HQO develops Quality Standards by working in partnership with multidisciplinary committees of clinicians, researchers, administrators, patients, and caregivers with expertise and lived experience in each Quality Standard topic area.
3. **Comprehensive Review** - A comprehensive review of evidence and performance measures takes place on the topic area.
4. **Draft Standard** – A concise Quality Standard is crafted with five to 15 measurable actions to take. This draft standard is posted for public comment.
5. **Final Standard.**

- criteria for transferring patients on OAT from a specialized addiction clinic to primary care; and
- when and how to taper stable patients off OAT.

The guideline should also contain quality of care standards, such as:

- number of clinic visits and urine drug screens per patient per year;
- physician practice volumes;
- identification and management of mental health and substance use disorders;
- communication with primary care;
- documentation standards for follow-up visits; and
- measurement of treatment retention rates.

The guideline should also address OAT prescribing for special populations, including pregnant/prenatal women, children and youth, older adults in long-term care homes, and patients with co-morbid addiction and mental health disorders.

Use of a standardized treatment assessment tool might help determine the appropriate level of care necessary to achieve optimal recovery for individuals with an OUD.

***Recommendation 5: Health Quality Ontario, in collaboration with the Ministry of Health and Long-Term Care, College of Physicians and Surgeons of Ontario (CPSO), and other professional organizations and regulators, as appropriate, should develop standards on opioid prescribing. The CPSO and other professional organizations should provide appropriate oversight to ensure adherence to these guidelines. The CPSO should focus its regulatory oversight on all opioids, not just methadone.***

Currently, the CPSO conducts a thorough assessment of individual prescribers and methadone clinics every one to five years. Where needed, reassessments for non-compliance with the CPSO methadone guidelines are done. The assessment focuses on the initial assessment, methadone dose titration, and urine drug screening and take-home schedules.

At the same time, the CPSO has not issued comparably detailed guidelines on opioid prescribing, and opioid prescribers are not assessed, except through random peer assessments or a college investigation. When physicians come to the attention of the College (for example, through a complaint from a patient or pharmacist), the physician is often subjected to an investigation. This may result in a suspension of the physician's opioid prescribing privileges, and/or a requirement that they attend an opioid prescribing course (usually the course offered by the Continuing Professional Development department of the University of Toronto Faculty of Medicine).

The lack of specific direction from the CPSO may have adverse consequences and may enable many physicians to continue to prescribe high opioid doses and dangerous drug combinations. At the same time, physicians fear CPSO sanctions, and since they do not know which prescribing practices will lead to the sanctions, they sometimes simply stop prescribing opioids altogether. This is harmful for pain

patients, and it may cause some addicted patients to turn to the illicit drug market, putting them at high risk for overdose.

The CPSO's intense oversight of methadone prescribers may also have adverse consequences. The Advisory Committee has heard of several physicians who are interested in addiction medicine but do not want to prescribe methadone because they do not want to undergo the onerous assessment process. Also, the intense focus on UDS and take-home schedules favours high volume clinics that are able to implement universal, rigid protocols for take-home doses and UDS, while neglecting other vital clinical services (for example, identification and management of mental illness and non-opioid substance use).

The CPSO should consider taking the following actions to address these problems:

- broaden the scope of the CPSO Methadone Committee to cover all opioid prescribing;
- work with the HQO to establish, and endorse, guidelines containing explicit opioid prescribing standards;
- provide education and monitoring for high prescribers, as identified by the Narcotic Monitoring System;
- have a peer review program for opioid prescribers, similar to the methadone assessment and the general random peer assessment of primary care and specialists. Initially, the peer review process should focus on physicians with a large volume of patients on high opioid doses; and
- ensure that the methadone assessment process does not discourage physicians from prescribing methadone. Re-design the assessment so that it focuses on quality of care, not just on compliance with take-home and UDS schedules.

## Health Care Delivery

Individuals with OUD have high rates of medical and psychiatric illnesses. In a study of 140 methadone patients over 50 years of age, past-year prevalence of mental health disorders was 32.9% for major depressive episode, 27.8% for post-traumatic stress disorder, and 29.7% for generalized anxiety disorder. High rates were also reported for physical problems: 54.3% had arthritis, while 44.9% had hypertension.<sup>68</sup> These complex patients require comprehensive treatment to meet their needs – medical treatment, addiction counselling and mental health services, primary care, and additional community supports. In Patients First, the Ministry committed to providing more integrated and responsive services, specifically for those facing mental health and addictions issues.

An integrated care pathway for OUD patients would have the following features:

- Ontarians with OUD will receive comprehensive primary care, including a full range of mental health and addiction services, including OAT. If this is not currently possible, implement thorough, complete, and ongoing communication and coordination between primary care and the OAT service;

- patients admitted to their local withdrawal management service, emergency department, or hospital with a serious complication of opioid use – for example, withdrawal, overdose, suicidal ideation, or trauma – would have immediate and convenient access to addiction medicine services;
- specialized clinics/services providing OAT would identify and manage mental illness and all substance use disorders (not just OUD); and
- OAT providers would communicate and coordinate patients’ treatment plans with community addiction, mental health, and social service agencies.

***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.***

Observational studies have shown that long wait times for a patient’s first appointment to a treatment facility are associated with poor attendance rates.<sup>69</sup> Addicted patients need urgent access to treatment because they are at extremely high risk of relapse in the first few days and weeks of abstinence, due to withdrawal symptoms, cravings, social instability, anxiety and depression.

New treatment models that provide immediate treatment access have been shown to be successful. For example, in the recently completed Hospital-based Services for Opioid- and Alcohol-addicted Patients (H-SOAP) trial,<sup>70</sup> 104 alcohol or opioid-dependent patients staying at a withdrawal management centre in Toronto were randomized to receive either usual care or an assessment, within one to three days, at a rapid access addiction medicine clinic. In a preliminary analysis, 84% of the immediate treatment group attended their first appointment, compared to only 24% of those offered usual care with standard booking procedures and wait times.<sup>71</sup>

In a fully integrated treatment pathway, rapid access addiction services would be immediately available to patients sent from the nearby emergency departments, withdrawal management service or primary care offices. The patient would be seen without an appointment. Working with a counsellor, the rapid access physician/NP would initiate OAT if indicated, screen for other mental health and addictions issues, provide brief interventions and make appropriate referrals to community services. Patients would also have access to a broad range of services and supports in addition to health care. Stable patients would then be transferred to primary care.

Rapid access clinics have been operating for several years at two Toronto hospitals, St. Joseph’s Health Centre and St. Michael’s Hospital, and they have recently been established in seven other communities across Ontario through the Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration (META:PHI) network. META:PHI, funded by HQO and Council of Academic Hospitals of Ontario, is a collaborative project to create new care pathways for the treatment of opioid and alcohol

addiction. Each site has a Rapid Access Addiction Medicine Service, staffed by OAT physicians and therapists, where patients are seen within a few days after referral by the emergency department, primary care or community services. Stable patients are connected to primary care for long term management.

The resources required for rapid access services are minimal, as clinical space is provided at no cost by the hospitals or withdrawal management services, physicians are compensated for their clinical services through OHIP, and the counsellors are on secondment from their primary service (e.g., withdrawal management center or CHC). META:PHI clinics have received strong and enthusiastic support from emergency department clinicians, hospital administrators, and addiction workers.

***Recommendation 7: The Ministry of Health and Long-Term Care and Local Health Integration Networks should ensure that models, pathways, and funding support Health Service Providers to develop appropriate transition plans tailored to the specialized needs of the patient to support continuity of care.***

To connect patients with the required supports in a clearly defined tiered system of care, transition plans should be developed within a community network of care comprised of: primary care physicians, OAT clinic physicians, NPs, physician assistants, nurses, and pharmacists.

