National consultation on the Section 56 exemption requirement for methadone prescribing

December 2017

Report to Health Canada
by the Canadian Research Initiative in Substance Misuse (CRISM)

CRISM-ICRAS
Canadian Research Initiative in Substance Misuse
Initiative Canadienne de Recherche en Abus de Substance

CIHR IRSC
Canadian Institutes of Health Research
Instituts de recherche en santé du Canada

Acknowledgements

This consultation was conducted by Nirupa Goel, PhD (Project Lead), with assistance from Denise Adams, PhD; Farihah Ali, MA; Athena Hyunh; Kamagaju Karekezi, MPH; Alice Lam, MA; Aïssata Sako, MSc, CRP; and Pam Sabioni, PhD.

Guidance and support were provided by the CRISM Nominated Principal Investigators: Julie Bruneau, MD, MSc; Benedikt Fischer, PhD; T. Cameron Wild, PhD; and Evan Wood, MD, PhD.

Consultation design and objectives were informed by Bobby Chauhan, Kirsten Mattison, and Neelam Merchant (Health Canada, Controlled Substances Directorate).

Executive Summary

Background and rationale. Canada has seen an extensive rise in opioid use and related morbidity (including opioid use disorders) and mortality. As a result, there is an urgent need to increase availability of and access to treatment options for opioid use disorder, including opioid agonist therapy. A potential barrier to the provision of opioid agonist therapy is the current regulatory requirement for a federal exemption for practitioners (i.e., physicians and nurse practitioners) to prescribe methadone maintenance treatment (MMT) under Section 56(1) (s.56) of the *Controlled Drugs and Substances Act*. Health Canada requested that a national consultation be conducted in order to assess, through expert opinion, the utility, advantages, and disadvantages of the s.56 requirement, to inform future Federal policy options regarding this regulatory requirement.

Methods. On this premise, and in close collaboration with Health Canada, the Canadian Research Initiative in Substance Misuse (CRISM) conducted a consultation, reaching out to over 250 stakeholders, including clinical leaders and other health service providers; representatives from provincial/territorial regulatory bodies, provincial/territorial and federal governments and regional health authorities; and people with lived and living experience with substance use (including family members). Respondents were located in all provinces and territories in Canada, and local, regional, and federal perspectives were represented. Stakeholders provided initial input through a web-based survey that included 3 open-ended questions jointly formulated by Health Canada and CRISM. Responses were analyzed for frequency of recurring themes. Further input was subsequently gathered through structured questions and open discussion, informed by the initial responses, through a series of 12 regional meetings held via group teleconferences. These follow-up discussions provided additional context on experiences with and perspectives on opioid agonist treatment.

Results. About three quarters of survey participants identified the s.56 exemption process as a barrier to care. At the same time, approximately one-third of the participants mentioned the importance of safety and education. These participants stated that the training currently required for methadone prescribing is needed and should continue, due to both the vulnerability of patients with opioid addiction as well as the unique characteristics and risks of methadone treatment (e.g., overdose). In most provinces and territories, teleconference participants supported the removal of the s.56 exemption due its administrative burden and lack of added value, on the condition that training and monitoring systems remain in place through regional authorities. Thus, the main recommendation from this consultation is to consider eliminating the s.56 exemption requirement, while also ensuring that strategies are in place to maintain appropriate training and monitoring for methadone treatment delivery.

In addition to the s.56 exemption, participants raised concerns about other challenges and barriers to opioid agonist treatment resulting from provincial and federal regulations. Suggestions and considerations for Health Canada were provided on how to address these barriers, which are described in more detail in the report. These include support for evidence-

based training and guidelines; improving access to other forms of evidence-based opioid agonist therapies; addressing barriers to treatment access in rural and remote communities; and supporting or providing resources for prescribers and patients, to allow for improved access to high-quality care.

Background

Methadone, a medication primarily used to treat chronic pain and opioid use disorder, is a controlled substance under the *Controlled Drugs and Substances Act* (CDSA), and activities with it are regulated under the *Narcotic Control Regulations* (NCR). The NCR require practitioners* (e.g., physicians and nurse practitioners) to obtain an exemption under section 56(1) (s.56) of the CDSA before they can prescribe, administer, sell or provide methadone. This special exemption requirement is unique to methadone and does not apply to other opioid medications, including buprenorphine, a drug also used to treat opioid use disorder, or those approved for pain management, such as controlled-release oxycodone, morphine, and fentanyl.

The regulatory and administrative context for methadone treatment in Canada has evolved since it was introduced in 1964[1]. As the use of methadone increased, the federal Department of Health and Welfare observed growing reports of dependence, overdoses, and the improper prescribing of methadone. Consequently, the Department created a clinical guideline for the use of methadone and amended the NCR to require all methadone prescribers to receive authorization issued by the federal Minister of Health. Physicians who were authorized to treat patients with methadone were required to follow federal guidelines for methadone treatment, register all patients with the Department, and submit monthly statistics to the Department. After the guidelines and restrictions were introduced, the number of patients receiving methadone treatment in Canada declined. However, this number has risen substantially since the 1980's, due to increased awareness of opioid use disorder and the changing medical, social, and legislative contexts.[1]

In 1995, oversight of the physician practice aspects for methadone treatment was transferred from Health Canada to the provinces and territories (P/T). Although not mandated by federal legislation, P/T licensing authorities developed or adopted guidelines, training requirements, audit processes and other mechanisms aimed at ensuring that physicians were knowledgeable and qualified to prescribe methadone for the treatment of opioid use disorder.[2] The NCR were amended in 1999 to replace the previous authorization requirement with the exemption under s.56 of the CDSA.

> Section 53(3) CDSA's *Narcotic Control Regulations* (NCR) states that "No practitioner shall administer methadone to a person or animal, or prescribe, sell or provide methadone for a person or animal, unless the practitioner is exempted under section 56 of the Act with respect to methadone."**

Subsequently, P/T created oversight mechanisms and regulations to support the administration of Health Canada's s.56 exemption process. Practitioners either apply directly to Health Canada

* Under the CDSA, "practitioners" include medical doctors, dentists, veterinarians, nurse practitioners, midwives and podiatrists. However, midwives and podiatrists are not authorized to conduct activities with methadone.
** http://laws-lois.justice.gc.ca/eng/regulations/C.R.C.%2C_c._1041/page-10.html#docCont

(Saskatchewan, Nova Scotia, New Brunswick, Newfoundland and Labrador, Prince Edward Island, the Northwest Territories, Nunavut and Yukon) or via their respective P/T licensing authority (British Columbia, Alberta, Manitoba, Québec and Ontario), which in turn makes a recommendation to Health Canada regarding the issuance of a s.56 exemption on behalf of the practitioner. Data from individual provinces suggest that a limited number of physicians in Canada have applied for and hold a valid s.56 exemption.[3,4]

Current Regulatory Processes

Each P/T, through their respective licensing authorities, have developed application procedures and educational requirements that providers must complete in order to be granted a s.56 exemption. As well, each P/T has issued or adopted clinical standards and guidelines for methadone prescription. The requirements for obtaining the exemption vary from province to province, but common requirements include:

- completion of an approved methadone workshop or course;
- a preceptorship (length varies between 1-2 days across jurisdictions); and
- a review of the physician's prescribing profile

Some provinces have additional requirements which can include:

- mentorship in the first years of practice;
- an interview with registrar staff;
- making efforts to provide non-pharmacological supports to patients;
- continuing education in addiction medicine (required hours vary across jurisdictions);
- undergoing a practice assessment;
- access to laboratory services and a pharmacy; and/or
- access and use of prescription monitoring programs (i.e., duplicate/triplicate forms, prescribing databases)

In Alberta and Saskatchewan, physicians must meet a different set of requirements depending on whether they wish to initiate methadone treatment, maintain methadone treatment, or provide temporary prescriptions. In Manitoba, New Brunswick, and Nova Scotia, nurse practitioners may apply for a s.56 exemption to prescribe methadone. Requirements for Yukon, Nunavut, and the Northwest Territories are not publicly available. Details of the specific requirements in each province are fully described in the forthcoming CRISM National Guideline for the Clinical Management of Opioid Use Disorder and are shown in Appendix 1 of this report.

