Prince Edward Island

Methadone Maintenance Treatment Program

Evaluation Report

September 2008

ONE ISLAND HEALTH SYSTEM

PEI Methadone Maintenance Treatment Program Evaluation Report

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Executive Summary

The Prince Edward Island Methadone Maintenance Treatment Program (PEI MMTP) was established as a pilot project in 2004. A formative evaluation was conducted to assess whether the present concept, design and operation of the PEI MMTP is achieving the desired outcomes of harm reduction and improved quality of life. The evaluation was conducted January to March of 2007 and assessed the first two years of operation (July '04 - August '06).

Methodology

The PEI MMTP has three goals, namely: 1) harm reduction, 2) improved quality of life, and 3) when and where appropriate, abstinence for program clients. These goals were formulated in line with Health Canada's (2002) Best Practices for Methadone Maintenance Treatment. Goal attainment was evaluated using the MMT Client Survey, i.e., personal interviews which were organized to collect information from client respondents regarding the following areas:

- Harm reduction outcomes: drug use, injection needle use, and blood borne disease(s);
- Quality of life outcomes: criminality, housing, employment, social, and health status;
- Abstinence outcomes: self-reported drug usage;
- Client perception and satisfaction with the program; and
- Personal information: age, gender, marital status, residence, education, and duration of opioid use.

The Core Provider Survey conducted with provincial addictions staff and community pharmacy staff, provided information about provider views and perspectives on the level of program implementation, stated in relation to best practices for methadone maintenance treatment.

Findings

PEI MMTP Client Survey - The vast majority of respondents to the client survey (n= 35 of which 32 were currently in the program and 3 had discontinued) reported decreased opioid use, with overall improvements in relation to harm reduction, quality of life, opioid abstinence outcomes as a result of entering the PEI MMTP. Figures are based on respondents who answered each specific question. Findings at the time of the evaluation indicated:

- 91% did not use opioids, and 71% did not use secondary drug (61% had stopped during MMTP and 10% did not use a secondary drug at time of entry);
- 91% did not use injection needles (64% stopped use since entry and 27% did not use needles at the time of entry);
- 60% stopped sharing needles during MMTP (only 6% reported sharing during MMTP);
- There was no increase in cases of Hepatitis C (51% were positive at entry to MMTP);
- 100% remained free of HIV / AIDS;
- 91% improved housing outcomes;
- 83% improved employment outcomes;
- 100% reported having social support (i.e., someone they could call for help);
- 80% reported having family support and 83% reported having good friend support;
- 91% improved their family support and 89% improved good friend support since entry;
- 89% improved family relations and 86% improved good friend relationships since entry;
- 100% reported an improvement in health status since entry.

Clients also reported a high level of satisfaction with PEI MMTP (4.4 on 5-point scale). Program access (e.g., ability to enter the program, location, and travel time) were areas of improvement.

PEI MMTP Core Provider Survey - From the perspective of the core providers, the PEI MMTP is still in development. However, there was recognition of progress over time, and that the program had achieved good client outcomes. A variety of suggestions for improvement were expressed through the Provider Survey, and these are summarized below.

Program Development and Design:

- Continue to strengthen relationships and collaborative processes between addictions services staff and collateral partners.

Program Policies:

- Address gaps in program policies and procedures may exist, particularly in relation to clinical processes as well as consequences for non-compliance.

Program Staff and Environment:

- Program resources: There were repeated comments voicing requirements for increased staffing and overall program funding.

- Training: A need for more consistent and ongoing education was repeatedly stated by respondents. Training needs were identified within at least 2 areas:
  - Educate addictions services staff and program collaterals on the program purpose, goals, philosophy, and benefits.
  - Continue professional development for providers directly responsible for methadone maintenance treatment.

- Facility / Location: A variety of clients and providers suggested that service be provided at sites other than, or in addition to, Provincial Addictions Treatment Facility (PATF) to improve access and reduce travel barriers.

Meeting Needs of Specific Groups:

- The program was designed for an adult target population. As the program further evolves and develops, it may be worth reviewing the needs of various target populations, such as offenders in correctional institutions, people living in rural or remote areas, First Nations and Inuit, and people who are homeless.

Research and Evaluation:

- While the survey found that evaluation of the program was rated as "not" to "somewhat" implemented, there were no specific staff suggestions in this area.

Conclusion

This formative evaluation supports continued implementation of PEI Methadone Maintenance Treatment Program. Results from the Client Survey strongly suggest that clients are achieving favorable outcomes in line with PEI MMTP goals as a result of involvement in MMTP. Information gathered through the Core Provider Survey indicates that many of the core program components consistent with best practices are in the process of becoming established. It is hoped that information from this evaluation will be used as a resource for ongoing program development and quality improvement.

Introduction

In 2006, a request was made to Corporate Services to conduct a formative evaluation of the PEI Methadone Maintenance Treatment Program. The purpose of the evaluation was to assess client outcomes in relation to stated program goals and the level of program implementation in relation to best practices for methadone maintenance treatment. The evaluation framework and methodologies were designed in late 2006. In early 2007 two surveys were conducted. A client survey was conducted to gather baseline information on client profiles, outcomes, and satisfaction with the program. A core provider survey was conducted to gather provider views and perspectives on the level of program implementation, stated in relation to best practices for methadone maintenance treatment programs. Evaluation findings were to be used to support and inform requirements for due diligence as well as ongoing program planning and quality improvement for the PEI MMTP.