A person may experience acute or chronic problems with mild or severe symptoms. A person may seek care at a variety of places, but no matter where a person enters the system, be it in an emergency room, CHC or walk-in clinic, patients require assessment, appropriate intervention, and a clear customized treatment plan.

As people with OUD stabilize or destabilize, the Local Health Integration Networks (LHINS) need to develop transition protocols to support patients with varying levels of intensity. Patients in crisis or requiring urgent interventions should be stabilized, and then referred to primary care for ongoing maintenance and support.

Special consideration should be provided to the following unique populations:

- pregnant women on OAT to ensure that they receive appropriate prenatal care;
- patients with intensive, continuous treatment needs (e.g., antiretroviral therapy) requiring services that offer more than one type of treatment at a time;
- older adults in long-term care homes with multiple co-morbidities;
- patients requiring Hepatitis B and C treatment;
- patients with concurrent disorders and dual diagnosis; and
- patients in corrections facilities whose health outcomes and health quality would be improved by transitioning to primary care under the LHINS and Ministry, rather than the Ministry of Community Safety and Correctional Services.

***Recommendation 8: The Ministry of Health and Long-Term Care and Local Health Integration Networks should prioritize opioid agonist therapy patients for attachment to primary care, particularly those models associated with interprofessional primary care teams. Family Health Teams and Community Health Centres should be contractually obligated to accept a specific number of patients who have a diagnosis of opioid dependence per year and provide opioid agonist therapy.***

Too often, patients with complex care needs, including OUD, have challenges securing a primary care provider. The Advisory Committee is aware of instances where primary care providers and clinics have refused to prescribe buprenorphine, or have refused to accept patients on this medication into their practice. Attaching OUD patients to primary care is further complicated by stigma around addictions and patients with addictions.

The Advisory Committee understands that the Ministry is considering changes as part of its Patients First initiative to create sub-regions within each LHIN that would have responsibility for ensuring that patients with complex needs are attached to a primary care provider, and receive comprehensive care from that provider. Patients with addictions should be a key focus in this effort. The Ministry should work with Family Health Teams (FHT), Family Health Organizations (FHO), Nurse Practitioner Led Clinics (NPLC), and CHCs to specify the clinical services that these primary care organizations are expected to provide to patients with OUD.

***Recommendation 9: Opioid agonist therapy and addiction treatment, with the appropriate regulatory oversight, should be fully integrated into the usual breadth of primary care services. Until such integration can be achieved, opioid agonist therapy prescribers and focused clinics should be required to try to attach patients to primary care providers and engage in regular bilateral ongoing communications; opioid agonist therapy prescribers and focused clinics should integrate the full scope of mental health and addiction services into their practice.***

Like all patients, those receiving OAT deserve excellent primary care that goes beyond the provision of methadone or buprenorphine. The system, rather than the patient, should bear the weight of ensuring this care is provided. The previous recommendation speaks to the responsibilities of the Ministry and the LHINs, but some of this responsibility should also fall to individual providers.

OAT services should be delivered using a bio-psycho-social model and a holistic health approach. Strong connections between mental health and physical health services, and between primary care and community addictions and mental health care (e.g., counselling, case management, housing) are especially important for people with serious substance use and mental health issues.

Ideally, OAT would be fully integrated into primary care, particularly in inter-professional health teams, with a strong community sector providing wrap-around supports. However, in the shorter-term, OAT providers should try to connect patients to a primary care physician and ensure regular two-way communication. If connection with a primary care physician is not possible, the OAT provider should provide primary care and full addiction and mental health services.

The OAT provider should ensure access to comprehensive primary care and create an appropriate circle of care to achieve optimal functional outcomes for their patients in their communities.

***Recommendation 10: The Ministry of Health and Long-Term Care should ensure all health care providers who regularly prescribe opioids should be provided with assessment and feedback reports related to opioid prescribing.***

The opioid crisis is fuelled, in part, by dangerous and inappropriate prescribing practices, such as inappropriately prescribing very high opioid doses or high amounts of lower dose opioids, co-prescribing of opioids with sedating drugs, and abrupt cessation of high opioid doses. Monitoring, assessment and feedback have been shown to improve prescribing practices for other classes of medications, such as antibiotics. Feedback could be organized through the Narcotic Monitoring System, in collaboration with HQO. Physicians, surgeons, and dentists could receive feedback on the number of patients for whom they have prescribed opioids, and the mean dose and duration of opioid therapy. Comparative information on their peers' prescribing would be provided. This might prompt high prescribers to re-examine their practices and seek additional education and mentorship.

***Recommendation 11: The Ministry of Health and Long-Term Care should work with service providers in both public and private institutions where opioid agonist therapy patients reside (e.g., residential treatment programs, long-term care homes, hospitals, corrections facilities) to ensure that:***

***a) patients on opioid agonist therapy are able to continue treatment in an uninterrupted fashion when admitted; and,***

***b) they provide rapid access to opioid agonist therapy, when clinically indicated or if requested by the patient at any point during their treatment.***

***The Ministry of Health and Long-Term Care should provide assistance in implementing these policies as requested.***

Patients and their families often prefer abstinence-based treatments to OAT, and many patients are able to achieve long-term recovery without recourse to OAT. However, OAT is the standard of care for patients with an OUD.<sup>72</sup> Abstinence-based treatment has a substantially higher relapse rate than methadone or buprenorphine treatment, even with intensive psychosocial counselling.<sup>73 74</sup> OAT tapers also have high relapse rates.<sup>75</sup> Detoxification and abstinence treatment for illicit opioid use also appears to increase the risk of overdose death (compared to ongoing illicit opioid use).<sup>76</sup> This is presumably because patients have lost tolerance after several weeks of abstinence and are at high risk for overdose if they relapse to their usual dose. Patients who are on OAT and stop treatment abruptly also have high mortality rates.<sup>77</sup>

***Residential treatment programs, hospitals, shelters, and long term care facilities:***

These facilities should continue OAT, uninterrupted, in admitted patients. There should be a duty to continue to provide this care.

Patients on OAT who are admitted to a hospital, residential treatment program or other residential facility should be able to continue OAT during their stay. If a patient with OUD is not on OAT, the facility should arrange rapid access to OAT when requested by the patient, or if the patient is experiencing strong cravings or withdrawal symptoms and is at high risk of relapsing.

Hospitals should be able to continue or initiate OAT, with the support of local physicians with training in OUD. The Ministry should support non-medical facilities that request assistance in providing OAT on-site. This will require collaboration with clinics and physicians with training in OAT, and support from a nearby pharmacy.

All patients with OUD should be educated about the benefits of OAT. Regardless of whether or not they are on OAT, they should be given naloxone kits and receive education on overdose prevention on discharge from the treatment facility.

***OAT and the criminal justice system:***

According to a report on prescription drug abuse in Canada, *First Do No Harm*, rates of prescription OUD, and crimes committed by people with OUD, have increased substantially in the past 10-15 years.<sup>78</sup> There is strong evidence that crime rates decline markedly when people with OUD enter OAT treatment. A meta-analysis of 24 studies found methadone treatment was consistently associated with reduced property and drug-related crimes.<sup>79</sup> In an American study of a nationally representative sample of over 2,000 patients on methadone treatment, charges and convictions dropped from 85% at baseline to 18% six years after enrolling in methadone treatment.<sup>80</sup> Smaller studies of methadone clinics have also documented dramatic reductions in crime rates.<sup>81 82</sup>

Buprenorphine treatment has only been available on the North American market for the past 10 years. For this reason there is limited longitudinal research outlining the impact on crime. Preliminary reports suggest that its effect is similar to methadone.<sup>83</sup> Physicians working in Sioux Lookout report that buprenorphine treatment has resulted in substantial declines in theft, violence, suicide, and overdose.<sup>84</sup>

There are practical barriers to initiating OAT in a prison setting. For example, often the date of discharge is unknown as many remanded inmates are released at court without advance notice. The Ministry of Community Safety and Correctional Services (MCSCS) should work with the treatment community to address these barriers and ensure that prisoners with OUD have access to OAT treatment at any point during their involvement with the criminal justice system – before, during, and immediately after their incarceration. As is stated in Recommendation 20, to reduce increased risk of overdose upon discharge, take-home naloxone kits should be readily accessible.

