

*Evaluation of the AFM's Methadone Intervention &  
Needle Exchange Program (m.i.n.e.)*

**Jennifer Bodnarchuk, Ph.D.**

**David Patton, Ph.D.**

**Brian Broszeit, B.Sc.**

**July 2005**

**AFM Research**

## **Addictions Foundation of Manitoba**

The Addictions Foundation of Manitoba is responsible for providing rehabilitation and prevention services for Manitoba citizens relating to substance use and problem gambling. *The aim of our research is to better inform rehabilitation practice, public education, and health policy.* Research fostered by the foundation contributes to a better understanding of how individuals, families, and communities can most effectively respond to harm associated with substance use and problem gambling.

### **VISION:**

*Leading the way to an addiction free society*

### **MISSION:**

*To contribute to the health and well being of Manitobans by reducing the harm associated with alcohol, other drugs and gambling through education, prevention, rehabilitation and research.*

### **VALUES:**

- *We respect the dignity of each individual*
- *We are guided by ethical standards and integrity*
- *We are client centred in our service*
- *We endorse relationships with the self help community*
- *We contribute to the development and sustainability of healthy communities*
- *We encourage partnerships with other organizations*
- *We promote continuous improvement, life long learning, research and best practice*
- *We support early intervention and harm reduction*

## TABLE OF CONTENTS

	Page
<b>Executive Summary .....</b>	<b>3</b>
<b>Introduction.....</b>	<b>7</b>
Philosophy of Harm Reduction.....	7
The Methadone Intervention & Needle Exchange Program (m.i.n.e.).....	7
Research on Methadone Maintenance Programs.....	9
<b>Method .....</b>	<b>11</b>
Data Sources .....	11
Administrative Data .....	11
Survey and Biological Testing.....	11
Data Analysis and Presentation .....	12
Percentages and Confidence Intervals .....	12
Statistical Tests .....	12
Analyses for Non-surveyed Clients .....	12
<b>Results .....</b>	<b>14</b>
Characteristics of Current Clients.....	14
Program Participation .....	16
Goal #1: <i>Reduce the harmful use of opiates, thus improving the health of users</i> .....	17
Respondents’ Reported Use of Opiates and Other Drugs.....	17
Urine Test Results for Opiates and Other Drugs .....	19
Health.....	21
Goal #2: <i>Provide a doorway through which clients can access other services, including health care services, rehabilitation programs, and housing programs</i> .....	22
Goal #3: <i>Reduce the spread of infectious diseases, including HIV/AIDS, hepatitis B and C</i> .....	25
Safe Injection and Sexual Practices .....	25
Testing for HIV and Hepatitis C.....	25
Goal #4: <i>Reduce the crime rate associated with opiate use</i> .....	27
Goal #5: <i>Improve the social functioning of those accessing the program. This includes employment status and the quality of personal relationships</i> .....	29
Employment and Education.....	29
Social and Family Relationships.....	30
Summary of Evaluation of Goals.....	31
Clients’ Views of the Program.....	31
Partnerships with Pharmacies .....	34
<b>Summary and Recommendations.....</b>	<b>35</b>
Summary .....	35
Recommendations.....	36
<b>References.....</b>	<b>40</b>
<b>Appendix A: Questionnaire .....</b>	<b>42</b>
<b>Appendix B: Consent Form .....</b>	<b>54</b>

## LIST OF TABLES AND FIGURES

	Page
<b>TABLES</b>	
Table 1. Demographic Information for Current m.i.n.e. Clients Obtained at the Time of Intake.....	14
Table 2. Average Number of Methadone Carries by Frequency of Visits to a m.i.n.e. Physician.....	16
Table 3. Comparison Between Urine Test Results and Self-Reported Drug Use for Opiates, Cocaine, and Cannabis.....	20
<b>FIGURES</b>	
Figure 1. Percent of Clients Who Reported Daily Opiate Use in the 6 Months Before the Survey .....	17
Figure 2. Percent of Clients Who Reported Regular Use of Drugs Other than Opiates at Intake and Time of Survey.....	19
Figure 3. Clients' Reports of Change in Eating Habits and Health Since Starting m.i.n.e. ....	21
Figure 4. Percent of Clients Who Reported Changes in the Frequency of Visits to Health Care Professionals From Before to After Starting m.i.n.e.....	23
Figure 5. Percent of Clients Who Reported Using Services Before and After Starting m.i.n.e.....	24
Figure 6. Number of Clients Reporting HIV Testing and Test Results Before and After Starting m.i.n.e.....	26
Figure 7. Number of Clients Reporting Hepatitis C Testing and Test Results Before and After Starting m.i.n.e. ....	27
Figure 8. Percent of Clients Who Reported Legal Involvement at Intake and Time of Survey .....	28
Figure 9. Percent of Clients Who Reported Employment and Education Problems .....	29
Figure 10. Percent of Clients Who Reported Problems in Social Relationships .....	30

# EXECUTIVE SUMMARY

## INTRODUCTION

In 2003, the AFM's existing methadone maintenance program, which was evaluated in 2002 (Patton & Lemaire, 2002), was expanded to include a needle exchange component. This addition marked the formal start of the AFM's Methadone Intervention and Needle Exchange (m.i.n.e.) program as it exists today, and this report details an evaluation of the program.

The m.i.n.e. program operates under the philosophy of harm reduction, which recognizes that substance use is not simply a switch that can be turned from "on" to "off." Rather, substance use exists on a continuum ranging from harmful or dependent use, which is associated with severe problems and consequences, to abstinence. Programs that employ a harm reduction strategy encourage any and all movement on the continuum away from harmful use and toward (although not necessarily with the immediate goal of reaching) abstinence (Wenger, 2002).

The goals of the m.i.n.e. program (Wenger, 2002), which were evaluated in this report, are to:

- 1) *Reduce the harmful use of opiates, thus improving the health of users.*
- 2) *Provide a doorway through which clients can access other services, including health care services, rehabilitation programs, and housing programs.*
- 3) *Reduce the spread of infectious diseases, including HIV/AIDS, hepatitis B and C.*
- 4) *Reduce the crime rate associated with opiate use.*
- 5) *Improve the social functioning of those accessing the program. This includes employment status and the quality of personal relationships.*

## METHOD

Information for this evaluation was obtained from four sources: (a) administrative data maintained for all clients in the AFM system, (b) a survey delivered to current m.i.n.e. clients, (c) biological testing of urine samples provided by m.i.n.e. clients at the time of the survey, and (d) a brief set of questions asked over the telephone to pharmacists who dispense methadone to m.i.n.e. clients.

For most percentage estimates in this report, 95% confidence intervals were calculated and are presented in the text as plus or minus a given amount. For example, the statistic "25% ± 5%" means that the corresponding 95% confidence interval is 20% to 30%. In other words, while the percent estimated from our sample of data is 25%, we are 95% sure that the percent for all m.i.n.e. clients is somewhere between 20% and 30%. As more members of the population are sampled, the confidence intervals get smaller.

## RESULTS

Administrative data were obtained for 120 (82%) of the 147 clients currently participating in the m.i.n.e. program, and 70 (48%) of the clients completed a survey and provided a urine

sample. No significant differences were found between surveyed clients and clients who did not partake in the survey except for marital status: more surveyed clients were married/common-law compared to the clients who were not surveyed, and fewer surveyed clients were single.

**GOAL #1.** The first goal of m.i.n.e. relates to opiate use. At intake, 66% ( $\pm 10\%$ ) of surveyed clients were using opiates other than the prescribed methadone on a daily basis, and at the time of the survey, 18% ( $\pm 7\%$ ) were doing so. Supporting these results, 19% of survey respondents had positive urine tests for opiates at the time of the survey. Non-methadone opiates used in the 6 months prior to the survey were taken by prescription in 52% ( $\pm 11\%$ ) of cases, and most clients (72%  $\pm 10\%$ ) used these drugs for pain management. Over 40% of clients reported improved eating habits, physical health, or mental health compared to before starting m.i.n.e. These outcomes provide support that the m.i.n.e. program is meeting its first goal: reducing the harmful use of opiates and improving the health of users.

**GOAL #2.** The second goal was harder to evaluate because while some clients were using services more than before starting m.i.n.e., other clients were using services less. For example, 34% ( $\pm 8\%$ ) of clients reported fewer visits to a family doctor compared to before starting m.i.n.e. and 21% ( $\pm 7\%$ ) reported more visits. Additionally, use of many services dropped after starting m.i.n.e., but the difference was only significant for five services: social assistance, hospitals, emergency rooms, pain management, and housing. The significant drop in these services suggests that the m.i.n.e. program may be helping to ease pressure on parts of the medical and social service systems. However, determining whether each client was accessing the services that he or she needed was not addressed by the current questionnaire, and future work should explore this issue in more depth.

**GOAL #3.** Over two-thirds (69%  $\pm 10\%$ ) of surveyed clients reported at intake that they had taken drugs by injection at some point in their lives. At the time of the survey, one-third (33%  $\pm 8\%$ ) of clients reported injecting drugs in the year prior. In addition to fewer clients injecting drugs, three-quarters of m.i.n.e. clients (75%  $\pm 8\%$ ) reported using safe sexual practices. Another prevention step is disease testing. Most clients (77%  $\pm 7\%$ ) had been tested for HIV prior to their involvement with the m.i.n.e. program, and almost as many (61%  $\pm 8\%$ ) were tested sometime during their m.i.n.e. participation. Likewise, 71% ( $\pm 8\%$ ) of m.i.n.e. clients were tested for Hepatitis C before starting m.i.n.e. and 66% ( $\pm 9\%$ ) were tested after. Thus, the m.i.n.e. program is making progress toward its third goal of reducing the spread of infectious diseases.

**GOAL #4.** The fourth goal of m.i.n.e. was assessed by comparing criminal activity reported at intake to the same activities reported in the survey. Compared to the time of intake, at the time of the survey a lower percentage of respondents reported three aspects of legal involvement: pending court appearances (intake: 14%  $\pm 7\%$ , survey: 6%  $\pm 4\%$ ), probation (intake: 22%  $\pm 14\%$ , survey: 6%  $\pm 4\%$ ), and parole (intake: 8%  $\pm 8\%$ , survey: 2%  $\pm 2\%$ ). Given the lengthy criminal histories of some of these individuals, these findings reflect a significant lifestyle improvement.

**GOAL #5.** Surveyed clients showed a trend toward improved outcomes in education and employment. For example, while 20% ( $\pm 7\%$ ) reported losing a job or being suspended from school within a year before intake, 11% ( $\pm 5\%$ ) reported this at the time of the survey. Regarding changes in social and family relationships since starting m.i.n.e., 45% ( $\pm 9\%$ ) of clients reported that their relationships had stayed the same. Of the 45% ( $\pm 9\%$ ) of respondents who reported that their relationships had improved, several reported increased trust and honesty with family and friends, as well as other positive changes in their relationships. Thus, this report shows some evidence that m.i.n.e. is meeting its fifth goal.