Opioid Dependency and Methadone Maintenance and Treatment

Opioid drugs are "painkillers" and include opiates (which come from the opium poppy), as well as other drugs that have morphine-like effects. Opioid dependence develops after a period of regular use of opioids (Canadian Center on Substance Abuse, 2005). The period of use required to produce a dependence varies with several factors, namely quantity, frequency, route of administration, individual vulnerability, and context in which opioid use occurs. Opioid dependence "is not a weakness of character or will". Rather, opioid dependence is a complex health condition with social, psychological and biological determinants and consequences, including changes to the brain. As with substance dependencies in general, aspects of opioid dependence include: cravings, withdrawal, tolerance, and personal neglect. This dependency is often associated with risky health practices, unstable social relationships, employment challenges, housing issues and criminality (American Psychiatric Association, 2000).

Methadone maintenance treatment is the most widely used treatment for persons living with opioid dependence (Health Canada, 2002). Like other chronic diseases, such as diabetes, MMT is delivered according to best practice guidelines. Treatment is individualized with no one regimen suited to all clients. In Canada, prescriptions are nationally regulated by the Office of Controlled Substances, Health Canada. Physicians apply for permission to prescribe methadone, either for pain or addictions treatment. Health Canada "Best Practices in Methadone Maintenance Treatment" (2002) lists the nine essential elements of MMT: methadone dose; medical care; treatment for other substance use; counseling and support; mental health services; health promotion, disease prevention and education; linkages with other community-based supports and services; outreach and advocacy.

From a pharmacological perspective, methadone alleviates the symptoms of opioid withdrawal and decreases or eliminates the constant craving for opioids. Methadone is long acting and prevents the onset of withdrawal for 24-36 hours, thereby discouraging illicit use of opioids between treatments. Methadone medication possesses other properties valuable to harm reduction, as follows:

- Methadone reduces the euphoric effect of non-methadone opioids (cross tolerance).
- Methadone is long-acting, thus discouraging illicit use of opioids between treatments.
- Methadone is taken orally, thus reducing risks associated with needles.
- Methadone tolerance develops slowly. The same dose can be used for many years where long-term use of medication is necessary (like the use of insulin to control diabetes).
- At the time of this review, methadone was the only opioid approved for long-term or more than 180 day outpatient drug treatment of opioid dependence (Health Canada, 2002), and the only drug covered for PEI MMTP patients by provincial drug programs (Personal Communication, 2008).

Program Model - PEI MMTP

Overview

The PEI Methadone Maintenance Treatment Program (PEI MMTP) was initially implemented in August 2004 as a pilot project with nine clients. This program is administered by the Department of Health under the Mental Health and Addictions Section of the Primary Care Division, and is managed by the Manager of the PATF. The service is located at the Provincial Addictions Treatment Facility at Mount Herbert.

The program employs a comprehensive, client-centered, community-based approach that focuses on the determinants of health. The program employs a multi-disciplinary approach to case management, and works in partnership with Public Health, family physicians, community pharmacies, Child and Family Services, Income Support, Probation Services, Corrections, the Pharmacy Board, the Medical Society, and other necessary services.

Program Goals

- The goals of the program are harm reduction, improved quality of life, and the ultimate goal of abstinence for program clients.

Target Population

The target population for the PEI MMTP is defined as those people who meet the following entrance criteria for the program:

- A diagnosis of opioid dependence is made by the PATF physician;
- Opioids is the drug of choice for at least one year;
- There are signs of physical dependence (withdrawal symptoms);
- There have been previous attempts to stop the abuse of opioids;
- The client is capable of giving informed consent;
- PATF physician determines the client to be medically manageable;
- The client has signed the treatment agreement;
- The client has signed the necessary releases of information.

Service Delivery Model / PEI MMT Client Clinical Flow

1. Assessment and Intake: Request for service; Screen; Screen presentation to MMT Committee; Committee decision regarding assessment; Assessment; Presentation of assessment to MMT Committee; MMT Committee decision regarding admittance to MMTP;

2. Stabilization / Induction (6 weeks)
   a. Phase I In-Patient Induction - Seven to ten days at Detox Unit, PATF.
   b. Phase II Out-Patient Care - The first four weeks after Induction is completed. Client visits PATF for assessment, urine tests, physician appointments, counseling, and group. Client may attend community support groups, e.g., AA, NA.
   c. Phase III Out-Patient Care - Group and counseling components are completed and clean urines are verified. Attends community support groups. Carries (take home doses) begin.

3. Community Phase: Consistent with best practice guidelines, clients can continue the Community Phase indefinitely. The client may return to a more intensive level of care if necessary. Client attachment to MMTP is emphasized because research shows that positive outcomes are more likely with continuous attachment to MMT.
   a. Phase IV - Client visits community pharmacy at least once a week for observed dose with take-home doses provided for other days. Has a physician appointment every 4-8 weeks. The client only reaches / maintains the Community Phase with ongoing clean urine tests. Clients can attend the MMT Support Group as well as other community support groups, e.g., AA, NA, PA.

4. Discontinuation of Treatment
   Discontinuation from the program can occur under three situations, as follow:
      i. Voluntary Tapering: The client is ready to discontinue treatment, and proceeds with assistance from the program to taper. Under this situation there is no pressure from the program for the client to taper, and in fact, best practice supports long-term maintenance treatment.

ii. Involuntary Tapering: refers to a process where the program requires that a client be tapered and discontinued from treatment. Reasons for discontinuation include non-compliance / unacceptable behavior as per treatment agreement.
iii. Client Transfer: Client files are closed when clients move out of the province.