## Youth

***Recommendation 12: Youth should have access to services specific to their developmental needs. Buprenorphine/naloxone should be the first-line opioid agonist therapy and should be the only treatment for youth that live in, or travel frequently to, communities where methadone is not available, in particular First Nations communities. Opioid agonist therapy clinicians and clinic staff should have access to education and connection to other supports as needed, in providing youth specific services.***

Any person, particularly those under 25 years of age, seeking care for OUD, should be offered a full range of treatment options, including abstinence-based treatment and/or OAT. Buprenorphine should be offered as first-line therapy for OAT for people less than 25 years of age. The advantages of buprenorphine versus methadone for OAT in young people should be clearly articulated to the patient before treatment is initiated. Buprenorphine should be considered the only treatment option for youth living in a First Nation community that does not offer on-site MMT. All those consenting to OAT should be counselled in the expected duration of OAT treatment, and should be offered the opportunity to taper down and discontinue OAT when clinically indicated and when safe to do so. In addition to OAT, youth seeking services for OUD should have access to preventative services such as immunizations, access to birth control and safe sex education, and drug and harm reduction counselling, as well as primary care, mental health screening and treatment, and case management support. All youth should be offered take-home naloxone and other harm reduction services.

***Recommendation 13: The Ministry of Health and Long-Term Care should support a pilot for a youth-specific opioid agonist therapy/addiction treatment program that will measure treatment outcomes of opioid substitution therapy, including optimal support for tapering down and off of opioid agonist therapy.***

A pilot program for a youth-specific OAT addiction program should measure outcomes in supporting tapering down and off of opioid substitution therapy. The CPSO, HQO, and other regulatory and professional associations should incorporate expectations of best practices for serving adolescents and youth with substance use disorders into existing treatment programs.

Many adolescents and youth in Ontario who seek treatment for OUD are funnelled into the adult services of the Opioid Substitution Program. For lack of youth-specific services, many young people will seek out services that they are directed to, largely by older or peer drug users. There are very few providers of addiction treatment services, and specifically medical treatment of OUD, who provide youth-specific services, or at the very least integrate services adapted to the needs of young people.

While the health care system has traditionally been organized to recognize the medical and mental health needs of paediatric patients under age 18 years, the reality is that young people up until age 25 years face challenges distinct from the adult population.

Increasingly, the medical literature recognizes the ongoing neurodevelopment of the young brain. Given the neurodevelopmental changes, the psychosocial stressors, and often co-occurring mental health and psychiatric issues for youth with substance use disorder, this population often requires adaptations and extra support for recovery and healing.

Accordingly, many community-based services for young people are now aligned along a broader age range, with the population often identified as “Adolescents and Transitional Aged Youth”.

## Indigenous People and Communities

Many Indigenous communities are suffering from extremely high rates of OUD, overdose, suicide and other addiction-related harms.<sup>85</sup> Every community in need should have access to culturally appropriate care. OAT must provide all patients with the holistic and culturally responsive care that is essential to their overall health and well-being. Furthermore, OAT must not interfere with patients’ daily activities or with their connections to their families and home communities.

Recommendation 1 states that buprenorphine should be the first-line treatment, and Recommendation 3 states that NPs should be allowed to prescribe buprenorphine. Both of these recommendations are particularly important for Indigenous communities. In addition, there are several other critical recommendations for improving the lives of Indigenous people with OUD.

***Recommendation 14: The Ministry of Health and Long-Term Care, in collaboration with Health Canada, First Nations leadership and Indigenous partners, should allocate sustainable funding for Prescription Drug Abuse programs that are based in community, land and culture. The programs should include treatment with buprenorphine/naloxone, as well as addictions recovery and relapse prevention counselling.***

Buprenorphine programs require stable, long-term funding for counselling, for daily medication dispensing, and for collection of urine drug tests. This is true for any agonist treatment program. Health Canada’s current level of funding for community prescription drug abuse programs is inconsistent, precarious and limited. This impedes access to treatment, impairs the quality of treatment and puts patients at ongoing risk of relapse, overdose, and suicide.

In the Sioux Lookout region, several communities have established recovery programs with community mental health workers who provide both conventional counselling and culturally appropriate, traditional healing practices. This comprehensive approach is enabling many patients to stop using opioids altogether and return to work, school and their family roles. Kanate and colleagues (2015) documented remarkable results for a buprenorphine program in North Caribou Lake First Nation.<sup>86</sup> A year after program initiation, criminal charges and medevac transfers decreased, the needle distribution program dispensed less than half its previous volume, and rates of school attendance increased.

***Recommendation 15: The Ministry of Health and Long-Term Care, the College of Physicians and Surgeons of Ontario, and other regulatory and professional bodies, should encourage all opioid agonist therapy providers to support transition from methadone to buprenorphine/naloxone when clinically or geographically indicated for First Nations patients and all other patients.***

Few First Nations communities are able to provide the infrastructure needed for MMT, including a pharmacy open seven days per week and on-site emergency medical care. Therefore many First Nations patients on MMT must travel long distances on a daily basis between their home communities and the MMT clinic and pharmacy. This is expensive for the community and patient, disruptive to the patient's work and family life, and dangerous during winter on poorly maintained rural roads. Sometimes patients are forced to leave their home communities and move near their OAT provider for extended periods.

Many First Nations communities prefer the use of buprenorphine for safety purposes and because it can be provided as part of a community-based psychosocial treatment program. However, some patients and community workers report that local MMT providers refuse to transfer patients from methadone to buprenorphine. MMT providers should facilitate the transfer of stable patients to buprenorphine when requested by the patient or community, and they should assist First Nation communities in establishing their own community-based buprenorphine programs.

Pregnant Indigenous women on methadone are often unable to return to their home communities with their newborn babies because the community does not have the infrastructure to dispense methadone. Increased access to buprenorphine treatment will allow pregnant women to return to their First Nations communities more easily and be better connected to family and community support networks.

***Recommendation 16: The Ministry of Health and Long-Term Care, in collaboration with Indigenous partners and Health Canada, should provide funding for training and programs that support recovery from Intergenerational/Historical Trauma and Post Traumatic Stress Disorder. Funding should provide support for:***

- ***wellness retreats for Chief and Council leadership;***
- ***training of Prescription Drug Abuse program workers in Trauma Informed Care; and***
- ***culturally appropriate aftercare programs that support individual, family, and community healing from Post-Traumatic Stress Disorder and Historical Trauma Transmission.***

Substance use disorders are often a symptom of underlying mental health issues, emotional pain, and human suffering. The Truth and Reconciliation Commission of Canada brought to light how seven generations of Indigenous people were separated from their language, culture, and spiritual traditions, effectively stripping them of their identity. In order to address the addiction, people must heal the lasting effects of unresolved intergenerational trauma.

## Pregnant / Post-Natal

***Recommendation 17: The Ministry of Health and Long-Term Care should provide additional supports to pregnant and post-natal women with opioid use disorder through the removal of barriers to treatment access, support for breast feeding and nutritional supplements, child care, and improved training and education on substance use disorders for:***

- *child protection workers;*
- *child protection services lawyers; and*
- *judges and jury members.*

Residential addiction treatment programs sometimes exclude pregnant patients from admission. There is no clear justification for these policies and they are harmful for the patient and the newborn baby. Child protection workers should receive training and education on addiction and on the treatment of OUD, so that they can help mothers maintain custody of their children and access vital community and family support.