Previously in hospital settings, practitioners who attended to patients already on methadone were required to obtain a temporary s.56 exemption. In March 2017, Health Canada issued a s.56 class exemption for all practitioners maintaining inpatients on methadone in hospitals, thereby removing the requirement for individual exemptions.

Changes have recently been made or are in process for treatment standards and s.56 exemption requirements in various provinces. For example, in British Columbia, the management of the methadone program has shifted from the College of Physicians and Surgeons of British Columbia to the British Columbia Centre on Substance Use, which has issued a new provincial guideline for opioid use disorder treatment and has dramatically scaled up and increased access to education and training. Alberta is in the process of developing a more consistent and structured preceptorship which can be accessed online (e-preceptorship), with an anticipated roll-out in early 2018. Saskatchewan recently updated their treatment standards and guidelines to include buprenorphine/naloxone. The treatment guideline for Québec is under revision by the Collège des médecins du Québec and the Ordre des pharmaciens du Québec and will include buprenorphine/naloxone in the new version. In addition, practitioners in Newfoundland have built a new education platform for methadone and buprenorphine/naloxone and are working with their regulatory College to classify it as an approved course option for fulfilling the provincial requirements.

Several provinces are developing regulatory pathways to authorize nurse practitioners to prescribe opioid agonist treatments. In British Columbia, standards for training and conditions for nurse practitioners to prescribe methadone have been developed, and these will come into effect in the near future. Similarly, Alberta plans to publish their methadone treatment guidelines for nurse practitioners in early 2018.

Monitoring and Diversion

Most provinces utilize some form of prescription drug monitoring, which is able to track if a patient is accessing the same medication from more than one prescriber or more than one pharmacy.[5,6] Some systems are designed with alert messaging features and are able to send real-time warnings to providers about potential misuse of controlled substances. Methadone and buprenorphine/naloxone prescriptions are currently monitored in British Columbia, Alberta, Saskatchewan, Ontario, New Brunswick, Nova Scotia, and Yukon. The Non-Insured Health Benefits program uses a prescription monitoring program which is also accessible to the First Nations Health Authority in British Columbia. Methadone, but not buprenorphine/naloxone, is tracked in Manitoba as well. Québec has an alert system, Programme Alerte, that is able to identify patients who are visiting multiple physicians or multiple pharmacies. Though not available in real-time, targeted and neighbouring pharmacies will receive a warning message about that patient. Other provinces have mandatory duplicate or triplicate prescription pads for controlled substances which are aimed at preventing diversion, forgeries, and alterations, though these activities are not equivalent to a prescription monitoring program. Prince Edward Island and Newfoundland and Labrador have recently committed to implementing provincial prescription monitoring programs, and stakeholders in Quebec have called for it as well.

In addition to prescription drug monitoring, many provinces have policies that are able to restrict certain patients to using a single pharmacy and/or a single prescriber for specific

medications (e.g., opioids, benzodiazepines, and stimulants). Further details on these programs and policies can be found in recent environmental scans.[5,6]

Data on diversion of methadone into the illicit market is difficult to collect, though some inferences can be made through toxicology reports for overdose-related deaths. Several provinces now conduct regular surveillance and tracking of overdoses and overdose-related deaths and perform toxicology analyses to identify the substances involved. The presence of methadone is reported in closed and certified cases in British Columbia, Saskatchewan, Manitoba, and Ontario. The most recent data available from these provinces indicate that methadone was detected in 9 - 24% of overdose deaths.[7-10] Reports from Alberta and New Brunswick do not isolate methadone in the toxicology results and data were not available for Québec, Nova Scotia, Newfoundland and Labrador, Prince Edward Island, and Yukon.

Consultation Process

Overview. In light of the current opioid crisis, the Minister of Health committed to engaging stakeholders to identify barriers to accessing treatment options for opioid use disorder. Health Canada enlisted the Canadian Research Initiative in Substance Misuse (CRISM), through its four regional Nodes, to lead a national consultation to determine whether the current exemption requirement for methadone prescribers poses an unnecessary barrier to methadone treatment provision and access. The recommendations resulting from this consultation process will inform Health Canada's future activities related to federal regulations for methadone and other steps to improve access to care.

Participants. Health Canada and CRISM jointly developed a stakeholder list, ensuring that regulatory bodies, P/T health departments or ministries, service providers, and people with lived experience were included. See Appendix 2 for the list of organizations that were contacted. Each of the four CRISM Nodes invited stakeholders from their respective regions to participate in the consultation via email. Of the 267 individuals that were contacted, a total of 145 participated in the consultation. Participants were located in all 13 P/T in Canada, and included federal-level stakeholders (Figure 1). Multiple types of participants provided input, with health practitioners making up the majority of the respondents (Figure 2). Those who selected the "Other" designation were academic researchers, advocates, consultants or advisors, and other types of health service staff.