Methodology

The review of the PEI MMTP was organized as a formative evaluation to answer the following evaluation question: "Is the present concept, design and operation of the Methadone Maintenance Treatment Program achieving the desired outcomes of harm reduction with the ultimate goal of abstinence, and improved quality of life?" The evaluation was conducted January to March of 2007 and assessed the first two years of program operation (July 2004 - August 2006).

The evaluation included the following components:

1. A program client survey using a formal structured questionnaire which could be administered either verbally or in writing;
2. a core program provider survey using a formal structured questionnaire which would be administered in writing.

Content for both questionnaires was defined by an Evaluation Working Group.

Client Survey

The Client Survey was based on a questionnaire tool developed by a Halifax clinic (Capital Health, 2005). Additional questions were added to the tool to reflect the PEI context and requirements of the current evaluation project. This survey was organized to collect information from client respondents in the following areas:

- Harm reduction outcomes: drug use, injection needle use, and blood borne disease(s);
- Quality of life outcomes: criminality, housing, employment, social support, and health status;
- Abstinence outcomes: self-reported drug usage;
- Client perception and satisfaction with the program;
- Other general information was also collected: client age, gender, marital status, residence, education, and duration of opioid use.

In addition to the survey, a letter of invitation, an information sheet, and letter of consent were prepared. Current program clients were verbally advised of the evaluation and survey by the program resource staff, and provided with the letter of invitation and information sheet at that time. If clients agreed to participate, they were provided with the choice of either completing the questionnaire on their own and mailing it to the evaluator or of being interviewed by the evaluator. Almost all clients who participated chose to be interviewed. Prior to the interviews, information about the evaluation was again reviewed with the clients and they were asked to indicate their consent to participate by signing a consent form.

The MMT Program Resource staff member attempted to contact clients who had discontinued the program to invite their participation. When contacted, these clients were provided with information about the evaluation and were asked if they would like to participate. Contact information for those who consented to participate in the survey was provided to the evaluator who followed up and scheduled interviews.

Core Provider Survey

The core provider survey was designed to obtain core provider perspectives on the PEI MMTP, specifically in relation to:

- The level of MMTP implementation in relation to best practices;
- Facilitators and barriers to program implementation;
- Purpose of MMTP;
- Collaboration Among Core Providers;
- Collaboration Between Core Providers and Collateral Providers;
- Opinion of how MMTP was implemented;
- Changes required to integrate MMTP into Addictions Services;
- Top Suggestions for Improvement;
- Situation on PEI Today if the Program had not been implemented.

The core provider survey was conducted as a self-complete mail survey.

Procedure

Data collection occurred during the months of January, February and March of 2007. Safeguards were in place to ensure appropriate protection of personal information. Reminder messages were used to increase the response rate. The analysis produced mixed methods technical reports for each survey. Results from the two surveys were used to compile this report.

Data Handling

Data were entered into SPSS or WordPerfect software and later analyzed using quantitative and qualitative techniques, respectively. An evaluator and the PEI MMT Program Resource staff member worked together to finalize the analysis and the reports.

Results: Client Survey

Demographics of Client Participants

The respondents were 35 of the 62 (56%) clients who had registered in PEI MMTP during the first two years of operation. Of the 35 survey participants, 32 were current clients and 3 had discontinued from the program. MMTP enrollment of participants ranged from 6-30 months.

Table 1. Demographics of 35 Client Respondents

Demographic	#	% of total
Gender		
Male	15	(43%)
Female	20	(57%)
Age		
21-30	12	(34%)
31-40	14	(40%)
41-50	5	(14%)
51-60	4	(12%)
Marital Status		
Single	17	(49%)
Common-law	5	(14%)
Separated	5	(14%
Divorced	4	(11%)
Other (married / widowed)	4	(12%)
County of Residence		
Prince	15	(43%)
Queens	18	(52%)
Kings	2	(6%)
High School Completion		
Less than senior high	15	(43%)
Senior high or more	20	(57%)

Summary of Client Outcome Measures

The outcome measures reported were specific to the three program goals: 1) to reduce harm, 2) to improve quality of life, and 3) to ultimately achieve abstinence. The following table provides an overall summary of survey findings, indicating the proportion of respondents (%) who reported improvements in each of the program goal areas as a result of their participation in PEI MMTP. Positive (+) changes were reported for all client outcomes reported.

Table #2. Summary of Client Outcome Findings

Goal / Client Outcomes	Respondents reporting (%)	Change (+ or -)
Harm Reduction		
• Decreased use of primary drug (opioids)	91%	+
• Decreased use of secondary drugs	20%	+
• Decreased use of injection drug needles	64%[1]	+
• Decreased positivity for Hepatitis C	Same	+
• Decreased positivity for HIV AIDS	Same	+
• Decreased other bloodborne infections	Same	+
• Health status improved since entry to MMT	100%	+
Quality of Life		
• Improved housing	91%	+
• Improved employment	83%	+
- Job obtained	37%	+
- Job readiness increased	46%	+
• Has someone that can be called for help	100%	+
• Has 'good friend' support	83%	+
• Family support improved since entry	91%	+
• 'Good friend' support improved since entry	89%	+
• Relationships with family improved since entry	89%	+
• Relationships with 'good friends' improved since entry	86%	+
Abstinence		
• From primary drug or opioid use (entry to evaluation)	91%	+
• From secondary drug use (entry to evaluation)	68%	+
Client Satisfaction (mean score)	4.4 / 5	+

[1] *Among respondents to the question, 73% reported the use of injection needles before entry to MMTP and 9% reported use at time of the evaluation (2 current; 1 discharged).*

Detailed Findings: Client Survey

Harm Reduction

Drug Use

91% of participants reported that they had stopped the use of their primary drug by the time of evaluation. At evaluation, 71% of the participants reported that they did not use a secondary drug (61% stopped during MMT and 10% did not use a secondary drug at entry).