***Recommendation 18: Buprenorphine should be prescribed to pregnant women who live in or travel to communities where methadone is not available, especially First Nations' women. Opioid agonist therapy should be consistently maintained during pregnancy, labour, and post-natal care.***

The Maternal Opioid Treatment: Human Experimental Research (MOTHER) study has found buprenorphine to be a safe and effective alternative to methadone for treating opioid dependence during pregnancy.<sup>87</sup> The trial found that babies born to women on buprenorphine had lower Neonatal Abstinence Scores and fewer days in hospital.

Women with OUD should be initiated or maintained on buprenorphine during pregnancy, particularly if they live in remote/rural communities where methadone is unavailable.

Buprenorphine is almost exclusively available as the combination product (buprenorphine/naloxone). Caution is recommended when using buprenorphine/naloxone in pregnancy, because there is little information on the safety of naloxone in pregnancy. Naloxone has minimal bioavailability when used as directed, and animal and human studies have found no evidence of fetal harm. Pure buprenorphine (without naloxone) is not marketed in Canada. The Advisory Committee recommends access to the mono-product through the Special Access Programme should be expedited and made available to all communities without barriers from the supplier and Health Canada. Therefore, given its apparent safety, buprenorphine/naloxone may be used until the mono-product is available.

## Physician Incentives / Funding

*Recommendation 19: The 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.*

### ***Incentives for OAT clinics to provide high quality care:***

Currently, the OHIP fee schedule incentivizes clinics to require patients to provide frequent urine samples and attend frequent office visits, as often as every one to two weeks. As outlined in the section Standards of Practice, this may be a factor in Ontario's low treatment retention rates, and it can be disruptive to patients' recovery. The Ontario Medical Association (OMA) and Ministry need to design financial incentives that promote high quality, comprehensive addiction care that enhances patients' well-being and recovery. If the fee for service model is maintained, there may need to be limits on the frequency of urine drug testing and office visits. Other models should also be considered (e.g., global funding for comprehensive, team-based OAT programs).

### ***Incentives for shared care between addiction medicine and primary care:***

Shared or collaborative care in psychiatry has been shown to be an effective and efficient model for delivering care to patients with mental illnesses. In shared care, the psychiatrist assesses the patient and communicates his or her recommendations to the primary care physician, in writing or (when necessary) by phone. The primary care physician is able to contact the psychiatrist with ongoing questions or concerns, and can request an urgent reassessment. Many patients have received high quality psychiatric care through shared care programs, and primary care physicians participating in these programs have become skilled in the management of common psychiatric problems.<sup>88</sup>

Demonstration projects suggest that addiction shared care would also be effective. Several shared care projects are underway in Ontario. For example, in Sioux Lookout the physician with training in OUD initiates buprenorphine treatment, while the primary care physician provides long term prescribing. Outcome evaluations of this model have been very positive.<sup>89</sup> The SUN:SHARE (Substance Use Network) project involves Women's College Hospital and several CHCs in Toronto.

Stipends are currently available to psychiatrists practicing in a shared care approach. They should also be made available to physicians with training in OUD who are practicing shared care in primary care clinics and rapid access clinics. A stipend is necessary because shared care physicians must spend time talking with primary care physicians about their patients via e-mail, phone and letters, and because it is common for patients to miss their initial visits.

***Incentives for primary care physicians to provide long term care of stable OAT patients:***

Recommendation 8 states that the Ministry should work with FHTs and CHCs in order to ensure that stable patients on buprenorphine can receive long-term care in a primary care setting. To implement this recommendation, the OHIP fee schedule may need to be adjusted to support buprenorphine treatment in primary care. Currently, the OHIP fee schedule reimburses methadone prescribing physicians at a rate that significantly surpasses other physicians managing patients with other chronic illnesses, such as diabetes or schizophrenia. This remuneration model offers few financial incentives for primary care physicians to prescribe buprenorphine and treat addicted patients, who require much more care and support than the average patient. Primary care physicians do not receive the monthly service fee for OAT, and physicians working in FHTs or FHOs are not reimbursed for routine office visits because they are “in basket” (longer psychotherapy visits are reimbursed).

The Ministry, OMA and LHIN should also remove disincentives for physicians practicing in patient enrollment models to provide care to OAT patients.

## **Harm Reduction / Overdose Prevention**

Over the past decade, Ontario has experienced a dramatic increase in opioid overdose fatalities. Overdose is now the third-leading cause of accidental death in the province.<sup>90</sup> This means more people die from overdose fatalities than from motor vehicle accidents.<sup>91</sup> Rates of patients presenting with overdoses in Ontario emergency departments have risen steadily in recent years,<sup>92</sup> contributing to a 25% increase in hospital stays for overdoses across the country.<sup>93</sup>

The rise in usage of illegally imported or manufactured drugs, specifically fentanyl, is contributing to high rates of overdose deaths in the province as they are typically 50-100 times more potent than other opioid variants (e.g., heroin, morphine). Due to this unknown, people may consume what appears to be a conservative amount that is within their given drug tolerance when it is actually a dangerously high, and often lethal, dosage.

Appropriate treatment is critical to the health, well-being, and survival of patients with OUD. However, treatment is not enough in and of itself; a broader public health approach is needed. Several strategies have been shown to reduce overdose deaths, including widespread access to take-home naloxone and education on overdose prevention, clear medical standards for physicians on safe opioid prescribing, access to online education and clinical support, and limits on reimbursement of high opioid doses by provincial drug plans and private insurers.<sup>94</sup>

***Recommendation 20: The Ministry of Health and Long-Term Care should quickly follow-through on its commitment to ensure naloxone is broadly and immediately available to all those who can benefit from it.***

The Advisory Committee strongly supports the Ministry initiative to make naloxone kits available through Ontario pharmacies at no cost and without prescription. The Advisory Committee encourages

the Ministry, the Ontario College of Pharmacists and other organizations to ensure rapid and widespread implementation of this program.

The Ministry created the Ontario Naloxone Program (ONP) in October of 2013. The ONP distributes naloxone, overdose prevention kits, and training supplies to eligible organizations throughout the province. These organizations provide naloxone kits and offer training on how to administer the drug to program clients at high risk of an opioid overdose. Eligible organizations currently include:

- Public Health Units (PHUs) that manage harm reduction programs such as the Needle Exchange Program (NEP);
- community-based organizations that have been contracted by their local PHU to manage a core NEP; and
- Ministry-funded Hepatitis C Teams.

Current naloxone kit distribution methods reach only a small sub-set of the larger portion of people facing serious OUD, who are in urgent need of necessary overdose prevention safeguards. The Advisory Committee is identifying several additional vulnerable populations that are at high risk of overdose. Estimates suggest that there are at least 15,000-20,000 individuals at high risk for opioid overdose in Ontario.<sup>95</sup> The Advisory Committee is calling for an immediate expansion of overdose prevention safeguards in Ontario, a recommendation that is also in direct alignment with expert advice stated in the Municipal Drug Strategy Coordinator's Network of Ontario's report, *Prescription for Life*. In addition to community pharmacies, naloxone kits should be distributed in the following settings:

- private OAT clinics;
- primary care settings;
- PHUs;
- CHCs and FHTs providing OAT treatment (e.g., kits made available to street involved/marginalized populations);
- community-based residential addiction treatment centres (including withdrawal management and abstinence-only residential treatment centres);
- in-patient medical wards and emergency departments;
- shelters; and
- correctional facilities (on discharge from incarceration).