**CLIENT VIEWS.** In addition to the evaluation of the program goals, valuable information was obtained from the surveys about the clients' views of the m.i.n.e. program. Many clients (53% of the 60 clients who answered the question) named the supportive and non-judgmental staff as the aspect of m.i.n.e. that helped them the most, and of the 46 clients who answered the question regarding what aspects of m.i.n.e. needed the most improvement, 17 (37%) replied that nothing needed improvement. Clients also provided various suggestions for making the program better, including more convenient and flexible times to receive methadone and other services, and more educational and peer groups. However, a common problem reported by methadone clients in other programs was not reported by m.i.n.e. clients: methadone clients from Toronto, Vancouver, and Montreal reported being dissatisfied with the methadone program staff (Fischer, Chin, Kuo, Kirst, & Vlahov, 2002). In contrast, m.i.n.e. clients were generally pleased with the staff. As described above, at least half the m.i.n.e. clients felt that the staff provided the program ingredient that helped them the most. Because program staff play such an essential role in program and client success, it's possible that the m.i.n.e. program is one of the better methadone programs available in Canada.

**PHARMACY PARTNERS.** When contacted by the AFM research team, pharmacists from m.i.n.e. partner pharmacies expressed their appreciation for the m.i.n.e. program. All pharmacists were satisfied with the operation of the program as far as their own involvement with it and while most pharmacists reported that they had had problems with some of the clients, all pharmacists were enthusiastically willing to accept more m.i.n.e. clients. Thus, given the pharmacists' overall positive response about the program and the fact that 74% ( $\pm 8\%$ ) of clients received their methadone from community pharmacy sites of the m.i.n.e. program, the partnerships with pharmacies appear to be working very well.

## **SUMMARY AND RECOMMENDATIONS**

This report supports the conclusion that overall the m.i.n.e. program is meeting its goals, making progress toward others, and making a significant positive impact in the lives of numerous clients. This evaluation also presents data that show where future efforts may be focused. Recommendations include:

- *Identify the clients who are at risk and have not yet been tested for HIV or for Hepatitis C and encourage them to be tested*
- *Concentrate effort toward reducing clients' criminal activities (related to opiate use or otherwise)*

- *Work with clients to continue to improve their social relationships*
- *Maintain and enhance supportive and non-judgmental characteristics in current and future m.i.n.e. staff members*
- *Consider client suggestions for improving the program*
- *Ensure that questions on the intake and assessment forms include time frames*
- *Between now and the next evaluation, review and clarify program goals and objectives*
- *Based on the revised goals and objectives, create outcome indicators that can be measured in a future evaluation survey*
- *The next evaluation should specifically measure the new outcome indicators*
- *Include a process evaluation in the next evaluation to determine why or how the m.i.n.e. program is making a difference in clients' lives*
- *Add questions to the survey questionnaire to gather better information*
- *Consider in-person interviews for the next evaluation*
- *Conduct a more extensive survey for the partner pharmacies*

Following these recommendations will likely improve the m.i.n.e. program and the next evaluation of m.i.n.e. Further, the improved evaluation will lead to further improvements of m.i.n.e. and suggestions for the next evaluation. Such an ongoing cycle of improvements will create the best situation for the program and more importantly, for the clients.

## INTRODUCTION

The mission of the Addictions Foundation of Manitoba (AFM) is to contribute to the health and well being of Manitobans by reducing the harm associated with alcohol, other drugs and gambling through education, prevention, rehabilitation and research. In partial fulfillment of this mission, the AFM provides several services, including the rehabilitation service for opiate dependent persons: the Methadone Intervention & Needle Exchange Program (m.i.n.e.). Further, the AFM conducts evaluations of its services to determine whether the service goals are met. This report details a second evaluation of the AFM's methadone program; a preliminary evaluation was conducted three years ago (Patton & Lemaire, 2002).

### PHILOSOPHY OF HARM REDUCTION

Before describing the m.i.n.e. program, it is important to discuss the philosophy of harm reduction, which guides many AFM programs, including m.i.n.e. This philosophy recognizes that substance use is not simply a switch that can be turned from "on" to "off." Rather, substance use exists on a continuum ranging from harmful or dependent use, which is associated with severe problems and consequences, to abstinence. Programs that employ a harm reduction strategy encourage any and all movement on the continuum away from harmful use and toward (although not necessarily with the immediate goal of reaching) abstinence (Wenger, 2002).

Movement on the substance use continuum is largely determined by an individual person's readiness to change, which cannot be predicted by the severity of consequences from the harmful use. Persons at the same place along the continuum may have different attitudes and opinions about their own use: some persons may be ready and have the desire to change their substance use behaviour, while others may see no problem with their behaviour. Further, some potential clients may want to reduce their substance use without completely stopping it (Fischer, Chin, Kuo, Kirst, & Vlahov, 2002; Prochaska, DiClemente, & Norcross, 1992).

Having a goal of abstinence is not required for acceptance into a program based on harm reduction. Clients must simply be willing to start the program and begin working toward reducing their harmful use. Further, the harm reduction philosophy recognizes that relapse is "a natural and expected occurrence" (MacMaster, 2004, p. 358) for persons with substance use problems, even during treatment, and relapse is not punished by expulsion from the program. Client retention is valued because even though clients may not desire abstinence when they start the program, several clients will progress through stages of change and in time will want to be free of substance dependence (Prochaska et al., 1992). Thus, rather than withholding rehabilitation until clients are ready to become abstinent, harm reduction strategies provide an important treatment option to help some substance users who are in the early stages of reducing or ending their use (MacMaster, 2004; Wenger, 2002).

### THE METHADONE INTERVENTION & NEEDLE EXCHANGE PROGRAM (m.i.n.e.)

In 2003, the AFM's existing methadone maintenance program was expanded to include an additional harm reduction component for their clients: needle exchange. The addition of this

component marked the formal start of the m.i.n.e. program as it exists today, and during the past few years m.i.n.e. has continued to expand its services. M.i.n.e. has increased the number of sites where clients can receive their methadone. Currently, the main m.i.n.e. site is at the Misericordia Health Centre on Sherbrook Street, and 57 pharmacies (27 outside the city of Winnipeg) have in the past or currently provide additional locations for m.i.n.e. clients to obtain their methadone doses. In addition to m.i.n.e., the AFM has recently started another methadone program in Brandon, Manitoba. This program, like m.i.n.e., provides methadone as well as medical and counselling services to its clients.

The m.i.n.e. program provides services for the largest number of methadone clients in the province. Other methadone clients receive services from private physicians, and organizations other than AFM provide needle exchange services. All of the estimated 900 to 1,500 Manitobans who struggle with opiate dependence are eligible for m.i.n.e.'s services, and m.i.n.e. has had approximately 100 clients at a given time over the past few years (Gates, 2002; Stevens, 2003, 2004; Wenger, 2004). Staff increases to address the waiting list have enabled the program to now accommodate almost 150 clients.

After an opiate dependent individual is admitted to the m.i.n.e. program, he or she receives information about methadone, including its possible side effects, the consequences of stopping methadone, the effects of taking other drugs with methadone, and the required dose adjustment after missing three doses. The client is seen by the m.i.n.e. physician, who prescribes an initial low dose of methadone. This methadone is adjusted over time until a stable, individualized dose is attained. During this initial phase, the client is required to visit the physician frequently and to attend m.i.n.e. six days a week to obtain the daily dose of methadone, which must be consumed in the presence of a m.i.n.e. staff member. The seventh daily dose is provided as a take-home dose, or a "carry", because m.i.n.e. is closed on Sundays. Another aspect to the early phase of the m.i.n.e. program is regular urine testing to confirm the clients' self-reports of substance use. Negative test results (showing no opiate use) over time may lead to additional take-home carries for the client, and as part of the harm reduction approach, positive test results do not cause clients to be discharged.

Clients are allowed to receive their methadone from a community pharmacy rather than commuting to the Misericordia Health Centre site. The pharmacist, client, and a m.i.n.e. staff member sign an agreement that the program rules will be adhered to, including: the pharmacist will provide methadone at a dosage level set by m.i.n.e., the pharmacist will witness the methadone consumption, and the client will attend the pharmacy on a regularly scheduled basis. Clients receiving their methadone from pharmacies continue to visit a m.i.n.e. physician on a regular basis.

Clients have no time limit on their stay in the m.i.n.e. program, and involuntary discharges from the program are rare. Such a discharge can occur because of violence or threats of violence toward staff members or other clients, missing three consecutive days at the clinic, ongoing erratic attendance, or diversion of methadone to other people. When clients are involuntarily discharged, they are provided with decreasing dosages of methadone (i.e., tapered) over 10 days. *Voluntary* discharge results from a joint decision between a client and the m.i.n.e. staff members. When such discontinuance of methadone is desired, tapering is

conducted at a slow and individualized rate under close supervision, and the client is fully counselled and supported throughout the process.

Counselling and support are available to all clients throughout their term in the m.i.n.e. program. Counselling is provided both one-on-one and in group settings, as well as at most community pharmacies that dispense methadone to clients. M.i.n.e.'s counselling strategy follows the philosophy of client-centered harm reduction, where all efforts of the client to move toward a healthier lifestyle are supported, and abstinence is not necessarily the goal for every client. The counselling and support includes referrals to other agencies, such as hospital services, other substance use and treatment programs, community mental health programs, food banks, and social service agencies. Such referrals are fundamental to fulfilling m.i.n.e.'s two-pronged strategy of harm reduction and being a gateway to other services.

The ultimate goals of m.i.n.e.'s strategy are to (Wenger, 2004):

- *Reduce the harmful use of opiates, thus improving the health of users.*
- *Provide a doorway through which clients can access other services, including health care services, rehabilitation programs, and housing programs.*
- *Reduce the spread of infectious diseases, including HIV/AIDS, hepatitis B and C.*
- *Reduce the crime rate associated with opiate use.*
- *Improve the social functioning of those accessing the program. This includes employment status and the quality of personal relationships.*

For more information about the m.i.n.e. program, refer to the preliminary evaluation report (Patton & Lemaire, 2002) or to *Methadone Intervention & Needle Exchange Program: Moving Best Practices into Action*, published in March 2004 by the AFM (Wenger, 2004).

## **RESEARCH ON METHADONE MAINTENANCE PROGRAMS**

Methadone maintenance programs are one of the most extensively evaluated forms of substance abuse treatment programs around the world, and numerous reports conclude that these programs are an effective means of harm reduction for opiate dependent persons (e.g., Health Canada, 2002; Wodak, 2002). The primary benefit to clients of methadone programs, as summarized by Bell (1998), is “the change from the behavioural features of dependency – being preoccupied with drug seeking and drug use – to being able again to focus on ‘normal’ pursuits” (p. 162).