Figure #1. Primary Drug Use

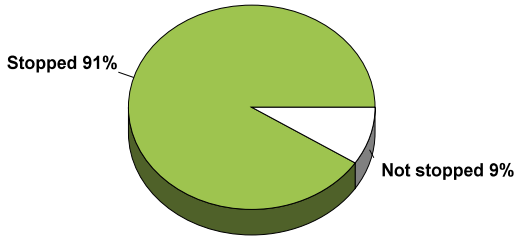
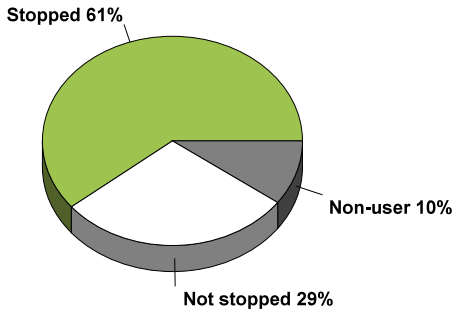


Figure #2. Secondary Drug Use

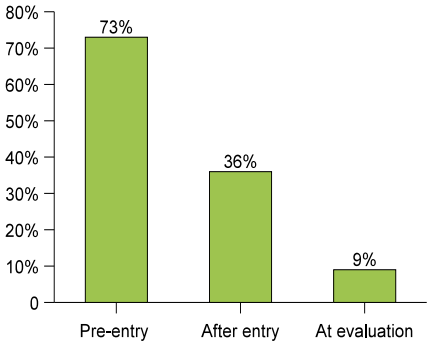


Injection Needle Use

Among the 35 survey participants injection needle use decreased from 73% prior to entry into MMT to 36% just after entry to MMT to 9% at the time of the evaluation.

Only two respondents reported sharing needles with other persons during the time that they were enrolled in MMT.

Figure #3. Needle Use

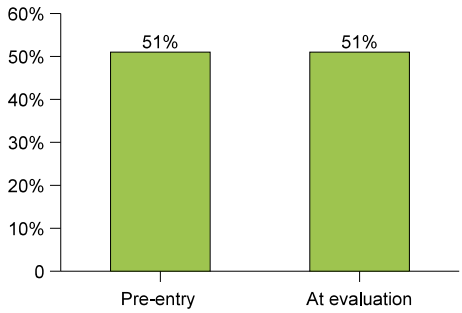


Bloodborne Disease

Bloodborne disease status was unchanged between entry and evaluation.

Among 35 respondents, 51% were positive for Hepatitis C at entry and at evaluation. None of the respondents were positive for other blood borne diseases such as HIV AIDS, Hepatitis A, or Hepatitis B at entry or at the time of the PEI MMT Evaluation.

Figure #4. Positive for Hepatitis C

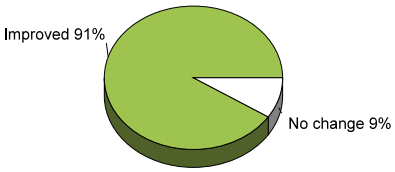


Quality of Life

Housing

When asked "Would you consider that your housing condition has improved since admission?" 91% of the client respondents reported improved housing. The remaining 9% lived in circumstances that allowed them to retain adequate housing despite opioid dependence.

Figure #5. Housing



Housing Situations

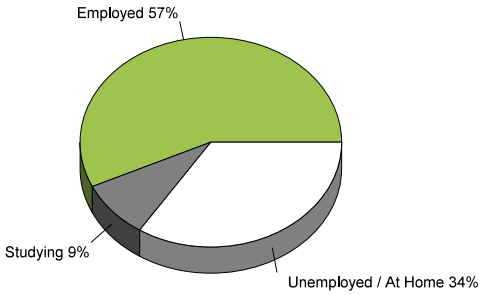
All respondents reported having shelter at the time of the evaluation. When asked the type of housing, 7 reported ownership, 17 rental, 9 living with others, and 2 unreported. The majority (91%) described their housing as adequate. After entering MMT 71% of the respondents changed residences. MMT enabled some clients to own a home, an achievement which was impossible prior to stabilization by methadone maintenance treatment.

Homeless	Yes = 0
Adequate Housing	Yes = 32 (91%)
Changed Residences	Yes =23 + 2 moved to PEI (71%)
Number of Residence Changes	18 made 1-3 changes; 6 made 4-6 changes (1 unreported)

Employment

When asked their employment status the participants in the PEI MMTP Client Survey replied as follows:

Figure #6. Employment

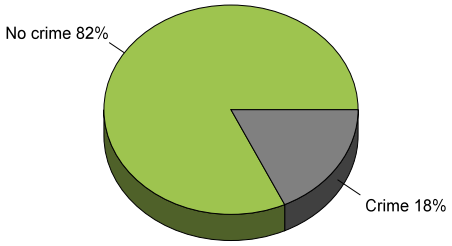


- 57% (20) were employed,
- 9% (3) were studying, and
- 34% (12) were "at home".
- None reported being permanently disabled, retired, or volunteer.