***Recommendation 21: The Ministry of Health and Long-Term Care should revise coverage of opioids under the Ontario Drug Benefit Formulary to:***

- ***place limits on reimbursement of high total daily doses of opioids; and***
- ***delist unnecessarily high dose formulations of potent opioids.***

High prescription opioid doses are associated with an increased risk of overdose death. Among those patients who died of an opioid-related overdose, the majority had received an opioid prescription within a few weeks prior to their death.<sup>96</sup> The risk of overdose death rises substantially when a patient is prescribed a dose of 100 mg morphine equivalent per day or above.<sup>97 98 99</sup>

Provincial drug plans can limit total daily high opioid doses through three strategies. First, the plans can delist high-dose formulations, such as transdermal fentanyl 100 mcg patches or hydromorphone 30 mg capsules. Second, limit the total daily dose regardless of the opioid and limit duration of script. Third, physicians should be required to apply for approval to the Exceptional Access Program (EAP) or Limited Use Program when prescribing doses above a certain threshold, such as 120 mg morphine equivalent per day. Both the Limited Use and EAP programs would allow for higher doses when necessary, for example, when treating palliative care patients.

Both the Workplace Safety and Insurance Board (WSIB) and Non-Insured Health Benefits (NIHB) have reimbursement limits. Anecdotally, the limits have been well received by physicians, but the Advisory Committee has not seen published evaluations of the two programs.

***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.***

People who inject illicit drugs are at a higher risk of overdose than other opioid users and bystanders are often reluctant to call 911 for help for fear of prosecution. Supervised injection services provide a clean and safe environment for people to inject previously obtained drugs under the supervision of a regulated professional who can administer naloxone and cardiopulmonary resuscitation when necessary. In addition to preventing overdose, staff can link clients with primary care, social services and OAT programs. The Ministry should support access to supervised injection services, where available, as a useful service for people who inject opioids.

## Social Determinants of Health

The risk of addiction is strongly influenced by social factors such as low socio-economic status, unstable housing, food insecurity, and violence within one's home or community. People facing addictions often face multiple health inequities and therefore require a multitude of community supports to overcome these adverse social factors and achieve a full and stable recovery.

***Recommendation 23: The provincial government should allocate funding to promote and support a range of supportive housing, including the Housing First approach for people with opioid use disorder.***

People with OUD often must spend hundreds of dollars per day to purchase illicit opioids, forcing them to use rent money or sell personal belongings. This process can often result in evictions, homelessness and life on the street, especially if these individuals were already economically marginalized prior to their addiction.

Housing is considered a key determinant of health. Housing improves physical health, mental health, and wellbeing. People with addictions are vulnerable to housing instability. Permanent and stable housing with a combination of supports can contribute to a patient's recovery. With access to affordable

housing, people with mental health problems who experienced homelessness can maintain housing with recovery-oriented supports, achieve housing stability, and see improvements in their quality of life. The recent Mental Health and Addictions Leadership Advisory Council report *Better Mental Health Means Better Health* identified the need for approximately 30,000 new supportive housing units in Ontario for those with mental health and addictions issues.

## Educational Supports

A key theme that resonated throughout all of the Advisory Committee’s discussions was the need for more education for patients and providers. Medical students, residents and community physicians receive almost no training in safe opioid prescribing, or training in the prevention of opioid overdose or in the identification and management of OUD. The Advisory Committee would like to see mandatory comprehensive education on these topics for all physicians, NPs, and pharmacists. The Advisory Committee also endorses the development of clear medical standards on opioid prescribing by HQO, in collaboration with other regulatory and professional associations/organizations as needed. A revised version of the national opioid guidelines will be available next year, but HQO and CPSO standards will have a significant and immediate impact on physician prescribing practices.

***Recommendation 24: The Ministry of Health and Long-Term Care should work with appropriate regulatory colleges, professional associations and organizations, and educational institutions to develop curriculum updates and align educational initiatives and standards on safe opioid prescribing by Ontario’s physicians and nurse practitioners, and safe opioid dispensing by nurses and pharmacists.***

Educational initiatives and medical standards should cover the following topics, but not be limited to:

- safe and appropriate prescribing and dispensing of opioids for acute and chronic pain in primary care settings and in emergency department and inpatient settings;
- overdose prevention;
- identification and management of OUD;
- reduction of stigma;
- trauma-informed care;
- harm reduction approaches; and
- treatment needs of specific populations, including youth and pregnant women.

The Washington State approach to opioid prescription has a medical policy enforced by the State Medical Regulator (equivalent to a provincial College of Physicians and Surgeons). The medical policy requires physicians to obtain a consultation from a pain specialist, either informal or formal, before prescribing opioids in doses greater than 120 mg morphine equivalent per day. The policy is accompanied by an educational program and a long-distance clinical support system. This comprehensive approach has been accompanied by reductions in high-dose opioid prescribing and opioid overdose deaths.<sup>100</sup>

The Advisory Committee and the Ministry expect that the great majority of family physicians will be in support of new HQO standards, with contribution from CPSO on safe opioid prescribing. A survey of Washington primary care physicians found consistent support for the policy requiring consultation at high doses.<sup>101</sup> In a random survey of Ontario's physicians, a large majority strongly recommended standards on opioid prescribing from provincial colleges.<sup>102</sup>

***Recommendation 25: The Ministry of Health and Long-Term Care should mandate hospitals and interprofessional primary care clinics (including Family Health Teams, Community Health Centres and Aboriginal Health Access Centres) to develop programs to support the initiation of opioid agonist therapy in patients presenting with opioid overdose or opioid use disorder, based on best practice treatment guidelines.***

Emergency departments often see high volumes of people presenting with acute and chronic pain, including those with serious cases of OUD. A study conducted by Vancouver General Hospital found that patients who had been prescribed opioids were three times more likely to experience an adverse event within two weeks post-discharge.

Due to the unique pressures and circumstances faced by staff in the emergency department and hospitals, mandatory training and related supports should be made available for hospitals across the province. Training should be based on best practice treatment guidelines. The training and guidelines should address safe opioid prescribing for acute and chronic pain, and the identification and management of OUD in the emergency department and hospital setting. Buprenorphine treatment has been shown to reduce rates of emergency room visits in patients with OUD.<sup>103</sup>

Physicians and nurses in emergency departments and hospitals should be trained in the use of take-home naloxone for patients at high risk for overdose, and buprenorphine treatment for patients with suspected OUD. Controlled trials have demonstrated that patients discharged from the emergency department or hospital are much more likely to attend an addiction medicine clinic if they are given a bridging prescription for buprenorphine in the emergency department.<sup>104</sup>

***Recommendation 26: 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.***

There should be a variety of training and mentoring programs for providers in Ontario depending on need and level of expertise. A pyramid model for training and coaching may be beneficial; for example, most health care providers would attend foundational courses, followed by more intensive models such as coaching and mentoring networks for those who wish to receive additional training. The ultimate goal of support and mentorship activities is to support the safe prescribing of opioids; therefore, it will be important to evaluate and measure the outcome of these programs.

For example, foundational training can be obtained through courses such as the Opioid Dependence Treatment Course or its elements through the CAMH Opioid Resource Hub, and the University of Toronto continuing professional development course on management of chronic pain and of OUD. For some providers, more involved coaching and training will be needed.

The Ontario College of Family Physicians (OCFP) has a program entitled the Medical Mentoring in Addiction and Pain (MMAP) Network that provides rapid access mentoring for family physicians by physicians with experience and expertise in chronic pain management and addiction medicine (including Opioid Substitution Therapy). The MMAP program is a collaborative and collegial network that operates through the various geographical areas of the province to provide locally appropriate advice and support. MMAP also provides an online portal discussion site, supported by McMaster University, which provides real-time access to mentors throughout Ontario and in the Atlantic Pain and Addiction Network (APN), thereby offering a rich array of clinical support and mentorship.

The Ministry has also recently implemented a program called Project ECHO (Extension for Community Healthcare Outcomes) that is adapted from the University of New Mexico. It is designed to use the Ontario Telemedicine Network to link primary care providers in a supportive community of practice. The program seeks to enhance their skills and confidence in managing chronic pain safely and effectively. Project ECHO helps fill a gap in our current health system, as many physicians note difficulties obtaining pain or addiction consultations. There is also a Mental Health and Addiction ECHO that providers can attend for those with concurrent disorders. An ECHO model for OAT has shown to expand buprenorphine prescribing by primary care providers in New Mexico<sup>105</sup> and should be considered in Ontario.