Methadone maintenance programs are not designed to cure opiate dependent persons of their substance abuse, but rather have a goal of harm reduction. The extent to which such harm reduction is successful depends on several individual and program characteristics (Health Canada, 2002). Research shows that better outcomes tend to occur for individuals who are older, have intact social networks of friends and family, are employed, have fewer mental health problems, have committed fewer crimes, and have less intense drug use. However, treatment success tends to be more affected by program characteristics (Farrell et al., 1994; Health Canada, 2002). The three features of successful methadone programs that stand out are: prescribing higher doses of methadone (i.e., > 50 mg), having a goal of client retention

and maintenance rather than abstinence, and providing a broad range of additional support services such as counselling, medical care, and social services. These key program characteristics likely improve outcomes due to their association with clients' longer stays in treatment, which have been shown numerous times to relate to better outcomes (e.g., Broome, Simpson, & Joe, 2001; Joe, Simpson, Greener, & Rowan-Szal, 1999).

It is within the context of these individual and program characteristics that the m.i.n.e. program was evaluated. That is, we determined how the goals of m.i.n.e. were met with the understanding that the factors listed above may enhance or detract from the success of individual clients. Based on previous research results and on the preliminary evaluation of AFM's methadone program, the goals of m.i.n.e. were expected to be met.

## METHOD

### DATA SOURCES

Information for this evaluation was obtained from four sources: (a) administrative data maintained for all clients in the AFM system, (b) a survey delivered to current m.i.n.e. clients, (c) biological testing of urine samples provided by m.i.n.e. clients at the time of the survey, and (d) a brief set of questions asked over the telephone to pharmacists who dispense methadone to m.i.n.e. clients.

**ADMINISTRATIVE DATA.** The AFM maintains a Management Information System (MIS) that contains information on all AFM clients. All persons who enter AFM programs, such as m.i.n.e., first go through an intake and assessment process. During this process, information is collected on personal details, such as age, gender, education, household income, employment status, and marital status, as well as on behaviours such as criminal activity and substance use. The clients' files are updated when changes are made in the clients' programs, for example, when a client is transferred to a new program within AFM.

**SURVEY AND BIOLOGICAL TESTING.** The survey questionnaire (see Appendix A) was designed to evaluate the goals of the m.i.n.e. program and included questions regarding physical and mental health, use of services, education, employment, drug use, safe injection practices, safe sexual practices, human immunodeficiency virus (HIV) and Hepatitis C testing, and crime. The questionnaire was developed from three main resources: (a) the questionnaire used in the preliminary evaluation of AFM's methadone program (see Patton & Lemaire, 2002), (b) the current Core Intake and Adult Rehabilitation Forms (version as of April 2002) used by AFM and (c) suggestions from the m.i.n.e. staff based on the expected goals of the program.

Urine samples provided by m.i.n.e. clients were tested by a m.i.n.e. staff member with Verdict II rapid screen test kits manufactured by MEDTOX Diagnostics, Inc. (Burlington, NC). Urine samples were tested for the presence of opiates (not including methadone), tetrahydrocannabinol (THC), and cocaine.

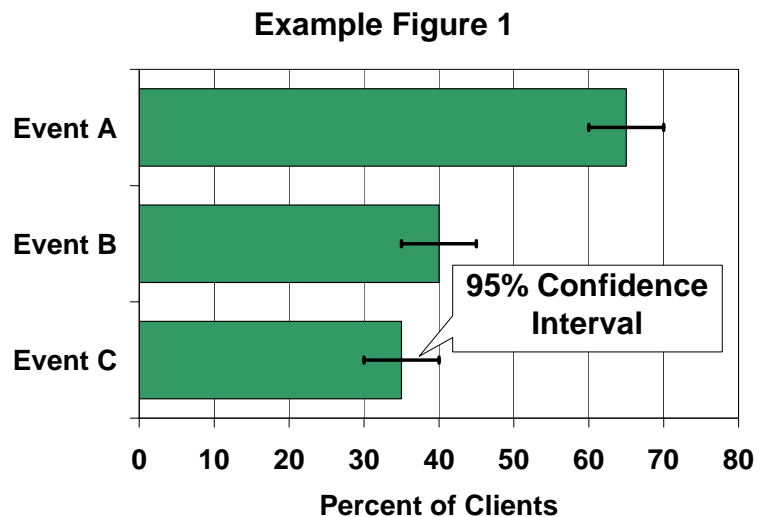
All clients of the m.i.n.e. program who attended the Misericordia Health Centre site or select pharmacies during an 8-week period during May and July 2005 were asked to complete the questionnaire and to provide a urine sample. Respondents indicated their willingness to participate in the evaluation study by signing a consent form, which informed the clients that neither their questionnaire answers nor their urine test results would affect their individualized methadone program. A copy of the consent form is provided in Appendix B. The questionnaire and urine test results were used solely for the purposes of this evaluation. Clients were compensated for their participation with \$10 gift cards for use at any Safeway grocery store.

## DATA ANALYSIS AND PRESENTATION

The main purpose of this evaluation was to assess whether the m.i.n.e. program was reaching its goals. This was accomplished by comparing clients' behaviours before they started m.i.n.e. to their behaviours at the time of the survey. These comparisons were done in two ways. Some behaviours were evaluated by comparing what the clients reported at the time of intake to what they reported on the survey. Other behaviours were evaluated by asking clients on the survey what they had done before starting m.i.n.e. and what they had done since starting m.i.n.e.

**PERCENTAGES AND CONFIDENCE INTERVALS.** Most results are presented as percentages of clients who reported each behaviour. Additionally, for most percentage estimates in this report, 95% confidence intervals were calculated and are presented in the text as plus or minus a given amount. For example, the statistic “25% ± 5%” means that the corresponding 95% confidence interval is 20% to 30%. In other words, while the percent estimated from our sample of data is 25%, we are 95% sure that the percent for all m.i.n.e. clients is somewhere between 20% and 30%. As more members of the population are sampled, the confidence intervals get smaller.

In the figures in this report, the 95% confidence intervals are presented as lines that span a certain distance on the right end of a bar (see Example Figure 1) or the top end of a column. This is interpreted to mean that Event A occurred for 65% of the clients in the sample, but we estimate that it occurred for 60% to 70% of all clients.



Note that the 95% confidence intervals do not provide information about the statistical significance of differences in the data. Separate statistical tests were performed as described below.

**STATISTICAL TESTS.** Statistical tests were performed for this report and are reported where significant differences were found. All statistical tests were conducted at the .05 significance level, and all analyses were performed with SPSS version 12.0 for Windows. Further details regarding the analyses and statistical tests are available from the authors by request.

**ANALYSES FOR NON-SURVEYED CLIENTS.** Not all current clients completed a survey, and we cannot be sure that the results from surveyed clients would be the same for clients not surveyed. However, to help us understand how different the surveyed clients were from the non-surveyed clients, we compared intake information from the two groups of clients during the analyses. If these two groups of clients were similar at intake, then we could have

assumed that the survey results would be similar for the non-surveyed clients. If the two groups were different, then we would not be able to assume the results would be similar. Only the demographic comparisons between the two groups are presented in the *Results* section of this report, and all comparisons are summarized here:

- Table 1 shows that surveyed and non-surveyed clients had similar demographics: they were similar in gender, age, education, income, and employment status. However, they differed in marital status: a higher percentage of surveyed clients were married/common-law and a lower percentage were single compared to non-surveyed clients.
- Both groups of current clients had similar drug use patterns at intake.
- Fewer surveyed than non-surveyed clients had committed and been charged with crimes.
- Surveyed clients reported statistically similar levels of problems in social functioning compared to non-surveyed clients, but in every case, a slightly lower percentage of surveyed clients reported the problem.

Thus, overall, surveyed and non-surveyed clients were similar, but differed in a few areas. The differences may mean that non-surveyed clients would have different outcomes, because as presented in the introduction, outcomes are generally better for clients who have intact social networks and have committed fewer crimes, among other things. However, given that there were similarities in a majority of areas compared, non-surveyed clients may also show outcomes similar to the surveyed clients.

## RESULTS

### CHARACTERISTICS OF CURRENT CLIENTS

Currently, 147 clients participate in the m.i.n.e. program. Intake and assessment data were sought for these clients and were obtained for 120 (82%) who entered m.i.n.e. or another AFM program after 1996. All current clients who attended m.i.n.e. during an 8-week period in May to July 2005 were asked to participate in the survey. Of the 147 current clients, 70 (48%) who attended during this time agreed to complete a questionnaire and provide a urine sample. No clients openly refused to complete the survey, but some said they did not have time at the moment and would return later to complete the survey.

Demographic information obtained from the MIS data is presented in Table 1 for both survey respondents and clients who did not participate in the survey. As shown, no significant differences existed on these measures for survey respondents compared to m.i.n.e. clients who did not partake in the survey except for marital status. More surveyed clients were married/common-law compared to the clients who were not surveyed, and fewer surveyed clients were single.