Criminality

Clients were asked "Has there been a decrease in your involvement in criminal behavior since admission to PEI MMTP?" Among the 35 respondents, 82% reported having no crime or being less involved in crime since admission to PEI MMTP.

Figure #7. Criminality

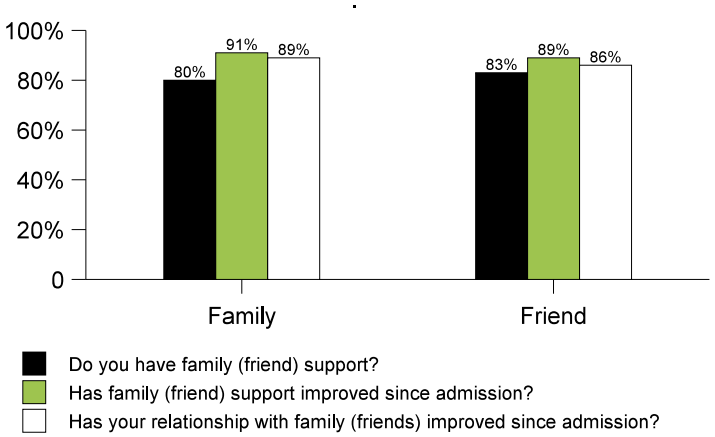


When answering this question some respondents indicated that prior to admission they had supported their opioid dependence by stealing (drugs and money), forging, and double doctoring. The most common criminal offences reported were **1)** possession and trafficking of illegal substances, and 2) theft of drugs, money, or other items.

Family and Positive Friends

Respondents were asked "Do you have someone you can call when you need help?" All respondents reported having social support.

Figure #8. Relationships with Family and Friends



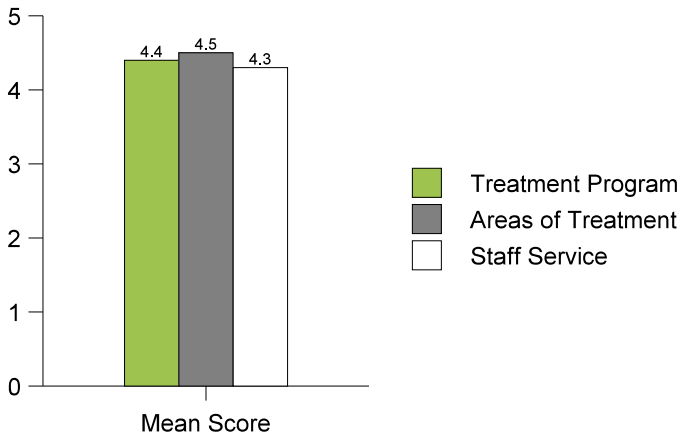
Respondents were then asked a series of three questions to evaluate the outcomes of their relationships with 1) family, and 2) 'good friends'. More than 80% of respondents replied positively to all six questions asked.

When answering the questions some respondents commented that making positive changes in relationships had been the most difficult challenge on the road to recovery.

Client Satisfaction

Client respondents were asked to rate a series of 27 questions as a means of evaluating three aspects of satisfaction with PEI MMT service: 1) treatment program outcomes, 2) areas of treatment received, and 3) staff service to them as a client.

Figure #9. Client Satisfaction Ratings



The overall mean score was 4.4 on a 5-point scale where the three component scores were 4.3, 4.4 and 4.5. When converted to a percentage this score represents 88%.

Client Perception of PEI MMTP

Respondents were asked a series of questions to assess their overall perception of PEI MMTP. Access to methadone medication and support services is viewed positively despite the inconveniences of travel, urine testing, and appointments. Increased access for untreated cases was the main change suggested by respondents. A more detailed summary follows.

Question	*Client Response*
Role of methadone medication in treatment	Methadone stabilizes client respondents so they can: #1) adopt a positive lifestyle #2) improve their quality of life #3) break the cycle of drug dependence
Best part of MMT for client	#1) Being away from Drugs #2) Having a new life #3) Having program supports / Having medication (tied)
Worst part of MMT for client	#1) Inconvenience of travel to PEI MMTP at the PATF #2) Inconvenience of routine urine tests #3) Inconvenience of frequent appointments
The one change that I would suggest in MMT	The dominant suggestion was to increase access to PEI MMTP.

Results: Core Provider Survey

Level of Implementation of Best Practice in PEI MMTP

Providers were asked to rate the current PEI MMTP in relation to 50 best practices for MMT programming (Health Canada, 2002) using a five-point scale ranging from 0 - 4 (0 = not at all implemented, 1 = somewhat implemented, 2 = half-way implemented, 3 = mostly implemented, and 4 = fully implemented). The provider ratings are summarized by six areas of MMT best practice (Health Canada, 2002).

Table #3. Level of Implementation of MMT Best Practices by PEI MMTP

Question	%*	Mean **
A - Program Development Design (16)		
Clear program philosophy & treatment goals	74%	2.00
Focus on retention and engagement	64%	1.98
A maintenance orientation	68%	2.44
A client / patient centered approach	72%	2.69
Accessibility	74%	1.96
Integrated comprehensive services	65%	1.86
- Medical care	62%	2.24
- Other substance use treatment	65%	2.19
- Counseling and support	71%	2.21
- Mental health services	52%	1.97
Health promotion / disease prevention / education	46%	2.17
- Linkages with other community-based services and supports	53%	1.86
- Outreach and advocacy	47%	1.68
- Client-patient involvement	61%	2.15
Involvement of wider community	52%	1.12
Adequate resources	56%	1.05
B - Program Policies (8)		
Open admission	53%	2.17
Timely assessment	55%	1.75
Adequate individual dosage	50%	2.36
Methadone dosage during pregnancy	35%	2.43
Unlimited duration of treatment	46%	2.77
Clear criteria for discharge [involuntary]	58%	1.66
Non-punitive approach to other drug use during treatment (urine	61%	2.07
Client-patient centered management of withdrawal [tapering]	56%	2.57
C - Delivery Modes (1)		
Continuum of program delivery to meet needs of different people at different treatment stages.	64%	1.88