Further funding for on-demand consultations (telephone, web-based, e-consultation) should be expanded to be accessible to all physicians, NPs, and pharmacists who require advice, including those who only wish advice for one or two patients and who may be hesitant to participate in a more intensive educational program.

A long-distance network will also help physicians manage OUD. Few family physicians are currently prescribing buprenorphine. Anecdotally, the Advisory Committee has heard that primary care physicians often refuse to take over buprenorphine prescribing, even if the patient is stable. This may be because they lack knowledge and experience in buprenorphine prescribing, or because they fear that the treatment is time-consuming or too complex. The Advisory Committee has also heard that primary care physicians sometimes abruptly stop prescribing opioids to patients with problematic opioid use. This can cause patients to seek illicit sources of opioids, putting them at increased risk for overdose death.

A long-distance clinical support and mentorship program would enable primary care physicians and NPs to contact a physician with training in OUD for same-day phone or e-mail advice. The Advisory Committee identified a number of physicians, NPs, and nurses in northern communities that are capable and willing to deliver training and clinical support through a long-distance mentorship network.

***Recommendation 27: The Ministry of Health and Long-Term Care should develop, in collaboration with other organizations (e.g., Health Quality Ontario, Centre for Addiction and Mental Health), a comprehensive education package, including patient rights and a standardized patient information package, for patients who are currently receiving opioids for pain management and considering and/or beginning opioid agonist therapy. This education package should be developed in consultation with: physicians with training in the treatment of opioid use disorder and pain/pain management, specialists in medical ethics, pharmacists, and people with lived experience with opioid use disorder.***

Over-prescribing or poor prescribing practices are not only caused by a lack of physician education – patients often do not understand the purpose, limits, and risks of a short-term or long-term opioid prescription to treat pain, or of a prescription to facilitate OAT. Patients must also be informed of the long-term side effects and risks to any opioid use, either for the purpose of pain management or to treat an addiction. It is the prescribing physician’s responsibility to thoroughly educate the patient on how to use their prescription safely, and ensure they fully understand the negative implications of long-term opioid use and diversion of unused prescriptions. A signed patient consent form may help to ensure the patient has received the appropriate information and understands the potential side effects and impacts on one’s life.

Patients being inducted on OAT should receive a thorough education on the available treatment options. As the patient has the ultimate choice for their treatment plan, physicians must ensure that their patients’ options have been explained fully to them along with what the consequences of their options may entail.

A standardized education package and patient consent form would ensure that patients receive the appropriate information that is necessary to provide informed consent.

## Technology

***Recommendation 28: The Ministry of Health and Long-Term Care should champion the use of electronic tools for the documentation of care plans and capturing and sharing of health information. This will avoid duplication, promote file sharing between care providers, and improve patient experience transitioning through the system.***

***Recommendation 29: The Ministry of Health and Long-Term Care should develop information systems that proactively identify providers with potentially dangerous opioid prescribing practices. The Ministry of Health and Long-Term Care and the College of Physicians and Surgeons of Ontario should work together to address dangerous prescribing practices. All clinicians should have access to the Narcotics Monitoring System.***

Electronic records eliminate the need to track down a patient's previous medical record and assist in ensuring that the data received by providers is accurate. Additionally, the health record can show prescribing of narcotics and highlight any risks, such as benzodiazepines or stimulants being concurrently prescribed by other providers. Electronic medical records can also reduce the risk of data duplication and allow for physicians to spot changes in a patient's health status more easily.

In addition to the development of electronic medical records, the Narcotics Monitoring System (NMS) must be improved to provide information to providers at the point of prescription. Currently the NMS alerts the CPSO when it identifies only extreme outliers, but there are challenges with the system and this does not regularly occur. The CPSO could require physicians to take a mandatory online course. The CPSO and NMS should set a cut-off which would trigger an intervention and an online course. This approach is a cost-effective way of reaching many physicians.

The NMS is a central database that enables review of monitored drug prescribing and dispensing activities within the community health care sector. The NMS has real-time Drug Utilization Review (DUR) capabilities. When a dispensing record is submitted by a pharmacy to the NMS, the system will conduct DUR checks. If potential issues, such as double-doctoring and poly-pharmacy visits are detected, the NMS will issue an alert to the pharmacy in real-time (i.e., at the time that the prescription is being dispensed). The NMS collects dispensing data from pharmacies in relation to all monitored drugs regardless of how the prescription is reimbursed (e.g., publicly funded drug programs, private insurance, and cash payments).

## Research

***Recommendation 30: The Ministry of Health and Long-Term Care should invest in research on the opioid crisis and opioid addiction treatment to address questions that impact clinical practice, community-based services and supports, and public policy.***

OUD and overdose is a major public health crisis in Ontario. Research is needed to inform clinicians, health care administrators and public policy makers about the optimal clinical approach to treating patients with OUD and the most effective public health interventions to control the opioid crisis.

Areas of focus should include, but not be limited to: effective regulatory and educational strategies to reduce opioid overdose and addiction rates; patient experiences with different models of OAT; factors affecting treatment retention rates; optimal duration of OAT; optimal support for tapering down and off of OAT; best practices for switching stable patients from methadone to buprenorphine; how to best initiate buprenorphine in the emergency department; optimal treatment in youth; and evaluation of mentorship and education/training programs.

# APPENDICES

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## Appendix 1 – Member Biographies

### **Dr. Meldon Kahan (co-chair)**

Dr. Meldon Kahan is an Associate Professor in the Department of Family Medicine at the University of Toronto, and Medical Director of the Substance Use Service at Women’s College Hospital. He is the Principal Investigator for the META:PHI project, which is establishing primary care-based addiction treatment pathways in seven sites across Ontario. He is a member of several provincial and national committees on addiction, including the Addiction Medicine Section of the College of Family Physicians of Canada, the Education Committee of the Canadian Society of Addiction Medicine, and the Executive Committee of the First Do No Harm Initiative of the Canadian Centre for Substance Abuse. Over the years he has written a number of peer-reviewed articles, guidelines, and educational publications on addiction-related topics. His main interests are primary care and addiction, methadone and buprenorphine treatment, and medical education in addiction.

### **Dr. Philip Berger**

Dr. Philip Berger is the Medical Director of the Inner City Health Program at St. Michael’s Hospital, Toronto, Canada and former Chief of its Department of Family and Community Medicine from 1997 to 2013. Dr. Berger is an Associate Professor at the University of Toronto’s Department of Family and Community Medicine, and was recently appointed the first Health Advocacy Lead for the Faculty of Medicine. A member of the Methadone Committee of the College of Physicians and Surgeons of Ontario and a past board member of the Ontario Addiction Research Foundation, Dr Berger has prescribed methadone for over 25 years and is a vocal critic of the CPSO Methadone Program. Dr Berger helped establish human rights-related health organizations arising from his work with torture victims, people with HIV and refugees and has been involved in campaigns to fight poverty and on behalf of people with addiction issues. He is a co-founder of Canadian Doctors for Refugee Care, a national organization of doctors who, since 2012, have been fighting federal government cuts to refugee health care.

### **Mr. Rob Boyd**

Rob Boyd has been working with youth and adults with mental health and substance use disorders in Ottawa for the past 25 years, including the last 11 years as the Oasis Program Director of the Sandy Hill Community Health Centre. Oasis is a leader in integrating mental health, addictions and primary care services for people who experience barriers accessing mainstream services. Oasis started offering methadone services in 2010 in response to emerging prescription drug use amongst people who use drugs in Ottawa and the shortage of methadone maintenance treatment services in Ottawa. The Oasis model is a blended funding model with fee-for-service physicians working in collaboration with primary care NPs and Opiate Case Management. Substance use counselling services are available on-site through

Addictions and Mental Health Services. Mr. Boyd is interested in and knowledgeable about drug policy issues and the impact drug policy has on increasing or decreasing harm to individuals and communities.