Figure 1. Number of respondents by Province/Territory

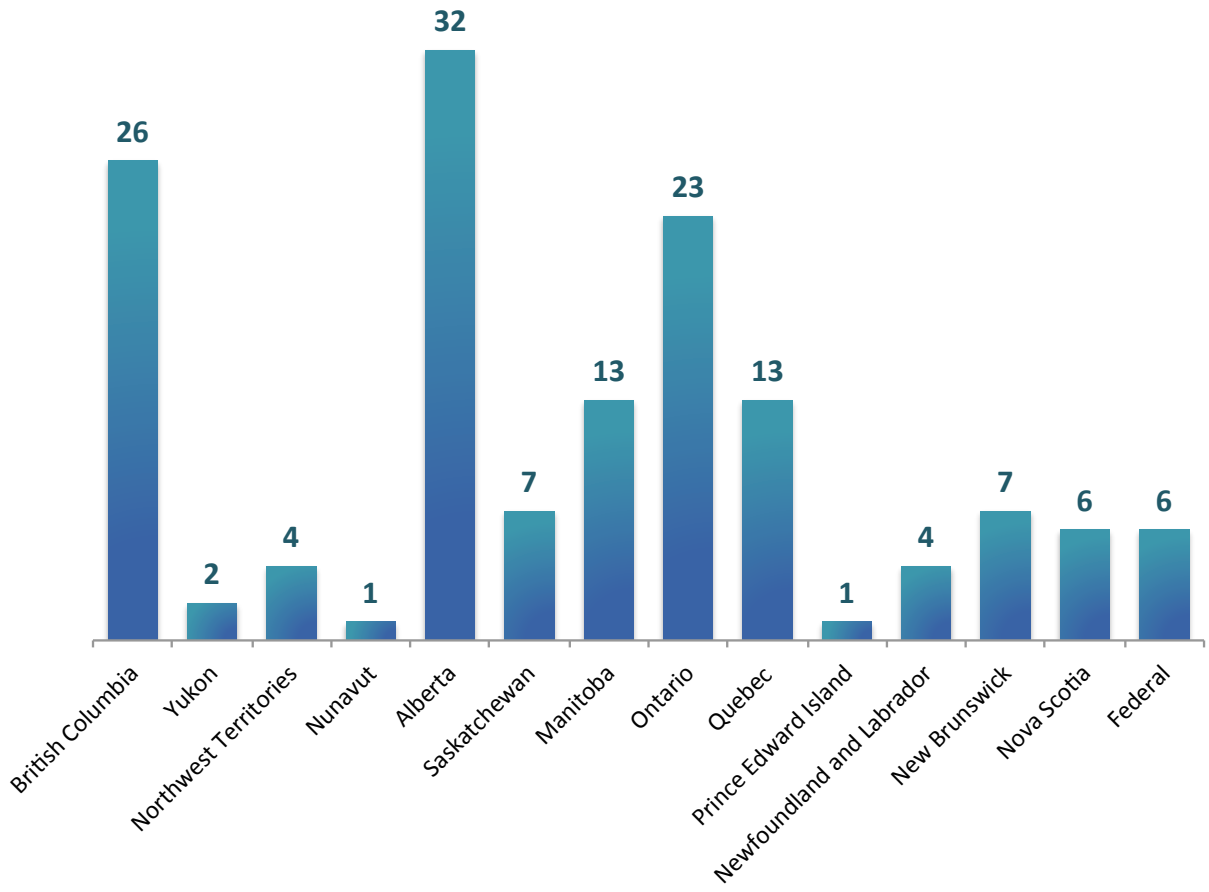
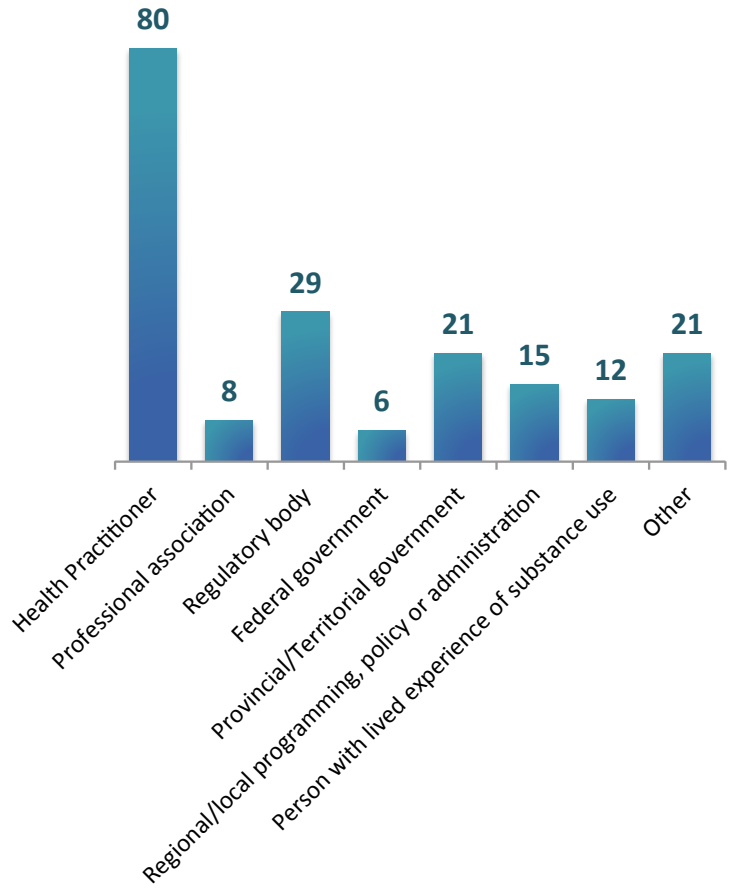


Figure 2. Number of respondents by type of profession or representation (multiple selections allowed)



Online survey. Health Canada and CRISM jointly developed an online survey, available in French and English, consisting of the following questions:

1. Do the Section 56 exemption requirements pose an administrative obstacle or barrier to treatment access for opioid use disorder in your jurisdiction? Please explain.

2. Please describe the potential benefits and repercussions of removing the federal requirement for methadone prescribing in your jurisdiction.

3. Do you have any other comments regarding the role of the federal government in barriers to access to medication-assisted treatments for opioid use disorder in your jurisdiction?

Survey responses were submitted as freeform text. The survey also asked participants for their name (optional), their region or jurisdiction, and their professional role. The survey was open to invited consultation participants from August 16 to October 23, 2017.

Analysis of online surveys. The content survey responses were analyzed manually by sorting freeform text into themes using a standardized coding structure. For question 1, responses were categorized as "yes", "no", or "undetermined." For question 2, responses were categorized as "benefits" or "repercussions." The accompanying explanations were categorized by identifying broad themes that appeared at least five times throughout all survey responses (e.g., insufficient number of prescribers). All responses were then coded independently by two research analysts. Codes were not mutually exclusive; response statements could be assigned to multiple codes as necessary. The analyses were merged and individual responses with discrepancies were re-coded by one of the analysts. The summary below describes the number of responses in each of the broad themes, along with explanatory statements. Codes that received less than eight responses (<5% of participants) were not included in this summary.

Follow-up teleconferences. Following the survey, each CRISM Node hosted one or more teleconference-based discussions with stakeholders in their regions. During these meetings, participants were given opportunities to provide additional feedback and comments about the s.56 process, discuss consequences that would result from maintaining or removing the s.56 exemption, and identify other regulatory challenges and barriers in their jurisdictions. Participants were asked directly if they would support the removal of the s.56 exemption requirement from federal legislation and to provide other recommendations for Health Canada related to access to care. Between September 12 and November 28, 2017, 12 teleconference discussions were held; these included 80 participants from most P/T in Canada (except for Yukon and Prince Edward Island). Each teleconference was attended by one or two CRISM staff who took comprehensive notes of the meeting.

Analysis of follow-up teleconferences. Teleconference discussion notes were compared with survey responses to identify themes that overlapped as well as new information. Overall, these discussions provided additional examples and context but did not identify new thematic categories. These examples, if mentioned by more than one province, are described below to provide clarity on experiences with methadone provision, but they were not quantified.

The most frequent types of suggestions or requests for moving forward with methadone regulation and access were consolidated into a main recommendation regarding the s.56 exemption and additional considerations to address barriers to care. Exemplary responses encompassing many of the recurring statements from the survey were selected and quoted below.

Results

Barriers posed by the s.56 exemption requirement

A substantial majority (110 responses) of respondents characterized the s.56 exemption process as a barrier or obstacle. Conversely, 31 participants did not view the s.56 exemption process as a barrier overall.

The most commonly cited (45 responses) type of barrier to methadone treatment was an insufficient number of care providers. Respondents explained that the existence of the exemption itself discourages many family physicians and general practitioners from applying, which limits the availability of methadone treatment to a relatively small number of qualified physicians. As a further consequence, methadone treatment is not well-integrated into primary care, which prevents access. The insufficient number of nurse practitioners who are licensed to prescribe methadone was also cited as a barrier by 10 survey responses and on seven of the regional teleconferences.

Methadone treatment access was characterized as particularly challenging in rural, remote, and Indigenous communities (18 responses). Within the wider context that these areas are under-resourced for health services, respondents explained that the lack of licensed prescribers and pharmacies located in or near these communities forces patients to travel long distances or relocate to receive their daily witnessed doses of methadone and to attend frequent follow-up appointments. The time and transportation logistics for patients living in rural and remote communities were described as being almost impossible to manage.

Nine survey respondents were concerned about the stigma that is caused or perpetuated by placing methadone treatment into a separate category that is outside of the general scope of practice. This stigma impacts both the providers, by identifying them as a methadone treatment provider, and the patients, who must seek a licensed provider instead of being able to receive care from their family physician.

Other barriers to treatment access that were frequently mentioned related to the administrative burden of applying for the exemption (33 responses) and the resulting delays to the patient for receiving care (18 responses). Participants described the bureaucratic requirements associated with the application as “rigid” and “discouraging” and commented that they needed administrative support to help manage the multiple application steps. Participants also expressed concern over the lag time between sending the application to Health Canada and receiving the exemption, stating that this wait causes an unnecessary delay for patients. A few responses (10) indicated dissatisfaction with the training requirements, noting the expense, burden, and time commitment required for completion, which can cause physicians to miss their normal clinic hours.