Question	%	Mean
D - Program Staff & Environment (10)		
Multidisciplinary program team	68%	1.98
Adequate human resources	64%	1.31
Competence, attitudes & behaviours in practice	65%	2.00
Relationship (building) and supports	61%	2.05
Adequate ongoing training	64%	1.05
Program environment	47%	1.90
Organized structured approach to treatment	56%	1.57
Safety	55%	2.06
Flexible routines	58%	2.00
Information collection and sharing	61%	1.85
E - Meeting Needs of Specific Group (13)		
People with multiple substance use disorders	62%	2.00
People who are dependent on oral opioids	62%	2.59
Women	58%	2.42
Pregnant women	50%	2.42
People who are homeless	41%	1.30
People living in rural or remote areas	46%	1.63
First Nations and Inuit	36%	0.96
People living with HCV	36%	2.50
People living with HIV / AIDS	36%	2.25
People with mental health disorders	42%	1.82
Offenders in correctional institutions	49%	1.56
F - Research & Evaluation (2)		
Address research gaps	36%	0.88
Evaluate programs	36%	1.17

* *% refers to the percent of total respondents who answered the question.*
** *The mean score is the mean score of all ratings provided in response to a particular area.*

Overall, the Provider Survey found that the PEI MMTP was between 'somewhat' and 'half-way' implemented. These perceptions are consistent with the fact that this was a relatively new program which was still under development and refinement. Of the fifty best practices rated, the following had ratings of 1.75 or less, potentially indicating areas for further attention as next steps in program development and improvement:

Program Development and Design:

- Outreach and advocacy (1.68);
- Involvement in wider community (1.12); and
- adequate resources (1.05);

Program Policies:

- Timely assessment (1.75); and
- Clear criteria for involuntary discharge (1.66).

Program Staff and Environment:

- Adequate human resources (1.31);
- Adequate ongoing training (1.05);
- Organized structured approach to treatment (1.57)

Meeting Needs of Specific Groups:

- People who are homeless (1.30);
- People living in rural or remote areas (1.63);
- First Nations and Inuit (0.96);
- Offenders in correctional institutions (1.56).

Research and Evaluation:

- Address research gaps (0.88); and
- Evaluate programs (1.17).

Facilitators and Barriers to Implementation of Best Practice

Core Providers identified the main facilitators and the main barriers to implementation.

The facilitators concerned the need for a methadone maintenance treatment program to address a range of issues associated with opioid dependence while the barriers concerned the need for providers to perform new tasks quickly with limited resources to establish methadone maintenance treatment programming.

Table #4. Facilitators and Barriers to MMTP Implementation

Facilitators	*Barriers*
Internal demand for treatment • Staff interest in and support for MMT • Availability of new provincial option • Regional and interprovincial demand • Desire to close a gap in service • Suggested by PATF Review (2003) • Instructed to pilot MMT External request for treatment • By public and political pressure • By justice system • By Islanders in MMT somewhere • By other potential clients Need to control public risks • Increased opioid use • Infectious disease • Decrease needle use • Decrease crime	Limited resources • Lack of staff • Lack of funding • Lack of resources • Lack of facilities • Client burden (cost - medication / travel) Implementation process • Limited planning (for pilot project) • Forced implementation • Lack of communication • Lack of program education / training Treatment philosophy / procedures • Differences in philosophy of treatment • Length of stay (limits bed availability) • Inadequate monitoring of client drug use (in harm reduction approach used by MMT) Physical set-up / location • Location (need transport for clients) • Need for separate clinic Negative attitudes • Staff resistance • Staff fear • Negative staff attitudes • Lack of community support and understanding

Provider Understanding of MMTP Purpose

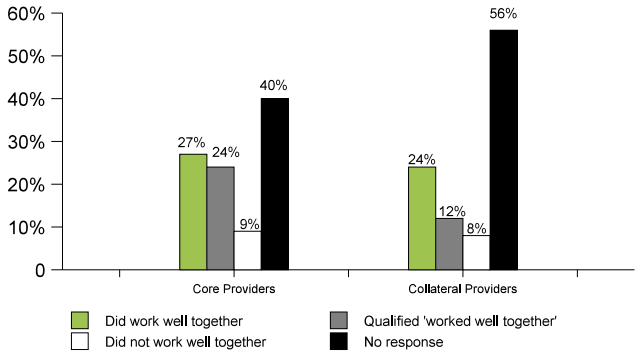
When the 'stated purposes' of the program were compared to 'reported purposes' as stated by survey respondents (n=66) it was found that:

- 75% of the mentions described the 'stated purpose' of harm reduction,
- 18% described improved quality of life,
- 3% described the ultimate goal of abstinence, and
- 4% did not describe one of the three 'stated purposes' of PEI MMTP.

Core Provider Collaboration

When the Core Providers were asked if Addiction Services and Community Pharmacists worked well together to deliver PEI MMTP, 51% indicated that PEI Addiction Services (East, Central and West) and PEI Community Pharmacies do work well together. Of the 51%, 27% answered with an unqualified "yes" and 24% gave a conditional response.