#### **Dr. Claudette Chase**

Dr. Claudette Chase has held many leadership roles, including serving on the Executive Committee of the Ontario College of Family Physicians (CFPC), where she later succeeded as President from 2002 to 2003. Dr. Chase also served as Director of the Family Medicine Program at McMaster University from 2005-2006. From 2011 to 2013, she participated on the Ontario Medical Association's Section on General and Family Practice Executive Committee. She was also a member of two province-wide government panels on narcotic abuse from 2012 to 2013. Currently, Dr Chase serves as a member of the Nishnawbe Aski Nation Prescription Drug Abuse Task Force, and was the Medical Director with the Sioux Lookout First Nation Health Authority. Currently, she is one of two family physicians serving Eabametoong (pronounced Yab-mAh-tung) First Nation, and continues work as a preceptor to family medicine and pediatric residents, medical students, and occasionally, NPs.

#### **Dr. Sharon Cirone**

Dr. Sharon Cirone is a Fellow of the College of Family Physicians of Canada (CFPC). She has a focused practice in Addiction Medicine in downtown Toronto, in both hospital and community-based practices. She also provides addiction medicine services and Opioid Substitution Therapy in North Caribou Lake First Nation in the Sioux Lookout region. Dr. Cirone works with adolescents and youth with alcohol and substance use disorders. Dr. Cirone is the Chair of the Addiction Medicine Program Committee at the CFPC, the Chair of the Education Committee at the Canadian Society of Addiction Medicine (CSAM) and on the Steering Committee of the Collaborative Networks in Mental Health and Addiction and Pain at the Ontario College of Family Physicians (OCFP). Dr. Cirone is also an Assessor for the Methadone Program Committee at the CPSO.

#### **Dr. Robert Cooper**

Dr. Rob Cooper graduated from Osgoode Hall Law School and the University of Toronto Medical School. He completed a family practice residency at the University of Toronto. He has an addiction practice in Toronto and Orillia. He is a Councillor for the Canadian Medical Protective Association and member of the Extent of Assistance Committee. He is Chair of the OMA section for Addiction Medicine and on the Board of the Ontario Long-Term Care Physicians. He has a Certificate from the Canadian Society of Addiction Medicine, a Distinguished Fellow of the American Society of Addiction Medicine, and a Diplomat of the American Board of Addiction Medicine.

#### **Ms. Gail Czukar**

Gail Czukar is the CEO of Addictions and Mental Health Ontario (AMHO). AMHO's 200 local member organizations provide a wide range of services across Ontario for people with addictions and mental illness. Ms. Czukar has held leadership roles at Humber River Family Health Team, CAMH, the Canadian Executive Council on Addictions (CECA), and in Legal Services in the Ontario Ministry of Health and Long-

Term Care. Gail has also developed community-based programs in mental health, addictions, and developmental disability, and has advocated for people with lived experience in her executive roles and as a legal clinic lawyer.

#### **Dr. Irfan Dhalla**

Dr. Irfan Dhalla is a general internist and HCO's Vice-President of Evidence Development & Standards. In this role, he and his colleagues promote evidence-based health care and policy in Ontario. Dr. Dhalla continues to practice at St. Michael's Hospital, where he cares for inpatients and teaches medical students and residents. He is an Assistant Professor in the Department of Medicine at the University of Toronto, with a cross-appointment to the Institute of Health Policy, Management and Evaluation. Dr. Dhalla's research, which has focused on improving health care through innovation and changes in policy, has been recognized with several major awards.

#### **Dr. Mike Franklyn**

Dr. Mike Franklyn is a family physician practicing in Sudbury for over 20 years. He provides addictions care for patients in Sudbury, as well as a number of communities throughout the North and is involved in a novel program to provide teaching and addiction care in remote fly-in First Nations communities in northwestern Ontario. Dr. Franklyn is the medical director of the new Harm Reduction Home (HRH), a managed alcohol program and shelter in Sudbury, and is site lead for the ARCTIC META-PHI/Rapid Access Addiction Medicine (RAAM) clinic. Dr. Franklyn is an Associate Professor of Family Medicine at the Northern Ontario School of Medicine (NOSM) and is a member of the Methadone Committee at the College of Physicians and Surgeons of Ontario (CPSO), and was a contributing author to the CAMH Buprenorphine Treatment Guidelines and sat on the Executive of Pregnancy Related Issues on the Management of Addictions (PRIMA).

#### **Ms. Tara Gomes**

Tara Gomes is an epidemiologist and Principal Investigator of the Ontario Drug Policy Research Network (ODPRN), a provincial network of researchers with expertise in pharmaceutical utilization, outcomes and policy that provides rapid research to inform drug policy in Canada. She is also a scientist in the Li Ka Shing Knowledge Institute of St. Michael's Hospital and the ICES, and is an Assistant Professor at the University of Toronto. Her research is focused on pharmacoepidemiology, drug safety and drug policy research leveraging large, administrative databases, and she has published over 100 peer-reviewed articles and over 50 policy reports in this area. She has worked closely with the Ontario Ministry of Health and Long-Term Care to develop evidence to inform policies related to opioid use and abuse in Ontario and has served as an expert for the US Food and Drug Administration and the US Department of Transportation in discussions related to opioid policies and regulations.

#### **Dr. Doris Grinspun**

Dr. Doris Grinspun is the Chief Executive Officer of the Registered Nurses' Association of Ontario (RNAO). She assumed this position in April 1996 after serving for six years as Director of Nursing at

Mount Sinai Hospital in Toronto. For over two decades, Dr. Grinspun has led many international programs in Latin and Central America, China, Australia and Europe. She has published and spoken extensively in Canada and abroad as a forceful advocate of the Canadian health system, and the contribution of registered nurses and NPs to its success. Dr. Grinspun's expertise in the areas of health, health-care and nursing policies and practices has earned her numerous awards including the Order of Ontario in 2003, honorary Doctor of Laws degree from the University of Ontario Institute of Technology in 2011, the Nursing Leadership Award from the Canadian College of Health Leaders and the Queen's Jubilee Medal in 2013.

**Mr. Wade Hillier**

Wade Hillier is Director of the Quality Management Division of the College of Physicians and Surgeons of Ontario. In this role, he oversees strategy and operations for three operational units: Practice Assessment & Enhancement; Applications & Credentials and Membership Services, Corporations & Physician Register. Since joining the College in 2001 Mr. Hillier has supported and led a variety of projects and initiatives with the ultimate goal of improving safety, consistency and access to patient-centred care clinical practice guidelines, quality assurance and out-of-hospital premises program development, increasing the annual number of physician assessments, enhancing the CPSO's oversight role in opioid prescribing, implementing new pathways for physician registration in Ontario and in the work conducted by the Quality Management Partnership of the College and Cancer Care Ontario.

**Ms. Carol Hopkins**

Carol Hopkins is the Executive Director of the Thunderbird Partnership Foundation (division of the National Native Addictions Partnership Foundation Inc.) since 2009. She holds a Masters of Social Work Degree from the University of Toronto and holds a degree in sacred indigenous knowledge equivalent to a PhD in western-based education systems. She also worked for the Nimkee NupiGawagan Healing Centre Inc., a youth solvent abuse treatment centre that is founded on Indigenous culture and life ways. Ms. Hopkins' work in best practices and policy initiatives have resulted in the development and implementation of the First Nations Mental Wellness Continuum Framework, the Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues in Canada and best practice guidelines for culturally based inhalant abuse treatment. Ms. Hopkins has also helped lead work funded by CIHR that has resulted in the Native Wellness Assessment and an Indigenous Wellness Framework. In 2015, Ms. Hopkins received the Champions of Mental Health Award for Research/Clinician. She has also taught social work courses for various post-secondary institutions and currently is a sessional faculty in the school of social work at Kings University College at the University of Western Ontario.