An additional finding from the online survey was that some participants (19 responses) *equated* the federal s.56 exemption process with the provincial requirements created by the regulatory Colleges. However, the majority of respondents seemed to understand the distinction between the provincial programs and the federal mandate. Acknowledging that the federal exemption is an administrative step, some responses (13) described s.56 as having “no added value” and simply a “rubber stamp.” Despite the understanding of the s.56 mandate, it was difficult to determine whether the barriers identified (e.g., paperwork and delays) were caused by the provincial or federal process, as the two are inextricably linked in their current form.

"I have not observed any value in the federal regulation. It is void of purpose; aside from being an artificial impediment to access. Governance of professional practices should be deferred to provincial Colleges mandated to govern regulated health professionals." -Survey respondent

Benefits to removal of s.56 exemption

Corresponding with the barriers and challenges described above, almost 70% of participants (100) viewed the removal of the s.56 exemption requirement as a beneficial step. A majority of participants (73) believed that the major benefit would be expanded access to methadone treatment due to an increased number of prescribers. Several of these comments highlighted the benefits of methadone treatment being provided in primary care; family physicians are abundant and accessible, thereby potentially decreasing wait times and increasing ease of access for patients. Moreover, a growing number of provinces allow nurses to prescribe methadone, which may be particularly impactful in rural areas where licensed methadone providers are sparse. Along the same lines, some respondents indicated that removing the s.56 exemption would "normalize" methadone and treat it similarly to other treatments for opioid use disorder (12 responses) and would serve to decrease the stigma attached to substance use treatment (21 responses).

"BENEFITS: I think that there would be less concern for practitioners to become involved in Opiate Agonist Therapy, that addiction management would have less stigma and be seen as more a part of mainstream medicine (just as depression and anxiety management are). It may be more easy to engage primary care physicians in this area of medicine, and the current crisis needs all physicians to be of some help." -Survey respondent

In addition, 20 survey respondents felt that reducing the administrative burdens and paperwork would be beneficial for both providers and patients, as this would lead to simplification of the process and remove the delays in providing treatment. Consistent with this suggestion, several provincial regulatory Colleges have already resolved the issue of the delay between the time the provider's application is sent to Health Canada and the receipt of the exemption certificate by authorizing the provider to prescribe methadone as soon as requirements are completed.

Confirming evidence for the results reported above was obtained during the follow-up teleconference meetings. Specifically, meeting participants from several provinces described the s.56 exemption as an unneeded step and stated that they intended to keep training requirements and regulatory mechanisms in place if the s.56 exemption was eliminated (only the Northwest Territories anticipated that they may recommend, but not require, prescribers to obtain education). In this scenario, education, monitoring, and prescribing regulations may still be controlled by the P/T Colleges or other regional authorities in the provinces where such mechanisms already exist. Teleconference participants from most P/T supported the

elimination of the s.56 exemption requirement, while some were indifferent, on their interpretation that this would not impact current oversight practices.

Participants from Ontario were an exception, highlighting that the regulatory College does not monitor or oversee prescribing physicians. Thus, if s.56 did not exist, the College of Physicians and Surgeons would have difficulty enforcing the educational requirements and would need to establish new mechanisms to regulate methadone prescribing. As such, most Ontario teleconference participants did not support the removal of the s.56 exemption without additional mechanisms to provide training and ensure safety due to the potential risks of inappropriate prescribing and patient harms that may occur if untrained physicians gain access to methadone provision. Furthermore, participants from Québec explained that regulatory bodies do not currently have a surveillance and monitoring system for methadone prescribers but they would encourage this development if s.56 was eliminated.

> *"Methadone is a highly dangerous medication, and its use by those who are not well-versed with its risks and benefits poses enormous risks to patients and the population in general. The federal requirement is unhelpful and redundant, BUT a local authorization (through the College of Physicians and Surgeons or similar bodies) is definitely necessary." -Survey respondent*

Potential repercussions from removal of s.56 exemption

Several of the participants (32) noted the potential for both benefits and negative repercussions, while an additional 20 people commented only on the possible negative outcomes following removal of the s.56 exemption requirement. The most common repercussions identified by these responses were the risks of diversion and harms such as overdose and death (26) and the potential for lower quality of care and providers not adhering to guidelines and standards of practice for methadone treatment (22). These participants noted that the negative outcomes could result if a large number of providers begin prescribing methadone without adequate training and a proper understanding of its pharmacodynamics and common patient care challenges. However, concerns about inappropriate prescribing and monitoring would be mitigated if training and oversight remained mandatory. Indeed, given the potential to improve training and oversight, the removal of the s.56 requirement could be accompanied by federal guidance and support for provincial efforts in this area. As mentioned above, representatives of P/T Colleges from many provinces stated that they would retain the existing regulatory procedures for methadone through the ability to authorize prescribers and therefore, these increased risks are not likely to occur.

> *"The only argument to keeping the exemption is the recognition that methadone is a toxic drug that is a leading cause of opioid overdose death in [redacted]. However, provincial oversight of all opioid prescribing over a certain threshold would mitigate this potential harm, along with the requirement that, like all prescribing, the methadone provider should ensure competency to prescribe the medication." -Survey respondent*

Additional barriers to methadone treatment

Through the survey and teleconferences, participants highlighted other barriers to methadone treatment that are not directly related to the s.56 exemption. The rigid structure for daily witnessing and allowance of take-home carries was cited by ten survey participants and by teleconference participants in six jurisdictions as a major impediment for patients. As noted earlier, the requirement to travel to a pharmacy daily places a large burden on patients, especially in rural and remote communities. Alternative delivery and witnessing models were suggested, including allowing delegates or nurse practitioners to deliver the methadone dose and/or witness the dose. This would require changes to the existing federal and provincial regulations that currently limit who can provide these services (i.e., only physicians and pharmacists). Moreover, ten survey participants noted particularly large challenges that Indigenous communities face in accessing treatment, which result from the distance between the community and a pharmacy or physician, the insufficient support for daily travel, the disconnect between the physician and the community's governance, lack of cultural safety training, and inadequate facilities for the safe storage of take-home doses. Some called for the federal government to address these types of barriers to methadone treatment delivery and work to improve access in rural, remote, and First Nations communities, as current regulations create impediments to providing appropriate and accessible services for these patients. Furthermore, participants noted that buprenorphine is less stringent in the requirements for take-home dosing; greater access to and uptake of this medication would ease some of the barriers to treatment.

In addition, 13 survey responses and additional teleconference participants mentioned that sufficient resources and funding to provide opioid agonist treatment services are not available. Examples of needed improvements include: physician billing codes that allow the physician to spend an adequate amount of time with each patient and to administer screenings and other tests; support and mentorship through a prescriber network or consultation service; resources and staffing to provide comprehensive, wrap-around care; financial support for taking the required methadone courses and additional training in non-pharmacological approaches; and funding or coverage for the medications.

Other considerations

One-third of survey participants (48) agreed that training and education on the safe provision of methadone treatment are needed before a provider begins prescribing, due to its unique pharmacodynamics and vulnerabilities that are common in patients with opioid use disorder. Specifically, the long half-life creates challenges for titration to an effective dose and therefore, methadone must be initiated and monitored carefully to avoid the relatively high risk of overdose and death during the induction phase. The narrow therapeutic window conveys high risks for patients and opioid-naïve persons, leading many to feel that prescriber training, regulation, and oversight are necessary for patient safety. Participants recommended that regulatory authority remain with the P/T Colleges, rather than the federal government, as the P/T bodies are best positioned to manage and respond to their own regional needs.

Eighteen survey responses and participants in five regional teleconferences suggested that the federal government could have a role in ensuring that the training, education, and standards and guidelines for practice are consistent across Canada. Currently, the training requirements vary considerably by P/T, as do the standards for dosing and take-home scheduling. Participants felt that physicians and patients would benefit from standardization of these practices, though these efforts would need to be led by P/T regulatory bodies.