Figure #11. Provider Collaboration



The challenges to working well together were identified as:

- the need for role understanding;
- the need for improved / increased communication;
- the need for improved documentation processes;
- The need for more frequent staff conferences; and
- the need for clear processes in relation to client inductions.

Collaboration Between Core Providers and Collateral Providers

When asked if MMT and collateral services worked well together to meet the needs of MMT clients 36% of the core providers responded positively, and all responses about collaboration between community pharmacies and addictions services were positive. Collateral services that worked well with PEI MMTP were identified as Social Services, notably Child & Family and Income Support.

Services said to not yet be engaged were education, employment, and provincial corrections. Reasons for limited involvement were that these collateral providers:

- had not been asked for input,
- did not understand MMT / PEI MMTP, and
- struggled with cash paying MMTP clients (working poor and unemployed).

Among the remaining core provider respondents, 8% stated that MMT and collateral providers did not work well together and 56% did not answer this question (often citing lack of information as the reason). According to the Survey, positive collaboration is greater among core providers only than among core providers and collateral providers (51% vs. 36%).

Opinion of How the MMTP was Implemented

Core providers were asked "What is your opinion of how this MMT was implemented?" Among the 66 core providers the opinions were distributed as follows:

- 50% negative,
- 8% positive,
- 5% neutral, and
- 37% non-response.

Negative responses were associated mainly with limited planning which occurred as a consequence of rapid start-up. Some respondents commented that the negativity had decreased as the MMT implementation progressed. Providers expressing a positive opinion cited public need and good process.

A detailed summary of opinions as to how MMTP was implemented appears in Table #5.

Figure #12. Tone of Responses to Question

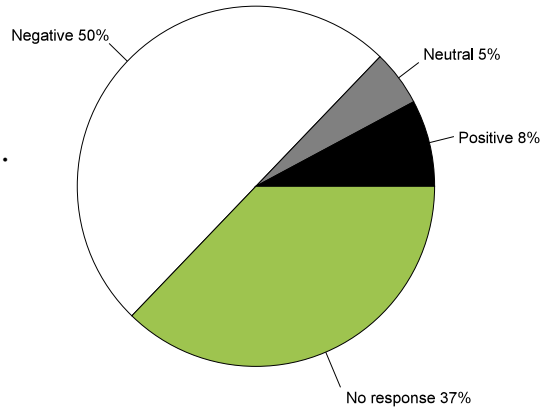


Table #5. Summary of Provider Opinions Regarding MMTP Implementation

Negative Opinions	Positive Opinions
Limited preparation • Just happened - there all of a sudden • Forced - lack of consultation or input • Rushed; cart before horse • Not enough training and communication • Poorly implemented; poor process Limited policies and procedures • No policies / procedures in place • Clinical policies / procedures limited • No consequences for noncompliance Philosophy • Philosophy of harm reduction vs. abstinence questioned	Response to public need • Implemented in response to need • A government decision Good process • Approach and process [were] good

Changes Required to Integrate MMT into PEI Addiction Services

The three most frequent suggestions for integrating MMT into PEI Addiction Services were:

- more staff,
- more staff education, and
- a different physical set-up.

Less frequent suggestions for integrating MMT into Addiction Services appear below.

Table #6. Summary of Changes Required to Integrate MMT into PEI Addiction Services

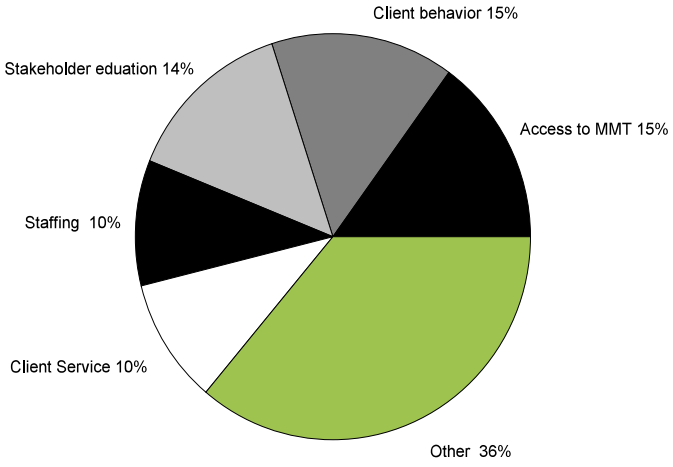
Highest Frequency (By 10 or more persons)	Medium Frequency (By 5-9 persons)	Lowest frequency (By fewer than 5 persons)
• More staff • More staff education • Separate clinic	• Other / central location • PEI-wide involvement • Better communication • Role understanding • More counseling • Provider collaboration • Better control of client behavior • Prioritize clients (first timers / ones needing help) • More resources • More PEI stats • More public relations • Permanent funding	• Harm reduction policy • Abstinence

Suggestions for Improving the MMTP

"What are the top three do-able suggestions for improving MMTP?" When the improvements mentioned with 10% or greater frequency were identified it was found that there were five main areas for improvement:

- Improve access;
- Improve client behavior / discipline;
- Improve stakeholder education;
- Increase staffing;
- Enhance client services.

Figure #13. Suggested Improvements in MMT



A more detailed explanation of the suggestions for improving PEI MMTP follows.