**TABLE 1.**

**Demographic Information for Current m.i.n.e. Clients Obtained at the Time of Intake**

	Survey Respondents		Non-Respondents		Total <sup>a</sup>	
	n	%	n	%	n	%
<b>Total</b>	49	<b>41</b>	71	<b>59</b>	120	<b>100</b>
<b>Gender</b>						
Male	39	<b>67</b>	38	<b>61</b>	77	<b>64</b>
Female	19	<b>33</b>	24	<b>39</b>	43	<b>36</b>
<b>(Current) Age in Years</b>						
20-24	2	<b>3</b>	4	<b>7</b>	6	<b>5</b>
25-29	6	<b>10</b>	12	<b>19</b>	18	<b>13</b>
30-34	9	<b>16</b>	9	<b>15</b>	18	<b>13</b>
35-39	14	<b>24</b>	17	<b>27</b>	31	<b>24</b>
40-44	12	<b>21</b>	9	<b>15</b>	21	<b>19</b>
45-49	8	<b>14</b>	6	<b>10</b>	14	<b>14</b>
50+	7	<b>12</b>	5	<b>8</b>	12	<b>7</b>

**TABLE 1 CONTINUED**

	Survey Respondents		Non-Respondents		Total <sup>a</sup>	
	n	%	n	%	n	%
<b>Education Level</b>						
Less than grade 9	9	<b>16</b>	11	<b>18</b>	20	<b>17</b>
Incomplete high school	22	<b>38</b>	18	<b>29</b>	40	<b>33</b>
Completed high school	13	<b>22</b>	19	<b>31</b>	32	<b>27</b>
Some college or university	5	<b>9</b>	3	<b>5</b>	8	<b>7</b>
Completed college or university	8	<b>14</b>	7	<b>11</b>	15	<b>13</b>
Other	1	<b>2</b>	4	<b>7</b>	5	<b>4</b>
<b>Annual Household Income</b>						
Less than \$10,000	19	<b>33</b>	14	<b>23</b>	33	<b>28</b>
\$10,000 - \$19,999	12	<b>21</b>	13	<b>21</b>	25	<b>21</b>
\$20,000 - \$29,999	3	<b>5</b>	9	<b>15</b>	12	<b>10</b>
Greater than \$30,000	11	<b>19</b>	8	<b>13</b>	19	<b>16</b>
Declined/Refused/Don't Know	13	<b>22</b>	18	<b>29</b>	31	<b>26</b>
<b>Employment Status<sup>b</sup></b>						
Employed full- or part-time	15	<b>27</b>	18	<b>30</b>	33	<b>28</b>
Not currently employed	41	<b>73</b>	42	<b>70</b>	83	<b>72</b>
<b>Marital Status<sup>*c</sup></b>						
Single	19	<b>35</b>	36	<b>59</b>	55	<b>48</b>
Married / Common Law	19	<b>35</b>	12	<b>20</b>	31	<b>27</b>
Divorced / Separated	11	<b>20</b>	11	<b>18</b>	22	<b>19</b>
Widowed	3	<b>6</b>	0	<b>0</b>	3	<b>3</b>
Other	2	<b>4</b>	2	<b>3</b>	4	<b>4</b>

\* Significantly different,  $p < .05$

<sup>a</sup>MIS data for 28 clients were not retrieved from archived files.

<sup>b</sup>Four clients had missing data for employment status.

<sup>c</sup>Five clients had missing data for marital status.

The aim of this evaluation was to determine how well the m.i.n.e. program is meeting its goals. Thus, after m.i.n.e. clients' program participation is described, results are presented for each of the five program goals mentioned in the introduction. In two final sections, qualitative information obtained on the client survey and from the telephone conversations with the pharmacists is presented.

## PROGRAM PARTICIPATION

The m.i.n.e. program is client-centered, which means that each client has his or her own individualized program. Programs differ in location of methadone receipt, number of methadone doses that can be taken home (“carries”), frequency of m.i.n.e. physician contact, and length of stay in the program.

Approximately one-quarter (26% ± 8%) of survey respondents reported currently receiving their methadone from the m.i.n.e. Misericordia site, while the others (74% ± 8%) received their methadone from community pharmacy sites of the m.i.n.e. program. Choice of location for receipt of methadone depends on the convenience of attending the Misericordia site, as well as the client’s stability on methadone. Some clients will go to the Misericordia site during the stabilization period, but other clients find attending that site too inconvenient and attend a pharmacy site instead. At both the Misericordia site and the pharmacies, clients receive similar treatment and monitoring.

As clients stabilize on methadone, they require less frequent visits with the m.i.n.e. physician and become eligible for more weekly carries of methadone (to a maximum of six). Thus, the frequency of m.i.n.e. physician visits is likely related to the number of carries, and Table 2 shows that the general trend is for clients with fewer physician visits to receive more methadone carries. However, there is also a large amount of variation in this trend, as indicated by the large range between the minimum and maximum number of carries for each physician visit schedule.

**TABLE 2.**

**Average Number of Methadone Carries by Frequency of Visits to a m.i.n.e. Physician**

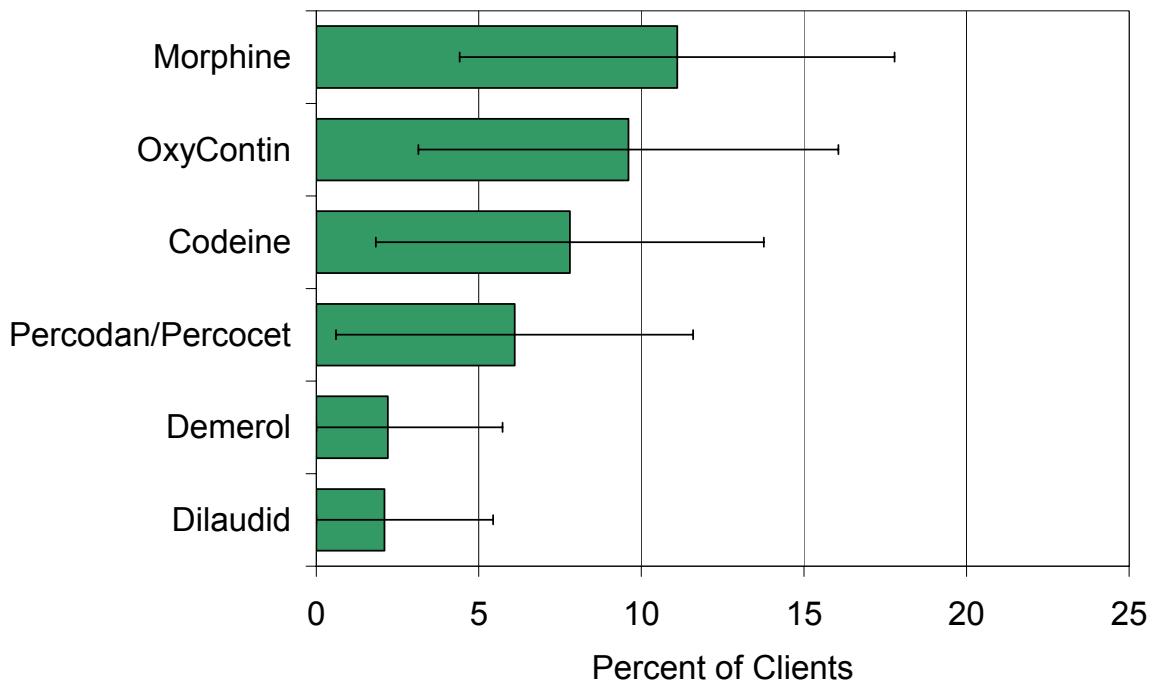
Frequency of Physician Visits	Number of Carries		
	Average	Minimum	Maximum
1-6 times a week	1.0	0	2
1-3 times a month	2.5	0	6
6-11 times a year	2.9	1	6
1-5 times a year	3.1	0	6

As mentioned in the introduction, length of stay in a methadone program is one key aspect of client success. Clients were asked to report length of stay for their current stay in m.i.n.e., and they reported attending m.i.n.e. for an average of 2.1 years, ranging from 1 month to 8 years. The majority of respondents (82% ± 7%) reported that this was their first time attending m.i.n.e., while 15% (± 6%) reported attending for the second time.

**GOAL #1: Reduce the harmful use of opiates, thus improving the health of users**

**RESPONDENTS' REPORTED USE OF OPIATES AND OTHER DRUGS.** The first goal of m.i.n.e. is to reduce the harm associated with opiate use, which includes reducing dependence on non-methadone opiates. Because opiate dependency is the main program eligibility criterion, frequent opiate use was expected for m.i.n.e. clients at intake, when approximately two-thirds of clients ( $66\% \pm 10\%$ ) were using opiates on a daily basis. Non-methadone opiate use was expected to decline for m.i.n.e. clients based on past research and experience, and overall,  $18\% (\pm 7\%)$  of survey respondents reported daily use of opiates other than the prescribed methadone in the 6 months before the survey. Figure 1 shows the range of opiates that were used daily.

Figure 1. Percent of Clients Who Reported Daily Opiate Use in the 6 Months Before the Survey



It is of note that some use of opiates is expected because not all opiates used are abused. Morphine and OxyContin were used by the highest percentage of clients, followed by Codeine. These non-methadone opiates used in the 6 months prior to the survey were taken by prescription in  $52\% (\pm 11\%)$  of cases, and most clients ( $72\% \pm 10\%$ ) used these drugs for pain management. These findings parallel a recent study of clients in the methadone maintenance treatment program at the Centre for Addiction and Mental Health in Toronto, Ontario (Brands, Blake, Sproule, Gourlay, & Busto, 2004). Researchers there found that persons dependent on prescription opiates were more likely to have ongoing pain problems requiring continued prescription opiate use in addition to the methadone. These researchers suggest that more research is needed to clarify the complex relationship between pain

management and addiction so that the best prevention and treatment can be provided to the clients dealing with these issues.

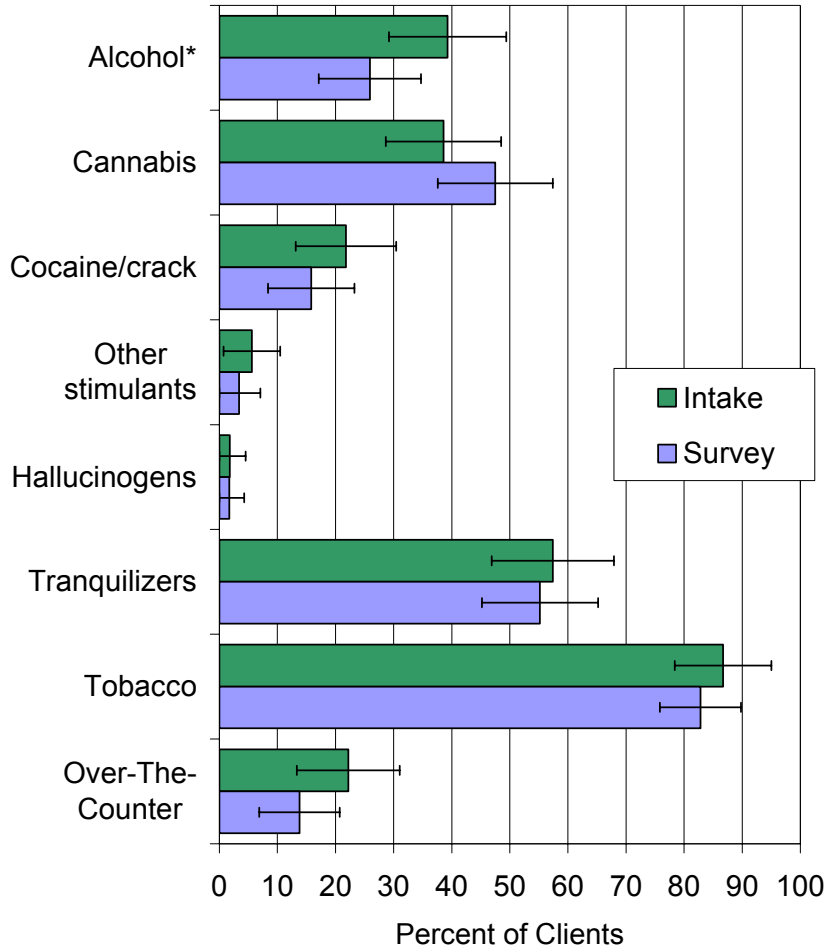
Besides helping clients to reduce and potentially eliminate their use of opiates, harm reduction strategies stress safe injection drug use practices and this topic is discussed in a subsequent section on HIV and Hepatitis C prevention.