Another theme identified from the data sources was the illogical and hypocritical nature of having a federal exemption for methadone, while similar policies do not exist for other opioid medications (24 responses). Some of these responses explained further that singling out methadone treatment in this way "perpetuates stereotypes around patients" and "sets an expectation that patients requiring methadone are of greater complexity." Survey and teleconference participants explained that other available medications can be dangerous to patients and do not require training or education in order to prescribe them. However, while the standard education received during the stages of general medical training presumably covers the safe use and management of such medications, education on opioids and other treatments for substance use is particularly lacking. Some called for more comprehensive addiction medicine training to be included in medical curricula, which could be included in residency training programs and through the development of interdisciplinary fellowships.

> *"It remains unclear at this time what benefit comes from having the exemption requirement in place especially when it only involves methadone and is not required for other OAT options." -Survey respondent*

Lastly, participants suggested that the federal government address barriers to accessing other treatments for opioid use disorder (21), including buprenorphine and injectable forms of opioid agonist treatment, such as diacetylmorphine and hydromorphone. For buprenorphine, one barrier to access in certain provinces is the requirement to obtain a methadone exemption in order to prescribe buprenorphine.

Recommendation and additional considerations

Based on the input received from the survey and the teleconferences, the following suggestions for Health Canada were developed to increase access to methadone and other forms of treatment for opioid use disorder:

Main Recommendation: Consider eliminating the requirement for practitioners to obtain a s.56 exemption and support regional authorities in regulating authorization and monitoring prescriptions.

At the federal level, this would normalize the regulation of methadone, treating it similarly (from a regulatory perspective) to other opioid medications. As some P/T do not have a robust regulatory oversight system in place already, Health Canada could support those jurisdictions by providing guidance around surveillance and monitoring systems.

Additional considerations to improve access to high-quality care:

Support P/T in adopting evidence-based and accessible training, guidelines, and standards of practice for methadone prescribing.

Health Canada could support P/T in setting a minimum standard for training and education to prescribe methadone, help ensure that training is evidence-based, and promote accessibility of educational resources. Health Canada could support or help facilitate consultations with P/T stakeholders to discuss improving consistency in the required coursework and prescribing guidelines across Canada.

Support increased access to all evidence-based opioid agonist therapies.

Some provinces (Saskatchewan and Manitoba) require a s.56 exemption in order to prescribe buprenorphine, an opioid agonist therapy with a superior safety profile compared to methadone, allowing take-home dosing for buprenorphine to be more flexible and started earlier than methadone. Removing the restrictions on buprenorphine would increase access to treatment by allowing a greater number of primary care physicians to prescribe this medication and by easing the travel and witnessing burdens on patients. As a major step towards increasing treatment access and improving safety, the forthcoming CRISM National Guideline for the Clinical Management of Opioid Use Disorder recommends buprenorphine as the preferred first-line therapy. In addition, barriers to access and restrictions on other forms of opioid agonist therapies (including diacetylmorphine and hydromorphone) has led to major gaps in care, especially for patients who were not successful with methadone or buprenorphine. Health Canada could support the removal of such barriers in order to make these treatments more widely available.

Support the development of education and regulatory pathways to allow nurse practitioners to prescribe methadone.

Health Canada could encourage and help facilitate the nursing regulatory bodies and relevant educational structures to develop application processes and evidence-based education for nurses to prescribe opioid agonist therapies. Increasing the scope of practice for nurses with the appropriate training and competencies would greatly improve access to treatment for patients with opioid use disorder.

Address barriers to access in rural, remote, and Indigenous communities.

While the s.56 exemption may pose some barriers to potential methadone prescribers (contributing to limited access to methadone), the lack of resources and services present major challenges in rural and remote areas, including Indigenous communities. Access to opioid agonist

treatment in these areas can be facilitated through alternative delivery models. Health Canada should facilitate policy changes federally and in each P/T to allow for safe delivery and witnessing models, performed by nurses or delegates that can improve access while also limiting the potential for diversion. In Ontario, a delivery model where the pharmacist may transfer custody of individual doses to a physician delegate for subsequent administration to the patient is being piloted, and would serve to benefit other regions if similar programs were adopted. In addition, support for telehealth and mobile services would alleviate time and cost burdens associated with traveling great distances to the nearest prescriber. Finally, supports for the safe storage and handling of methadone and buprenorphine in Indigenous communities are needed in order to facilitate take-home dosing.

Support access to high-quality care by providing resources for prescribers and patients.

Providers urged Health Canada to support the development of provincial networks to improve access to knowledge for those providing care to patients with substance use disorder. These networks are critical for mentorship and providing consultation for challenging activities (e.g., buprenorphine induction) or cases. Building a community of practice promotes consistency and elevates standards of care. Further, resources and staffing are needed to promote medication coverage for patients, to allow comprehensive, wrap-around care, and to participate in training.

Summary

With the growing numbers of persons with opioid disorder in Canada, the demand for evidence-based treatment and access to services is increasing. Thus, all jurisdictions need to expand access to evidence-based treatments for opioid use disorder and address barriers faced by health care providers and patients. Historically, methadone treatment has been subject to federal regulation since the 1960's and is currently restricted to prescribers who hold a section 56 exemption under the *Controlled Drugs and Substances Act*. Canadian provinces and territories are responsible for the oversight and monitoring of methadone treatment and have either developed or adopted educational modules and training requirements to support prescribers in the safe use and delivery of methadone treatment. Many consultation participants from all regions felt that appropriate and accessible training is invaluable in order to prevent harms from unsafe prescribing such as overdose and death. Participants stated that the potential for diversion and misuse of methadone should be balanced with the need to provide effective and accessible treatment. Thus, participants from most provinces and territories supported the removal of the section 56 exemption due its administrative burden and lack of added value, under the conditions that the mandate for training, monitoring, and surveillance programs remain or be created through regional authorities.

Through this consultation, participants recommended additional steps for removing barriers and improving access to high-quality opioid addiction care. Supporting evidence-based education and prescribing standards would improve quality of care and promote consistency in practice. In addition, regulations that create barriers to all opioid agonist therapies should be reviewed, including the requirement in certain provinces for a s.56 exemption to prescribe buprenorphine and restrictions on providing diacetylmorphine and hydromorphone. Support for nurses to provide addiction care through the development of training resources and regulatory pathways to authorize prescribing would increase the number of care providers accessible to the patient population. Furthermore, residents of under-resourced areas, such as rural, remote, and Indigenous communities, face substantial challenges in obtaining methadone treatment. Alternative delivery and administration models, through nurses or other delegates, would serve to ease the burdens of these patients who are located far from physicians and pharmacies. Finally, providers expressed the need for increased support for providing comprehensive care and for mentorship from experienced prescribers, through staffing, funding for training, and consult services, in order to improve their own practices and ensure patient safety. Overall, the suggestions provided by participants across Canada are designed to balance the need for patient safety and the need for accessibility.