**Ms. Mae Katt**

Mae Katt is a Primary Health Care NP living in Thunder Bay. Her ancestry is Ojibway from the Temagami First Nation. She has a diverse 35-year nursing career in primary care, community and mental health, addictions, adolescent health, maternal, and child health. Her health policy and research experience is in youth suicide, early psychosis, diabetes, cancer care, health human resources, acquired brain injury and community development. Ms. Katt is coordinator of a Mobile Treatment Team that provides Suboxone

treatment in a First Nations high school, as well as remote and rural First Nations. She is a member of the Mental Health and Addictions Leadership Council, appointed by Minister of Health Eric Hoskins. She was a member of the RNAO's committee to produce the Best Practice Guideline: "Engaging Clients Who Use Substances". Ms. Katt has held senior management responsible for First Nations health programs, both as Regional Director (Ontario) for Health Canada's First Nations and Inuit Health, and Health Director for Nishnawbe Aski Nation, representing 49 remote and rural Ojibway and Cree First Nations.

#### **Dr. Tara Kiran**

Dr. Tara Kiran is a family physician and researcher at the St. Michael's Hospital Academic Family Health Team in Toronto. Dr. Kiran's research focuses on evaluating the impact of Ontario's primary care reforms on quality of care. She has published on the effect of physician payment on diabetes care and cancer screening. In 2015, she was recognized with a New Investigator Award from the North American Primary Care Research Group. Dr. Kiran is currently the Quality Improvement Program Director and Board Chair for the St. Michael's Hospital Academic Family Health Team and is also a Primary Care Advisor for the Toronto Central Local Health Integration Network.

#### **Dr. Ken Lee**

Dr. Ken Lee is currently involved in the ARTIC META:PHI project. This project has developed a care path for patients with Addictions (opiates and alcohol) to re-direct from the emergency room to a Rapid Access Addiction Medicine Clinic. As well, he provides medical consultation to Addiction Services of Thames Valley (ADSTV) and the London Drug Treatment Court (LDTC). He currently runs a Suboxone Clinic in conjunction with ADSTV Addiction Counselors. Dr. Lee's general medical practice is located within the Canadian Mental Health Association, providing medical and psychiatric care to persons diagnosed with serious mental illness

#### **Dr. Bernard Le Foll**

Dr. Bernard Le Foll, MD PhD MCFP is a clinician-scientist specialized in drug addiction. He is the Medical Head of the Addiction Medicine Service and Medical Withdrawal Service at CAMH. He is the Head of the Translational Addiction Research Laboratory within the Campbell Family Mental Health Research Institute of CAMH and Head of the Alcohol Research and Treatment Clinic within CAMH. He is a Professor at University of Toronto in the Departments of Family and Community Medicine, Psychiatry, Pharmacology and Institute of Medical Sciences and holds several graduate faculty appointments. He received specialized training in drug addiction and behavioural and cognitive therapy in France, has written addiction treatment guidelines and various reviews on neurobiology and treatment of drug addiction. Dr Le Foll is the CAMH Principal Investigator of the OPTIMA clinical trial evaluating treatment approaches for prescription opioid use disorder. Dr Le Foll has published 140 peer-reviews manuscripts, several book chapters and has been involved on the Editorial Boards of 19 scientific journals. Dr Le Foll has received numerous awards and his research is funded by CIHR, NIH and other funding agencies. He has been consultant/advisor for CAMH, CCSA, NIH and Health Canada.

#### **Ms. Sabrina Merali**

Sabrina Merali is the Program Manager for the Mental Health and Addiction Initiative at the RNAO's International Affairs and Best Practice Guidelines Centre. She is a Registered Nurse with a Bachelor's with Honors degree in Health Sciences, specializing in Rural Health from the University of Western Ontario. She also obtained her Bachelors of Science in Nursing and Masters of Nursing from the University of Toronto, specializing in Community Health. In her current role, Sabrina supports guideline development, knowledge translation and implementation activities for nurses and the inter-professional team. Most recently, Sabrina supported the development of the Engaging Clients Who Use Substances Best Practice Guideline including supporting the systematic review and related manuscript publication. She actively works to support uptake of best practices amongst nurses and other health care providers through creation of knowledge translation resources and tools, facilitation of workshops and learning institutes and leading implementation projects, particularly focusing on mental health and addiction.

#### **Dr. Peter Selby**

Dr. Peter Selby is the Director of Medical Education and a Clinician Scientist at the CAMH. He is a Professor in the Departments of Family and Community Medicine, Psychiatry, and the Dalla Lana School of Public Health at the University of Toronto. He is also a Clinician Scientist in the Department of Family and Community Medicine. Dr. Selby is the executive director and creator of the TEACH project – a continuing education certificate program in Applied Counselling for Health. He is also the Director of the Opioid Dependence Treatment certificate course and the Principal Investigator of the STOP study implementing addiction treatment in 300 primary care settings in Ontario. Dr. Selby has received grant funding totaling over \$65 million dollars from CIHR, NIH, and the MOHLTC, and has authored and published a number of reports, chapters and books informing health care policy. He is the Co-Chair for the Ministry of Health Cessation Task force and the Chair of the Canadian Centre for Substance Abuse National Task Force on Treatment for Prescription Drug Misuse. Dr. Selby mentors Fellows in Addiction Medicine and Addiction Psychiatry, junior investigators and medical students. An innovative communicator, Dr. Selby is a sought-after speaker for many subjects, including addictive disorders, motivational interviewing, and health behavior change.

#### **Dr. Sheryl Spithoff**

Dr. Sheryl Spithoff is a family physician and addiction medicine physician at Women's College Hospital and a lecturer at the University of Toronto. She is currently completing her masters and has an appointment at Women's College Hospital Research Institute. Her research interests include the primary care management of addictions, equitable access to care, and health policy.

## Appendix 2 – Glossary of Terms

APN	Atlantic Pain and Addiction Network
CAMH	Centre for Addiction and Mental Health
CHC	Community Health Centres
CMHN	Collaborative Mental Health Network
COPD	Chronic Obstructive Pulmonary Disease
CPSO	College of Physicians and Surgeons of Ontario
DUR	Drug Utilization Review
ECHO	Extension for Community Healthcare Outcomes
EAP	Exceptional Access Program
FHO	Family Health Organization
FHT	Family Health Team
GAIN	Global Appraisal of Individual Needs
HQO	Health Quality Ontario
H-SOAP	Hospital-based Services for Opioid- and Alcohol-addicted Patients
ICES	Institute for Clinical Evaluative Sciences
LHIN	Local Health Integration Network
MCSCS	Ministry of Community Safety and Correctional Services
MMAP	Medical Mentoring in Addiction and Pain Network
META:PHI	Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration
MMT	Methadone Maintenance Treatment
MOHLTC	Ministry of Health and Long-Term Care
MOTHER	Maternal Opioid Treatment: Human Experimental Research
NAOMI	North American Opiate Medication Initiative
NAS	Neonatal Abstinence Syndrome
NEP	Needle Exchange Program
NIHB	Non-Insured Health Benefits

NMS	Narcotics Monitoring System
NP	Nurse Practitioner
NPLC	Nurse Practitioner Led Clinic
OAT	Opioid Agonist Therapy
OCFP	Ontario College of Family Physicians
ODB	Ontario Drug Benefit
ODPRN	Ontario Drug Policy Research Network
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
ONP	Ontario Naloxone Program
OST	Opioid Substitution Treatment
OUD	Opioid Use Disorder
PDA	Prescription Drug Abuse
PHU	Public Health Unit
PTSD	Post-Traumatic Stress Disorder
UDS	Urine Drug Screens
WSIB	Workplace Safety and Insurance Board

## Appendix 3 – Notes

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