M.i.n.e. clients reported taking other drugs besides opiates both at intake and at the time of the survey. Figure 2 shows results for clients who reported regular use of other drugs. Regular use, for the purposes of this evaluation, was defined as monthly, weekly, or daily use of the drug. As shown in the figure, for most drugs, clients' regular use at intake did not differ significantly from their use at the time of the survey. Most use showed potentially declining trends from the time of intake to the time of the survey, with a significant difference only for alcohol: at intake, 39% ( $\pm 10\%$ ) of surveyed clients reported regular alcohol use compared to 26% ( $\pm 9\%$ ) on the survey.

Regular cannabis use showed a potentially increasing trend: at intake, 39% ( $\pm 10\%$ ) of surveyed clients reported using cannabis regularly, whereas on the survey, 48% ( $\pm 10\%$ ) reported this. Although the increase was not statistically significant in this evaluation, cannabis use by methadone clients is a topic that has been explored in several research studies. A recent review showed that most studies have found increased cannabis use is unrelated to increased heroin or cocaine use (Epstein & Preston, 2003). Further, according to Seivewright (2003), cannabis is "a drug generally considered lower down the 'tariff'" (p. 251) for methadone clients, and it may be that cannabis use is helping these clients to avoid more harmful drug use (Fischer et al., 2002). However, cannabis use by itself is not without adverse effects. For example, it has been linked to respiratory problems, cognitive impairments, and possibly cancer (Hall & Solowij, 1998). Thus, the pros and cons of increased cannabis use need to be considered for clients of the m.i.n.e. program.

Overall, opiate use declined drastically from the time of intake to the time of the survey, significantly fewer clients reported using alcohol at the time of the survey compared to the time of intake, and cannabis was the only drug that showed an increase in usage.

Figure 2. Percent of Clients Who Reported Regular Use of Drugs Other than Opiates at Intake and Time of Survey



\* Significantly different

**URINE TEST RESULTS FOR OPIATES AND OTHER DRUGS.** The self-report survey results for opiates, cocaine, and cannabis were compared to urine test results for these same drugs. Because the survey did not ask about the timeframe of most recent drug use, the self-report categories of “Not used recently” and “May have used recently” were created from the questions on the frequency of drug use. Some respondents did not report their frequency of drug use, but did provide urine for testing, so an additional self-report category of “Missing” was also created. Table 3 presents positive and negative urine test results for each of these three categories of self-reported drug use for each of the three drugs. It is of note that positive tests can result after varying lengths of time for these different drugs. Positive tests for opiates and cocaine can occur 2-4 days after last taking the drug, while positive results for cannabis can occur up to 30 days later.

**TABLE 3.****Comparison Between Urine Test Results and Self-Reported Drug Use for Opiates, Cocaine, and Cannabis**

	Self-Reported Drug Use						Total for Urine Test	
	<i>Not used recently</i>		<i>May have used recently</i>		<i>Missing</i>		<b>n</b>	<b>%</b>
	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>	<b>n</b>	<b>%</b>		
<b>Opiates</b>								
Negative	20	<b>95</b>	29	<b>71</b>	8	<b>100</b>	57	<b>81</b>
Positive	1	<b>5</b>	12	<b>29</b>	0	<b>0</b>	13	<b>19</b>
<b>Cocaine</b>								
Negative	45	<b>94</b>	5	<b>56</b>	12	<b>92</b>	62	<b>89</b>
Positive	3	<b>6</b>	4	<b>44</b>	1	<b>8</b>	8	<b>11</b>
<b>Cannabis</b>								
Negative	21	<b>68</b>	7	<b>25</b>	8	<b>73</b>	36	<b>51</b>
Positive	10	<b>32</b>	21	<b>75</b>	3	<b>27</b>	34	<b>49</b>

In general, the results of Table 3 reflect results presented earlier. For example, Table 3 shows that overall, 19% of survey respondents tested positive for opiates, and a similar percentage of respondents reported daily use of opiates. However, Table 3 shows that one of the clients who tested positive denied using opiates recently. Additionally, three clients who tested positive for cocaine denied using it recently.

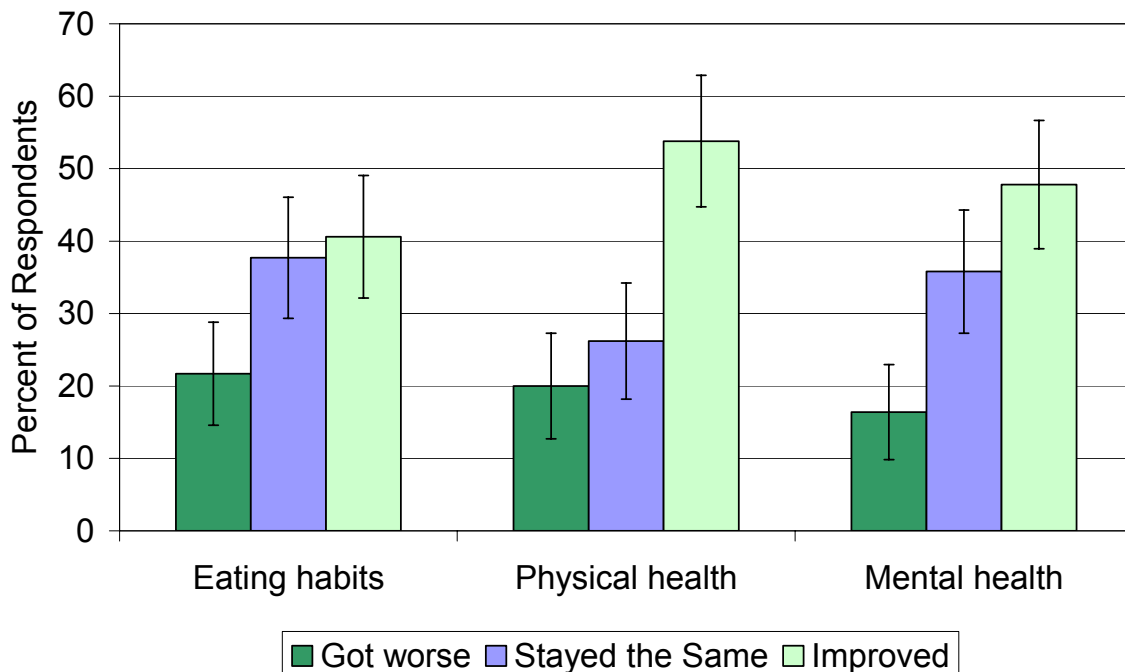
Of the respondents who reported that they *may* have used either opiates or cocaine recently, 29% tested positive for opiates and 44% tested positive for cocaine. The relatively small percentage testing positive is likely due to the timeframe differences mentioned above: the recent use category covers more time than that required for a positive urine sample (2-4 days for both drugs). Thus, recent drug use may not have been recent enough to produce a positive urine test.

While relatively few clients tested positive for opiates (19%) or cocaine (11%), 49% tested positive for cannabis use. In part, this increased percentage of positive test results may be because of the longer length of time during which positive tests can occur after using cannabis (up to 30 days). However, this higher percentage of testing positive also reflects the reports that cannabis is one of the drugs that is used most regularly. For example, as shown in Figure 2, almost 50% of respondents reported regular use of cannabis.

The higher percentage of positive urine tests for cannabis compared to those for opiates and cocaine occurred for both *not used recently* and *may have used recently*. For example, 32% of respondents who reported not using cannabis recently tested positive, versus 5% and 6% for opiates and cocaine, respectively. In other words, about one-third of respondents who reported not using cannabis recently provided a urine sample that tested positive for the drug. This does not necessarily mean that clients are more likely to provide false information about their cannabis use compared to other drugs. Rather, it points to the fact that cannabis stays in a person's body much longer than the other drugs. For example, if a client used opiates, cocaine and cannabis two weeks before the survey, he or she would likely test negative for opiates and cocaine, but test positive for cannabis. Thus, when interpreting the comparisons in Table 3, it is important to keep in mind the different lengths of time during which positive test results can occur after consuming the different drugs.

**HEALTH.** A second part to the first goal of m.i.n.e. is to improve the health of clients. Figure 3 shows the reported improvement in eating habits, physical health, and mental health.

Figure 3. Clients' Reports of Change in Eating Habits and Health Since Starting m.i.n.e.



In support of the report of improved eating habits, several clients described eating healthier foods, eating more regularly, and gaining weight. Regarding physical and mental health, clients provided a myriad of comments about feeling better in different aspects of their lives: fewer illnesses, more energy, improved concentration, better sleep, more self-esteem, and overall having a better outlook on life.

*My head space and attitude has changed for the best.*

*I'm more clear headed goal oriented.*

*A lot of changes, sleeping, eating, and a positive attitude.*

In summary, these outcomes provide support that the m.i.n.e. program is meeting its first goal: reducing the harmful use of opiates and improving the health of users.

***GOAL #2: Provide a doorway through which clients can access other services, including health care services, rehabilitation programs, and housing programs***

A second goal of m.i.n.e. is to provide clients with the opportunity to access needed services such as health care. Given the improved physical and mental health reported by m.i.n.e. clients (as presented in the previous section), less use of the health care system may be expected. Indeed, as Figure 4 shows, use of family doctors, dentists, psychologists, and psychiatrists decreased for some clients. For example, 34% ( $\pm$  8%) of clients reported fewer visits to a family doctor compared to before starting m.i.n.e. and 27% ( $\pm$  10%) reported fewer visits to a psychologist.