Appendix 1: Provincial educational and training requirements to prescribe methadone and buprenorphine for opioid use disorder

Methadone

For **all provinces**, the requirements to obtain and maintain authorization to prescribe methadone for opioid use disorder are:

- Licensed to practice medicine and in good standing with the provincial regulatory college
- Where applicable, licensed as nurse practitioner and in good standing with the provincial regulatory college
- Obtained a Section 56 methadone exemption from Health Canada, and have the exemption endorsed by the provincial regulatory college
    - In Quebec, British Columbia, Alberta, Manitoba, and Ontario, practitioners may obtain a methadone exemption by contacting their provincial licensing authority directly
    - The initial exemption is issued for one year, with subsequent exemptions issued every three years

Province*	Education and Practice Requirements
British Columbia	• Completion of an eight-hour online course (includes both Mainpro+ and MOC CME credits) through the Provincial Opioid Addiction Treatment Support Program, hosted by the BC Centre on Substance Use (BCCSU) • Two half-days of preceptorship, or additional learning as needed (with BCCSU-approved preceptor) • If Methadone 101 has been previously completed through the College of Physicians and Surgeons of B.C., but physician has not yet completed a preceptorship, or has completed educational requirements in another province or jurisdiction, they may contact the BCCSU for guidance • A temporary methadone exemption (valid for 60 days, non-renewable) may be obtained through completion of specific modules of the online course and PharmaNet review

Alberta	• Completion of Methadone Maintenance Treatment (MMT) workshop or course
	recognized by the CPSA
	• Experience in an Opioid Dependency Program (ODP) setting or evidence of appropriate post-graduate training
	• Standards for initiating physicians:
	  ○ Complete a period of direct training, supervision and mentorship with an experienced, CPSA-approved Initiating Physician until approved as competent in MMT
	  ○ Show documentation of clinical competence
	  ○ Document ongoing education relevant to MMT that is acceptable to the CPSA, e.g.:
	  ▪ Completion of a recognized course on the fundamentals of addiction medicine within two years of acquiring methadone exemption
	  ▪ Minimum of 40 hours of formal Continuing Medical Education (CME) in some aspect of addiction medicine every five years (time spent at a recognized MMT workshop/course qualifies)
	  ▪ Equivalent education acceptable to the Council of the CPSA
	  ○ Must have access to laboratory services and a pharmacy
	  ○ Must collaborate with maintaining physicians of former patients and pharmacists dispensing to current patients
	  ○ Make reasonable efforts to provide non-pharmacological support to patients (e.g., pharmacy, addiction services, counselling)
	• To maintain methadone treatment for a patient stabilized by a specialist, must submit a letter of support from the initiating physician with application for a methadone exemption
	• Standards for maintaining physicians:
	  ○ Maintain an ongoing association with an experienced Initiating Physician
	  ○ Have an understanding of methadone pharmacology and, in addition to the MMT workshop/course, attend the original MMT workshop/course or another approved educational course relevant to addiction medicine, within five years of acquiring a methadone exemption
	  ○ Must collaborate with initiating physician and other healthcare providers (e.g., pharmacist, counsellor, laboratory)
	• Standards for both initiating and maintaining physicians:
	  ○ An interview with the registrar of the CPSA or his/her designate may be required
	  ○ If going away or suspending their practice, must ensure the patient receives continued care from another physician trained in MMT
	  ○ Must access prescribing databases, including the Triplicate Prescription Program (TPP) and/or Netcare
	• Requirements for temporary prescribing physicians in hospitals and corrections: Please see *Alberta MMT Standards and Guidelines*

Saskatchewan	*Similar to education and practice requirements for Alberta, with the following distinctions:* • Initiating physicians must complete two days of direct training • Initiating physicians must have mentorship and support from an established methadone prescriber during the first two years of practice • Initiating physicians must document a minimum of 30 hours of formal CME in addiction medicine every five years • New methadone prescribers will be limited to a maximum of 50 patients until the first audit • Must access the Pharmaceutical Information Program (PIP) Viewer prescribing database • Requirements for temporary prescribing physicians in hospitals and corrections: Please see *Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence,* available from the CPSS.
Manitoba	• Completion of provincial Opioid Replacement Therapy Methadone 101 course, two-day addiction and methadone training course in Ontario, or online CAMH Opioid Dependence Treatment Core Course • Alternative training programs, such as a six- to eight-hour review of assessment and guidelines with an experienced addiction medicine certified methadone provider, may be considered with prior approval from the CPSM • Completion of several supervised shifts in a methadone/buprenorphine clinic (minimum of four half days) • Alternatively, extensive experience in methadone/buprenorphine addiction practice in another province may fulfill requirements, if discussed with the CPSM registrar *Note: in Manitoba, nurse practitioners may also obtain an exemption to prescribe methadone if they fulfill the requirements below:* • Must maintain prescribing authority for controlled drugs and substances • Attend Opioid Replacement Therapy 101 course • Complete minimum of four half-days training with experienced methadone provider • Must apply for and receive a methadone exemption from Health Canada Before the Section 56 exemption period expires, practitioners must submit a renewal application specifying education and practice completed to maintain methadone prescribing competency
Ontario	• Must complete an application form and agree to practice in accordance with the CPSO's expectation document (available from the CPSO) • Complete the CAMH Opioid Dependence Treatment Core Course • Complete two days of clinical training with a MMT physician approved by the CPSO *Nurse practitioners must complete approved education for controlled substances and may only prescribe methadone on a continuation basis, only in hospital*

	settings
Quebec	• Must complete and submit an application form for methadone exemption to the Collège des médecins du Québec (CMQ) • Must attend a one-day professional development program accredited by the continuing education department of the University of Montreal and provided by L'Institut National de Santé Publique du Québec • In the application to the CMQ, must name a mentor willing to support the physician if necessary
New Brunswick	• Participation in a formal in-person training program deemed appropriate by the CPSNB • Alternative training programs or a mentorship from an experienced prescriber may be considered with prior approval • Must demonstrate completion of additional training in addiction medicine every five years *Nurse practitioners:* • Must maintain prescribing authority for controlled drugs and substances
Nova Scotia	• Complete an application form and agree to practice in accordance with the *CPSNS Methadone Maintenance Treatment Handbook* • Successfully complete the CAMH Opioid Dependence Treatment Core Course or equivalent approved course • Complete eight hours of clinical training with a MMT physician approved by the CPSNS • Within each three-year renewal cycle, must have a practice review conducted by an experienced MMT prescriber • Within three years of receiving exemption, complete the Opioid Dependence Treatment Certificate Program • Must access the PMP prescribing database *Nurse practitioners:* • Must meet CRNNS requirements and standards to prescribe controlled drugs and substances • Follow requirements above for practicing according to guidelines, initial coursework, and clinical training • Must apply for and receive a methadone exemption from Health Canada
Prince Edward Island	• Agree to participate in practice review(s) if required by the CPSPEI • Complete a Methadone Maintenance Treatment workshop/course recognized by the CPSPEI • Complete the CPSPEI Commitment Form • Maintain an ongoing association with an experienced physician who has been prescribing MMT for at least two years • Complete ongoing education relevant to MMT, including: ○ A recognized course on the fundamentals of addiction medicine

	within two years of acquiring a methadone exemption ○ Minimum 20 hours of formal CME in some aspect of addiction medicine every five years (MMT workshop or course qualifies) or equivalent acceptable to the CPSPEI • Review the CPSO Methadone Maintenance Guidelines
Newfoundland and Labrador	• Complete an application form and agree to practice in accordance with the CPNSL's expectation document • Successfully complete the CAMH Opioid Dependence Treatment Core Course • Complete two days of clinical training with a MMT physician approved by the CPSNL • Within three years of receiving exemption, complete the Opioid Dependence Treatment Certificate Program

Buprenorphine/naloxone

Province	Education and Practice Requirements
British Columbia	• **The practitioner does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder, but completion of the buprenorphine/naloxone training modules of the BCCSU Provincial Opioid Addiction Treatment Support Program course are strongly recommended, in addition to consultation via the RACE line for additional expert support *Nurse practitioners:* • **NPs are currently limited to continuation prescribing only (subject to change in fall 2017)** • NPs must complete additional education and a preceptorship of a minimum of two half-days' length, under the guidance of a practitioner with expertise in the prescribing of buprenorphine/naloxone and treatment of clients with substance use disorders, and with a license to prescribe methadone • The preceptorship needs to cover the competencies associated with initiation, dosing, writing prescriptions, urine drug testing, carry policy, counselling and documentation
Alberta	• **The practitioner does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Current recommendations** for *physician* prescribing of buprenorphine/naloxone for opioid use disorder: ○ Completion of accredited buprenorphine course (www.suboxonetrainingprogram.ca [formerly known as www.suboxonecme.ca], CAMH Opioid Dependence Treatment Core