Table #7. Summary of Suggested Improvements

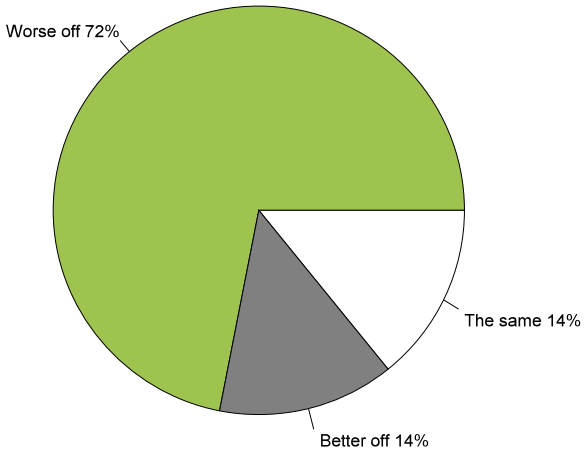
Suggested Improvement	Explanation
Access to MMTP	Refers to the accessibility of location and the intake capacity.
Client discipline / behavior	Refers to the use of behavior protocols to control wait room "roaming" through PATF and polydrug use / abuse guidelines / consequences. (This is the most frequently cited area for improvement by pharmacies).
Stakeholder education	Refers to the provision of information appropriate to the role of the stakeholder (incl. life skills lost / never learned)
Staffing	Refers to number and type of staff (i.e., community physicians, Addictions services staff at all sites), and specialized staff such as an addictionologist.
Client services	Ensure a spectrum of clinical services for clients (including provision of needed information to client).
Other suggestions	Miscellaneous suggestions offered by three or fewer respondents. These included: team approach, adequate resources, separate facility, and program philosophy.

Situation in PEI Today if MMT Had Not Been Implemented

"What would the situation be like in PEI today if MMT had not been implemented?"

- According to 72% of the core provider respondents (n=44), the situation on PEI would be worse without the PEI MMTP
- In other words, three-quarters of those who answered the question supported having MMT to treat opioid dependence among Islanders.
- The PEI MMTP is a good program according to 100% of pharmacists and 28% of addiction services staff.

Figure #19. Without MMT PEI Would Be ...



Examples of specific answers include:

Without PEI MMTP:

- There would be negative effects for opioid users and non-users.
    - The three most frequently cited negative effects were increased crime, increased use of illicit drugs, and increased use of system services by untreated opioid users.
    - Less often mentioned were increased deaths increased hepatitis C, increased HIV, increased complex untreated cases, increased IV needle use, increased violence, and increased recidivism.
- Opioid users would not have learned about or developed a better quality of life.
- Other treatment options would be in use.

- Opioid users, whether PEI patients discharged by a physician, federal prison inmates, dependents moving closer to family / friends, or travelers, would have to explore other treatment options. Options? Programs off-Island. Other treatment modalities. Family doctors who "aren't following them". Drugstores where pharmacists are left to "police" clients.

- There would be little or no change. PEI would be "no better" or "no worse" than in 2004 (would use "other mood alterants with little / no consequence").

- There would be better use of resources. (Some providers suggested that "the more opioid patients then the more bed days" thereby reducing the resources that are available for other clients requiring in-patient detox).

Conclusion

From the perspective of PEI MMTP clients, very positive outcomes were reported for all program goals, and the clients attributed their positive progress over time to their involvement in the PEI MMTP. Respondents regarded methadone maintenance treatment as an essential stepping stone to stabilization and ultimately to positive life outcomes. Methadone maintenance treatment increased client willingness to work with the program providers and thereby further enhance the impact of methadone on their life outcomes. Clients identified program access (i.e., admission to the program, location, and travel time) as areas to consider for improvement.

From the perspective of MMTP core providers, there was recognition that while the methadone maintenance treatment program is still in development there has been progress over time, that the program has addressed an important need, and that the program has achieved good client outcomes. The Core Provider Survey identified a number of areas for improvement or attention, and these are summarized below.

Program Development and Design:

- Involvement in wider community: Continue to strengthen relationships and collaborative processes between addictions services staff and collateral partners along the continuum of methadone maintenance treatment.

Program Policies:

- In general, providers felt that a gap in program policies and procedures existed, particularly in relation to clinical processes as well as consequences for non-compliance. Two specific areas identified for policy development included "timely assessment" and "criteria for involuntary discharge".

Program Staff and Environment:

- Program resources: There were repeated comments voicing requirements for increased staffing and overall program funding. In general, there was a common sentiment that the current resource model was not aligned with the program mandate / responsibilities.

- Training: A need for more consistent and ongoing education was repeatedly stated by respondents, with training needs identified within at least two areas:

    - Program Awareness - Promote the program purpose, goals, philosophy, and benefits to addictions services staff and collateral providers.

    - Professional Development - Support providers directly responsible for methadone maintenance treatment programming.

- Facility / Location: Various suggestions were made in relation to location / accessibility. A number of respondents suggested the service be provided at sites other than, or in addition to, the PATF in order to improve client access / travel barriers.

Research and Evaluation:

- While the survey found that evaluation of the program was rated as "not" to "somewhat" implemented, there were no specific staff suggestions in this area. However, program evaluation is a standard component of program operation.

This formative evaluation supports continued implementation of the PEI Methadone Maintenance Treatment Program. Results from the client survey strongly suggests that clients are achieving favorable outcomes in line with PEI MMTP goals as a result of involvement in the program. Information gathered through the core provider survey indicates that many of the core program components consistent with best practices are in the process of becoming established. Survey respondents also suggested a variety of possible opportunities for improvement. It is hoped that information from this evaluation will be used as a resource for ongoing program development and quality improvement.

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