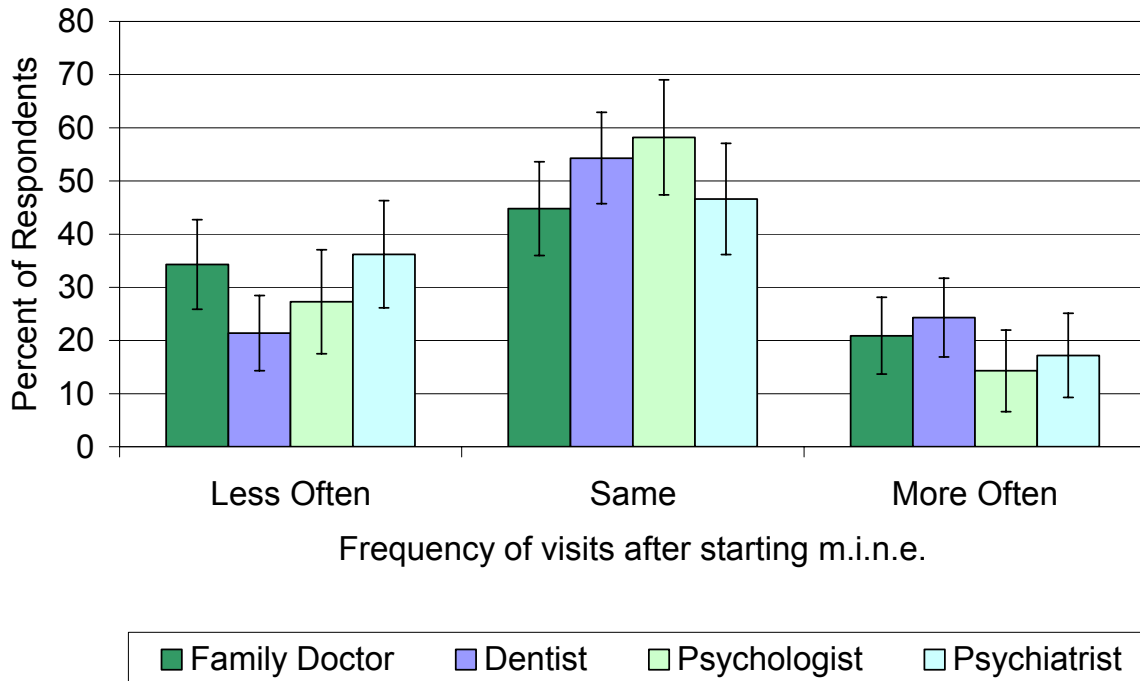
As discussed in the preliminary evaluation of the AFM methadone program (Patton & Lemaire, 2002), there are reasons besides improved health that clients may not be accessing these health care services. For example, clients receive health care attention from the counsellors and physicians at the m.i.n.e. program and may not feel the need to obtain such services elsewhere. As well, clients may not be able to access the services for various reasons, including the difficulty in finding a family doctor or other problems faced by the clients.

*Seeing my nurse/therapist regularly is sufficient.*

*I find it extremely difficult to find and establish a permanent family doctor,  
I have yet to find one.*

*I made one or two appointments but was having problems at the time,  
so I missed them.*

Figure 4. Percent of Clients Who Reported Changes in the Frequency of Visits to Health Care Professionals From Before to After Starting m.i.n.e.

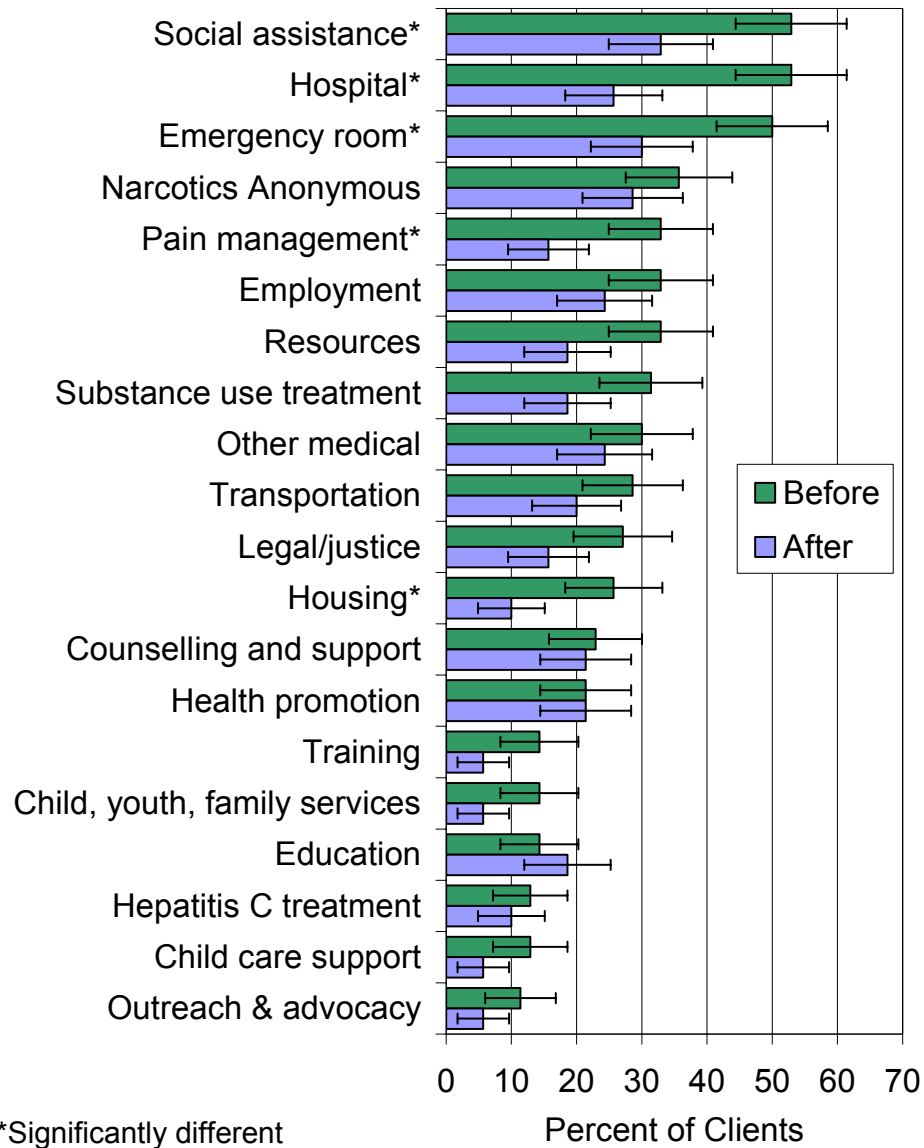


In contrast to the situations where clients are accessing health care services less often, the m.i.n.e. program may be helping other clients to become more aware of their health care needs and to seek the necessary care, thus increasing their use of the health care system.

*I take action when something is going on with my health today.  
As before all I wanted to do was get drugs.*

Clients were also asked about their use of social services, health promotion, legal services, and other resources. Figure 5 presents the percentage of clients who reported using these services before and after starting m.i.n.e. Use of most services dropped after starting m.i.n.e., but the difference was only significant for five services: social assistance, hospitals, emergency rooms, pain management, and housing. The significant drop in these services suggests that the m.i.n.e. program may be helping to ease pressure on parts of the medical and social service systems. For example, the program may prevent medical emergencies for its clients. However, the specific reasons for the decreases in service use were not explored in the survey, and because almost all services showed a decrease, part of the explanation may be in the time frame of the question. The time before starting m.i.n.e. is likely much longer than the time since starting m.i.n.e. for many clients, and clients may have used these services long before starting m.i.n.e.

Figure 5. Percent of Clients Who Reported Using Services Before and After Starting m.i.n.e.



The only service that showed a potentially increasing trend was education. This increase is supported by more evidence discussed in a later section on social functioning.

In summary, this section shows that some clients have used services more and some clients have used services less, but overall, determining whether each client was accessing the services that he or she needed was not addressed by the current questionnaire. Future work should explore this issue in more depth.

**GOAL #3: Reduce the spread of infectious diseases, including HIV/AIDS, hepatitis B and C**

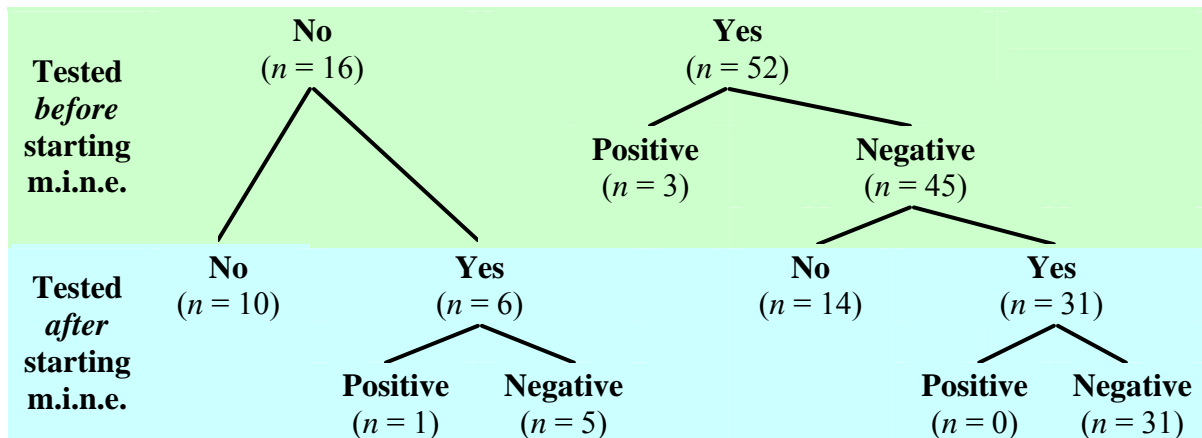
Injection drug users are at risk for contracting HIV and, to a greater extent, Hepatitis C. Because a majority of m.i.n.e. clients have injected drugs, reducing the harm of HIV and Hepatitis C is another goal of m.i.n.e. This goal is accomplished through promoting the use of safe practices, including safe practices when injecting drugs and safe sexual practices. Further, testing for HIV and Hepatitis C is an important harm reduction step because once persons are diagnosed with HIV they are more likely to adopt behaviours that prevent the spread of the disease (Centers for Disease Control and Prevention, 2000; Millson et al., 2003), and once persons are diagnosed with Hepatitis C, the disease can be managed and potentially treated (Centers for Disease Control and Prevention, 1998; Loughlin, Schwartz, & Strathdee, 2004).

**SAFE INJECTION AND SEXUAL PRACTICES.** As mentioned, injection drug use is common among persons admitted to the m.i.n.e. program: at the time of intake, 69% ( $\pm 10\%$ ) of surveyed clients reported that they had taken drugs by injection at some point in their lives. On the survey, roughly one-third (33%  $\pm 8\%$ ) of clients reported injecting drugs in the past year. Seven (32%) of these clients did so daily, and while 14 (67%) reported using needles more than once, 19 (86%) did not share needles. Likewise, most m.i.n.e. clients reported other safe practices that help to prevent the spread of HIV and Hepatitis C: 75% ( $\pm 8\%$ ) of respondents reported using safe sexual practices, with 13% ( $\pm 6\%$ ) using the condoms provided by m.i.n.e.

**TESTING FOR HIV AND HEPATITIS C.** Most clients (77%  $\pm 7\%$ ) had been tested for HIV prior to their involvement with the m.i.n.e. program, and almost as many (61%  $\pm 8\%$ ) were tested sometime during their m.i.n.e. participation. Of clients who were tested for HIV and reported their results on the survey, 4 (7%) tested positive, which is similar to the estimate of 6% reported in a study of injection drug users from nine Ontario cities (Millson et al., 2003). In all cases but one, the m.i.n.e. clients' positive tests occurred before starting the program (see Figure 6).