	Course, or other equivalent course approved by CPSA); must submit proof of course completion to the CPSA ○ Must be registered to prescribe TPP drugs ○ Initiating physicians must have experience in treating opioid use disorder (postgraduate training, ODT experience, professional certification with CSAM/ASAM, or equivalent approved by CPSA) ○ Physicians providing maintenance treatment must have a relationship with a physician experienced in treating opioid use disorder (i.e., a qualified initiating physician) ○ Temporary buprenorphine-prescribing physicians (i.e., in hospital or incarceration environments) will be permitted to maintain a buprenorphine dose without completion of a buprenorphine prescribing course. A temporary prescribing physician must have a relationship with a physician experienced in treatment of OUD and consult with an experienced physician regarding any dose changes *Nurse practitioners:* • Must complete requirements for prescribing controlled drugs and substances (CDS) ○ Must complete a CDS educational module recognized by CARNA OR have graduated after September 2015, and complete the CARNA CDS jurisprudence module. • Prescribe using the TPP • Complete an approved buprenorphine/naloxone prescribing course • Initiating nurses must complete four half-days of preceptorship with a physician or nurse practitioner experienced in treatment of OUD • Maintaining nurses must complete two half-days of preceptorship with a physician or nurse practitioner experienced in treatment of OUD • Temporary prescribing is permitted for maintaining the same dose without completion of a buprenorphine/naloxone prescribing course. Temporary prescribers must have a relationship with a physician or nurse practitioner experienced in treatment of OUD and consult with them for any dose changes. • Prescribing methadone or buprenorphine for opioid use disorder requires special authorization and has further requirements
Saskatchewan	• **The physician must hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder or **have spent a minimum of one day with another physician who has received an exemption from Health Canada** to prescribe methadone and is experienced in prescribing buprenorphine • **Additional requirements** for prescribing buprenorphine/naloxone for opioid use disorder: ○ Completion of an approved educational buprenorphine prescribing program ○ Completion of a CME program which includes a minimum of six hours of training in addiction medicine every two years ○ Must have a relationship with one or more addictions counsellors

	and one or more pharmacists, and regularly test patients for non-medical or illegal drug use ○ Must have access to the PIP to monitor other prescriptions ○ Must prescribe using the physician's personalized prescription pad or CPSS-approved electronic prescribing ○ Must agree to and cooperate with audits by the College ○ Requirements for temporary prescribing physicians in hospitals and corrections: Please see *Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence*, available from the CPSS
Manitoba	• **The physician must hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Additional requirements** for prescribing buprenorphine/naloxone for opioid use disorder include: ○ Completion of online buprenorphine/naloxone education program (i.e., www.suboxonetrainingprogram.ca) *Nurse practitioners:* • Must maintain prescribing authority for controlled drugs and substances • Complete the online www.suboxonetrainingprogram.ca program
Ontario	• **The physician does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Current recommendations** for prescribing buprenorphine/naloxone- for opioid use disorder: ○ Completion of CAMH Opioid Dependence Treatment Core Course ○ Completion of CAMH Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians ○ Ongoing continuing education (e.g., online buprenorphine/naloxone education program: www.suboxonetrainingprogram.ca) ○ A one-day clinical observership of an opioid-dependency practice *Nurse practitioners:* • Must complete approved education for controlled drugs and substances
Quebec	• **The physician does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Current requirements** for prescribing buprenorphine/naloxone for opioid use disorder: ○ For physicians licensed to prescribe methadone with sufficient experience monitoring opioid dependence (at least 10 patients), completion of online buprenorphine/naloxone education program [e.g., www.suboxonetrainingprogram.ca or Institut national de santé publique du Québec (INSPQ) one-day course] ○ For physicians new to treating opioid use disorder, completion of a one-day professional development program accredited by the continuing education department of the University of Montreal and

	provided by L'Institut National de Santé Publique du Québec

New Brunswick	• **The practitioner does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder
	• **Current recommendations** for prescribing buprenorphine/naloxone for opioid use disorder:
	  ○ Completion of training deemed appropriate by the CPSNB
	  ○ Evidence of buprenorphine/naloxone training may be requested by the CPSNB
	Nurse practitioners:
	• Must maintain prescribing authority for controlled drugs and substances

Nova Scotia	• **The practitioner does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder
	• **Current recommendations** for physician prescribing of buprenorphine/naloxone for opioid use disorder:
	  ○ Completion of CAMH Opioid Dependence Treatment Core Course
	  ○ Completion of CAMH course: CAMH Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians
	  ○ Familiarity with the individual patient factors to be taken into consideration in the choice of buprenorphine for opioid dependence as an OAT
	  ○ Familiarity with the CAMH buprenorphine/naloxone practice guidelines
	Nurse practitioners:
	• Must meet CRNNS requirements and standards to prescribe controlled drugs and substances
	• Must possess the knowledge, skill and ability to prescribe buprenorphine/naloxone (i.e., seeking and completing a buprenorphine/naloxone education course)
	• The medication must be required for the client population treated by the nurse practitioner
	• Recommended completion of the CAMH course: Buprenorphine-Assisted Treatment of Opioid Dependence: An Online Course for Front-Line Clinicians
	• Formal or informal consultation with a prescriber experienced in the use of buprenorphine/naloxone is strongly recommended.
	• No provincial exemption is required to prescribe buprenorphine/naloxone, however, individual districts' health authorities may set and enforce policies for prescribing

Prince Edward Island	• **The physician does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Current requirements** for prescribing buprenorphine/naloxone for OUD: ○ Completion of online buprenorphine/naloxone education program: (i.e., www.suboxonetrainingprogram.ca)

	○ Completion of a recognized course on the fundamentals of addiction medicine within first two years of commencing prescribing ○ Completion of a minimum of 20 hours of formal CME in some aspect of addiction medicine every five years or equivalent training approved by the CPSPEI ○ Completion of "Commitment by Physicians who Undertake Buprenorphine Treatment for Opioid Dependency" form
Newfoundland and Labrador	• **The physician does not need to hold a methadone exemption** to prescribe buprenorphine/naloxone for opioid use disorder • **Current requirements** for prescribing buprenorphine/naloxone for opioid use disorder: ○ Completion of CAMH Opioid Dependence Treatment Core Course or equivalent program approved by the CPSNL ○ Completion of an educational program on prescribing buprenorphine (i.e., www.suboxonetrainingprogram.ca) ○ Establishment of a program for the regular testing of patients receiving buprenorphine for drugs of possible abuse ○ Participation in ongoing continuing medical education (CME) in opioid-dependence treatment and/or addiction medicine

**Note: Information was not available for Yukon, Northwest Territories, or Nunavut*

Appendix 2: List of organizations contacted

Organization	Region
ACT Medical Clinics	Alberta
Alberta Addicts Who Educate And Advocate Responsibly	Alberta
Alberta College of Pharmacists	Alberta
Alberta Dental Association and College	Alberta
Alberta Health	Alberta
Alberta Health Services	Alberta
Alberta Medical Association	Alberta
Boyle McCauley Health Centre	Alberta
Calgary Urban Project Society	Alberta
College and Association of Registered Nurses of Alberta	Alberta
College of Physicians and Surgeons of Alberta	Alberta
Health Upwardly Mobile	Alberta
HIV Community Link	Alberta
Inner City Health and Wellness Program	Alberta
Opioid Dependency Program	Alberta
Safeworks	Alberta
Streetworks	Alberta
The Addiction Recovery & Community Health Team	Alberta
University of Alberta	Alberta
AIDS Network Kootenay Outreach and Support Society / Rural Empowered Drug Users Network	British Columbia
BC Association of People on Methadone	British Columbia
British Columbia Centre on Substance Use	British Columbia
British Columbia Ministry of Health	British Columbia
British Columbia Nurse Practitioner Association	British Columbia
British Columbia Pharmacy Association	British Columbia
Centre for Addictions Research of British Columbia	British Columbia
College of Pharmacists of British Columbia	British Columbia
College of Physicians and Surgeons of British Columbia	British Columbia
College of Registered Nurses of British Columbia	British Columbia
Doctors of British Columbia	British Columbia
First Nations Health Authority	British Columbia
Fraser Health Authority	British Columbia
Interior Health Authority	British Columbia
Island Health Authority	British Columbia
Northern Health Authority	British Columbia
Portland Hotel Society	British Columbia