Of those who reported no testing prior to m.i.n.e., 6 were tested after starting m.i.n.e. and 10 had not yet been tested at the time of the survey. Of the 6 who were tested, one tested positive for HIV. Of the 10 who were not tested, 5 reported never injecting drugs, 4 others reported not sharing needles, and 8 reported using safe sexual practices. Fourteen other clients tested negative before starting m.i.n.e., but had not been tested since starting m.i.n.e. Four of these clients reported never injecting drugs, 6 others reported not sharing needles, and 10 reported using safe sexual practices. Even though most of the 24 clients who have not been tested for HIV since starting m.i.n.e. used safe injection and sexual practices, these clients should be encouraged to be tested for HIV.

**Figure 6. Number of Clients Reporting HIV Testing and Test Results Before and After Starting m.i.n.e.<sup>a</sup>**



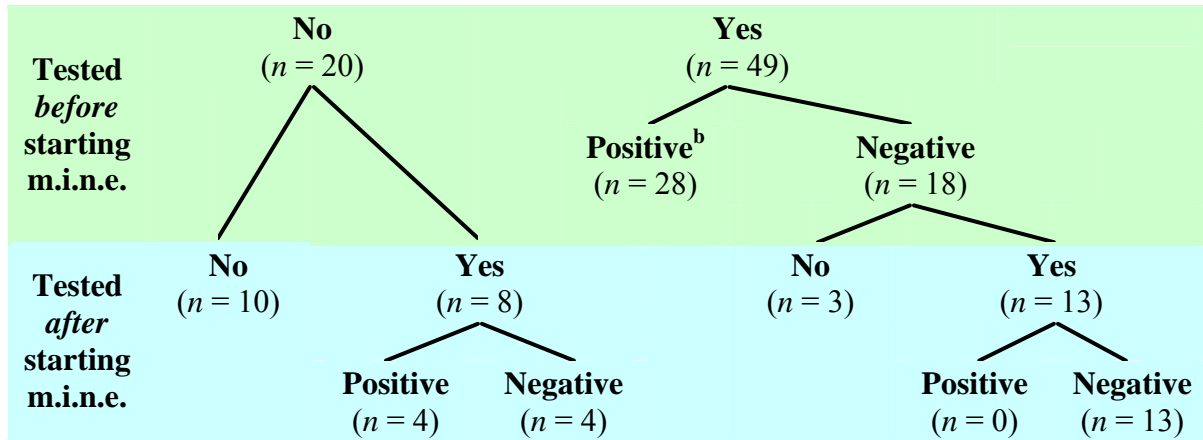
<sup>a</sup>Not all respondents answered every question, so the numbers do not always sum together.

Similar to the results for HIV testing, 71% ( $\pm 8\%$ ) of m.i.n.e. clients were tested for Hepatitis C before starting m.i.n.e. and 66% ( $\pm 9\%$ ) were tested during m.i.n.e. participation. But as expected, positive test results were much more common for Hepatitis C: 57% ( $\pm 10\%$ ) of those tested reported positive results. This estimate is comparable to the overall rate reported in a study conducted in Baltimore, Maryland, where 67% of methadone maintenance clients were infected with Hepatitis C (Loughlin et al., 2004). However, only 28% of clients in Maryland had self-reported positive status, and the rest tested positive after agreeing to be tested as part of the research study. This comparison suggests that the m.i.n.e. clients are knowledgeable and honest about their Hepatitis C status.

Figure 7 shows that there are some clients who need to be further encouraged to be tested for Hepatitis C: 13 surveyed clients reported not being tested for Hepatitis C since starting m.i.n.e. The majority of these clients did report safe practices regarding needle use and sexual practices. Of the 10 clients who reported no testing prior and no testing since starting m.i.n.e., 6 reported never injecting drugs, 3 others did not share needles, and 9 used safe sexual practices. Of the 3 clients who reported negative Hepatitis C tests before starting m.i.n.e. and were not tested since starting m.i.n.e., 2 reported never injecting drugs, the other reported not sharing needles, and 2 reported using safe sexual practices.

In summary, the m.i.n.e. program is making progress toward its third goal of reducing the spread of infectious diseases: injection drug use decreased in m.i.n.e. clients and most clients were tested at least once for HIV and Hepatitis C; however, further testing should be encouraged for some clients.

**Figure 7. Number of Clients Reporting Hepatitis C Testing and Test Results Before and After Starting m.i.n.e.<sup>a</sup>**



<sup>a</sup>Not all respondents answered every question, so the numbers do not always sum together.

<sup>b</sup>Two clients who tested positive for Hepatitis C before m.i.n.e. tested negative after m.i.n.e.

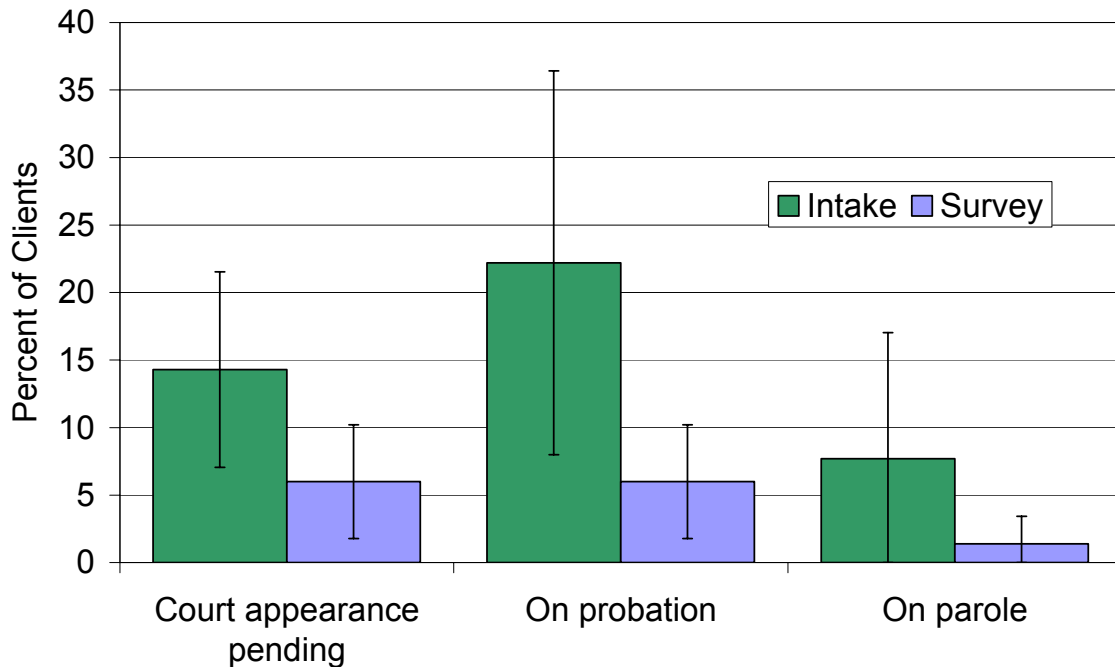
**GOAL #4: Reduce the crime rate associated with opiate use**

A fourth goal of m.i.n.e. is to reduce the crime rate associated with opiate use. To assess progress toward this goal, the criminal activity of m.i.n.e. clients reported at intake was compared to the same activities reported in the survey. As seen in Figure 8, a lower percentage of respondents reported three aspects of legal involvement: pending court appearances, probation, and parole. If clients reported on the survey that any of these aspects of legal involvement were related to something that happened before starting the m.i.n.e. program, those respondents' data were not included in the "Survey" bars. This was done because the m.i.n.e. program would not have had an influence on events that occurred before the client started m.i.n.e. Given the lengthy criminal histories of some clients, this reduction in legal involvement reflects a notable lifestyle improvement.

M.i.n.e. clients were also asked both at intake and in the survey whether or not they had committed or been convicted of a crime. At intake, 19% ( $\pm 7\%$ ) of clients reported that in the year prior they had committed a crime such as stealing, shoplifting, or dealing, and on the survey, 30% ( $\pm 8\%$ ) of respondents reported committing a crime in the prior 6 months. At intake, 9% ( $\pm 5\%$ ) of clients reported that they had been charged or convicted of a crime in the year before intake, and on the survey, 23% ( $\pm 7\%$ ) of respondents reported being charged with a crime in the 6 months before the survey. This was a significant increase in the number of clients being charged or convicted of a crime. There are many possible explanations for these increases in reports of crime. First, the crime information was obtained at intake from one question about committing crimes and one question about being charged or convicted of a crime. Conversely, the survey asked 13 questions about committing a crime and 13 questions about being charged or convicted of a crime. Having more questions about specific types of crimes may have helped the clients better remember any recent criminal activity. A second possibility is that the clients may have trusted the staff more at the time of the survey

compared to at intake. At intake, clients are unfamiliar with the organization and may be hesitant to provide details of their criminal activity. They may fear that providing such information will hurt their chances to enter the program. After being in the program, client trust is increased, perhaps reducing hesitation about reporting criminal activity.

Figure 8. Percent of Clients Who Reported Legal Involvement at Intake and Time of Survey



Given the prior comparisons, it is interesting that the percentage of clients reporting driving while impaired did not change from intake to the time of the survey: 17% ( $\pm 6\%$ ) reported such activity at intake and 17% ( $\pm 6\%$ ) did so at the time of the survey. As suggested above, if clients are more likely to report criminal activity in the survey, this may suggest that the actual number of clients driving while impaired has declined. However, in a more conservative interpretation, the percentage has not changed, but remains at a relatively low number.