Providence Health Care	British Columbia
Surrey Area Network of Drug Users	British Columbia
Vancouver Area Network of Drug Users	British Columbia
Vancouver Coastal Health Authority	British Columbia
Western Aboriginal Harm Reduction Society	British Columbia
595 Prevention Team / Manitoba Harm Reduction Network	Manitoba
Addictions Foundation of Manitoba	Manitoba
College of Pharmacists of Manitoba	Manitoba
College of Physicians and Surgeons of Manitoba	Manitoba
College of Registered Nurses of Manitoba	Manitoba
Manitoba Area Network of Drug Users	Manitoba
Manitoba Dental Association	Manitoba
Manitoba Health, Seniors and Active Living	Manitoba
Northern Region Health Authority	Manitoba
Winnipeg Regional Health Authority	Manitoba
Assembly of First Nations	National
Canadian Association of People Who Use Drugs	National
Canadian Indigenous Nurses Association	National
Correctional Service Canada	National
Department of National Defense	National
Health Canada, First Nations and Inuit Health Branch	National
Indigenous Physician Association of Canada	National
Inuit Tapiriit Kanatami	National
Moms Stop the Harm	National
moms united and mandated to saving Drug Users	National
Thunderbird Partnership Foundation	National
Veterans Affairs Canada	National
College of Physicians and Surgeons of New Brunswick	New Brunswick
Department of Health	New Brunswick
New Brunswick College of Pharmacists	New Brunswick
Nurses Association of New Brunswick	New Brunswick
St. John Regional Hospital	New Brunswick
College of Physicians and Surgeons of Newfoundland	Newfoundland and Labrador
Department of Health and Community Services	Newfoundland and Labrador
Eastern Health Authority	Newfoundland and Labrador
Newfoundland and Labrador Pharmacy Board	Newfoundland and Labrador
Government of Northwest Territories, Health and Social Services	Northwest Territories
Yellowknife Primary Care Clinic	Northwest Territories
College of Physicians and Surgeons of Nova Scotia	Nova Scotia
College of Registered Nurses of Nova Scotia	Nova Scotia

Halifax Area Network of Drug Using People	Nova Scotia
Nova Scotia College of Pharmacists	Nova Scotia
Nova Scotia Department of Health and Wellness	Nova Scotia
Nova Scotia Health Authority	Nova Scotia
Government of Nunavut, Department of Health	Nunavut
Addictions and Mental Health Ontario	Ontario
Centre for Addiction and Mental Health	Ontario
Centre for Addiction and Mental Health: Strengthening Your Voice	Ontario
College of Nurses of Ontario	Ontario
College of Physicians and Surgeons of Ontario	Ontario
Drug User Advocacy League	Ontario
Health Quality Ontario	Ontario
Nurse Practitioners' Association of Ontario	Ontario
Ontario College of Family Physicians (OCFP)	Ontario
Ontario College of Pharmacists	Ontario
Ontario Drug Policy Research Centre	Ontario
Ontario Medical Association	Ontario
Ontario Ministry of Health and Long-Term Care	Ontario
Participatory Research in Ottawa: Understanding Drugs	Ontario
Public Health Ontario	Ontario
Registered Nurses Association of Ontario	Ontario
Royal College of Dental Surgeons of Ontario	Ontario
Sandy Hill Community Health Centre	Ontario
Sioux Lookout Meno Ya Win Health Centre	Ontario
St. Joseph's Health Centre	Ontario
St. Michael's Hospital	Ontario
Toronto Drug Users Union	Ontario
University of Toronto	Ontario
Women's College Hospital	Ontario
Health Prince Edward Island	Prince Edward Island
Prince Edward Island College of Pharmacists	Prince Edward Island
Association québécoise de la douleur chronique	Quebec
Association québécoise pour la promotion de la santé des personnes utilisatrices de drogues	Quebec
Collège des médecins du Québec	Quebec
Comité des usagers du Centre de réadaptation en dépendance de Montréal - Institut universitaire	Quebec
Direction régionale de santé publique du Centre-Sud-de-l'Île-de-Montréal	Quebec
Meta d'Ame	Quebec
Ministère de la Santé et des Services sociaux du Québec	Quebec

Ordre des dentistes du Québec	Quebec
Ordre des infirmières et des infirmiers du Québec	Quebec
Ordre des pharmaciens du Québec	Quebec
Université de Montréal	Quebec
College of Dental Surgeons of Saskatchewan	Saskatchewan
College of Physicians and Surgeons of Saskatchewan	Saskatchewan
Saskatchewan College of Pharmacy Professionals	Saskatchewan
Saskatchewan Ministry of Health	Saskatchewan
Saskatchewan Registered Nurses Association	Saskatchewan
Saskatoon Health Region	Saskatchewan
Substance Abuse Services Center	Saskatchewan
University of Saskatchewan	Saskatchewan
Government of Yukon, Health and Social Services	Yukon
Government of Yukon, Tourism and Culture	Yukon
Government of Yukon, Yukon Medical Council	Yukon

References

1. Fischer B. Prescriptions, power and politics: the turbulent history of methadone maintenance in Canada. *J Public Health Policy.* 2000;21(2):187-210.
2. Strike CJ, Urbanoski K, Fischer B, Marsh DC, Millson M. Policy changes and the methadone maintenance treatment system for opioid dependence in Ontario, 1996 to 2001. *J Addict Dis.* 2005;24(1):39-51.
3. Luce J, Strike C. A Cross-Canada Scan of Methadone Maintenance Treatment Policy Developments: A Report Prepared for the Canadian Executive Council on Addictions. *Ottawa, Ontario: Canadian Executive Council on Addictions.* 2011(April 2011).
4. Eibl JK, Morin K, Leinonen E, Marsh DC. The State of Opioid Agonist Therapy in Canada 20 Years after Federal Oversight. *Can J Psychiatry.* 2017;62(7):444-450.
5. Sproule B. Prescription monitoring programs in Canada: best practice and program review. *Ottawa, Ontario: Canadian Centre on Substance Abuse.* 2015. Accessed from: http://www.ccsa.ca/Resource Library/CCSA-Prescription-Monitoring-Programs-in-Canada-Report-2015-en.pdf.
6. Health CAfDaTi. Environmental scan: Prescribing and dispensing policies to address harms associated with prescription drug abuse. 2015. *Accessed from:* https://www.cadth.ca/sites/default/files/pdf/ES0291_Prescription_Drug_Abuse_e.pdf.
7. Service BC. Illicit Drug Overdose Deaths in BC January 1, 2007 – August 31, 2017. 2017. *Accessed from:* http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/deathinvestigation/statistical/illicit-drug.pdf
8. Office of the Chief Coroner. Drug Overdose Deaths Saskatchewan, 2010 to 2017. 2017. *Accessed from:* http://publications.gov.sk.ca/documents/9/99949-Drug Toxicity Deaths - January 1 2010 - March 31 2017.pdf
9. Public Health Ontario. Opioid-related morbidity and mortality in Ontario. 2017. *Accessed from:* http://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx.
10. Crabb J. New Manitoba numbers released on fentanyl overdose deaths. *CTV News Winnipeg.* May 10, 2017. Accessed from: http://winnipeg.ctvnews.ca/new-manitoba-numbers-released-on-fentanyl-overdose-deaths-1.3407035