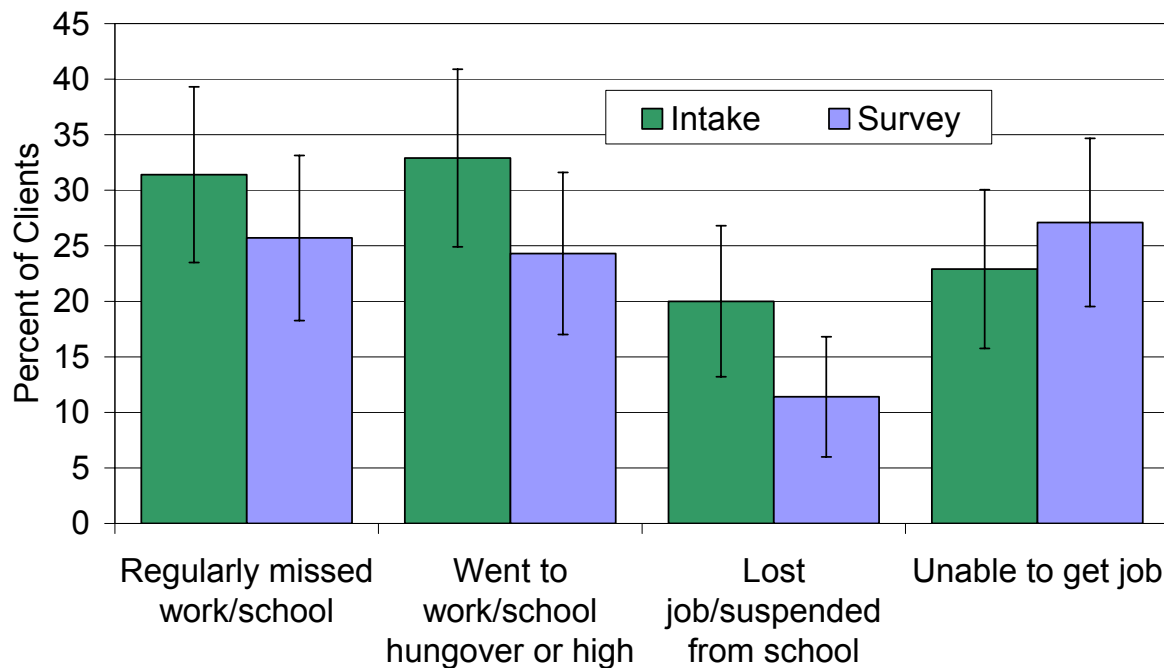
In summary, the goal of m.i.n.e. to reduce crimes associated with opiate use is supported by the possible decline in the percentage of clients with court appearances pending, who are on probation, or who are on parole. Further evaluations of outcomes related to this goal are not as easy to interpret because of inconsistencies in how questions were asked during the two data collection periods. However, information from the survey can provide a baseline measure for the next evaluation of the m.i.n.e. program.

**GOAL #5: Improve the social functioning of those accessing the program. This includes employment status and the quality of personal relationships.**

Improving the social functioning of clients is the last of m.i.n.e.'s program goals discussed in this report, and like other goals, can be assessed by comparing clients' reports at intake with their reports at the time of the survey. This section reviews social functioning in the areas of employment, education, and personal relationships.

**EMPLOYMENT AND EDUCATION.** The intake process includes a general assessment of the social functioning of potential clients. At intake, many m.i.n.e. clients reported difficulties related to employment and education, but by the time of the survey, clients reported improvements in three of the four areas assessed (see Figure 9). For example, while 20% ( $\pm 7\%$ ) of clients reported losing a job or being suspended from school within a year before intake, 11% ( $\pm 5\%$ ) reported this at the time of the survey.

Figure 9. Percent of Clients Who Reported Employment and Education Problems<sup>a</sup>

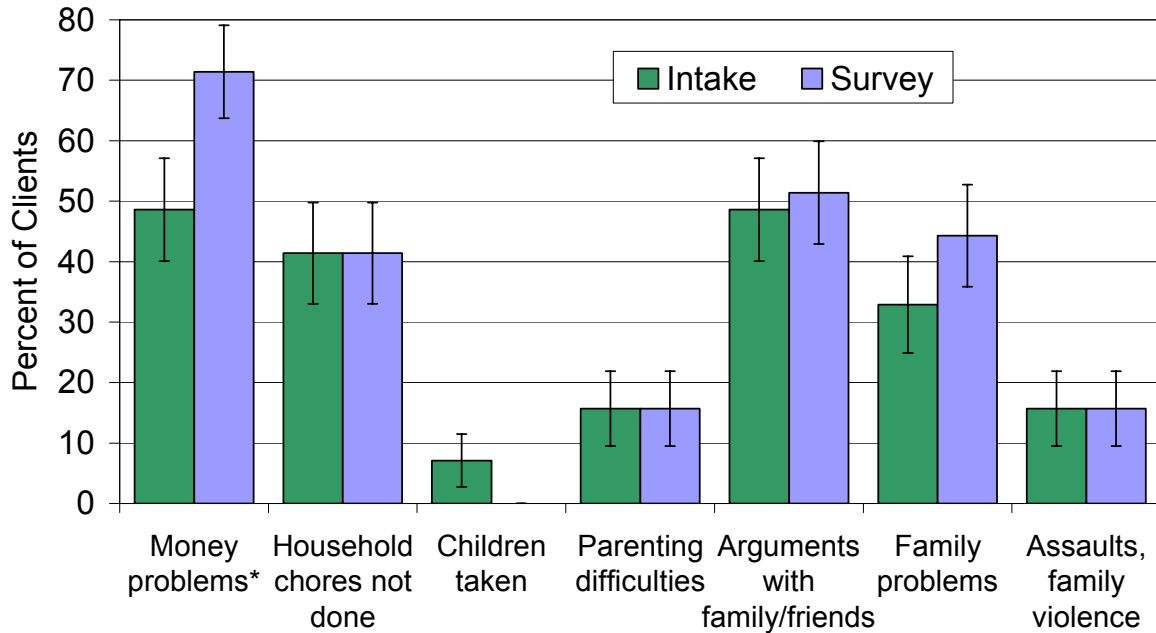


<sup>a</sup>Questions at intake referred to the "past year," while survey questions referred to the "past 6 months."

Additionally in the realm of education and employment, 15% ( $\pm 6\%$ ) of clients completed some schooling or training in trades or professional fields since starting m.i.n.e., 15% ( $\pm 7\%$ ) returned to a previous job that he or she left, and 25% ( $\pm 8\%$ ) started a new job. Overall, 32% ( $\pm 8\%$ ) of clients were employed either full- or part-time at the time of the survey compared to 26% ( $\pm 9\%$ ) at intake.

**SOCIAL AND FAMILY RELATIONSHIPS.** In addition to education and employment, clients provided information regarding problems with social and family relationships at both intake and on the survey. Figure 10 presents the differences at these two time points.

Figure 10. Percent of Clients Who Reported Problems in Social Relationships<sup>a</sup>



<sup>a</sup>Questions at intake referred to the “past year,” while survey questions referred to the “past 6 months.”

\* Significantly different

The only significant difference between the time of intake and the time of the survey was for money problems: at intake, 49% ( $\pm 9\%$ ) of surveyed clients reported such problems, whereas at the time of the survey 71% ( $\pm 8\%$ ) did so. The percentage reporting this problem on the survey was similar to the percentage of non-respondents reporting it at the time of intake (69%  $\pm 9\%$ , not shown in the figure).

In support of the lack of change in social relationships just reported, when the clients were asked on the survey how their social and family relationships had changed since starting m.i.n.e., 45% ( $\pm 9\%$ ) reported that their relationships had stayed the same. However, an additional 45% ( $\pm 9\%$ ) of respondents reported that their relationships had improved since starting m.i.n.e. Several clients reported increased trust and honesty with family and friends, as well as other positive changes in their relationships. Thus, there are likely different survey questions that could be asked to better measure the positive changes in m.i.n.e. clients’ social relationships.

*Get along with people & family better.*

*Less arguing, generally better in all aspects.*

*I know now my family & friends care! They want to see me get better.*

In summary, some clients reported fewer problems in the areas of education and employment, and roughly half of the clients reported that their social and family relationships had improved since starting m.i.n.e. However, many clients reported ongoing problems in social functioning; thus, this area should receive further attention.

### **SUMMARY OF EVALUATION OF GOALS**

In conclusion of this section on goals, the data suggest that m.i.n.e. is meeting well its goal of reducing opiate use and improving the health of clients. Three other goals are being met to some degree, and this report shows where improvements have yet to be made. Finally, the goal of providing a doorway through which clients can access other services is difficult to evaluate given the information presented in this report. Future evaluations should work to determine better ways to assess progress toward this goal.

While the central aim of this evaluation was to evaluate whether the m.i.n.e. program was reaching its documented goals, other details about m.i.n.e. were learned during the process. The next two sections discuss what was learned both from the open-ended questions asked of the survey respondents and from the brief telephone conversations with the pharmacists who provide methadone to m.i.n.e. clients.

### **CLIENTS' VIEWS OF THE PROGRAM**

On the last page of the survey, m.i.n.e. clients were asked three questions: what they thought had helped them the most, what aspects of m.i.n.e. needed the most improvement, and an open question to write about anything they wanted. A vast majority of clients took time to answer these questions, providing a wealth of descriptive information about the clients' experiences in the program.

Although no questions were asked on the survey specifically about the m.i.n.e. staff, when the clients were given the opportunity for a written answer addressing what they felt was the aspect of m.i.n.e. that helped them the most, 32 (53%) of the 60 clients who answered the question spontaneously mentioned something positive about the staff. Clients were extremely appreciative of the help they received from the staff, as represented in the sample of client comments below. The attitude expressed by these clients is important because supportive and non-judgmental staff likely have a positive impact on many client outcomes (Fischer et al., 2002; Health Canada, 2002).

*There there to help you whether you give up on yourself. They don't judge you.*

*Supportive staff & physicians especially when I first started I was given a lot of attention & support/encouragement which I really needed at the time.*

*The staff are always good to talk to, and very caring.  
This is a safe place to come to!*

*The nice attitude friendly non-judgemental councillors.*

*I on I talks with nurse or doctor. Knowing they are their if needed.*

*The incredibly supportive and nice people here. They make me feel very comfortable and I can tell that they care about me, and how I'm feeling.*

Of the 46 clients who answered the question regarding what aspects of m.i.n.e. needed the most improvement, 17 (37%) replied that nothing needed improvement. The other 29 (63%) who replied to the question provided a variety of answers. While only a minority of clients suggested program changes, certain themes echoed opinions expressed by methadone clients from other Canadian cities, as reported by Fischer et al. (2002). Fischer and colleagues conducted focus groups with heroin users from Toronto, Montreal, and Vancouver. Some of these users were in a methadone program, some had been in the past, and others knew about methadone programs, but had never attended.

The first general theme was that clients desired more convenient and flexible times to receive methadone and other services. A client in Fischer et al.'s study (2002) said "*They say it's supposed to help you get on with your life, but it doesn't allow you to get on with your life...e.g., they expect me to go to the clinic at 9am everyday, but I had to be at my job at that time*" (p. 505). Similar suggestions were offered by m.i.n.e. clients.

*On helping working people obtaining their methadone on either weekly or twice week pickup. We are responsible we do have to work and function properly every day.*

*Flexibility for carry's*

*Open longer daily.*

*More doctor times. They need to be here more.*

Second, Fischer et al. (2002) reported that "users felt they were uninformed" (p. 505), and some m.i.n.e. clients also desired more information about the program.

*How to come of this program with positive results. More info on what to expect.*

*You need to inform people more about the dental problem.*

*I think when you first come here, everything that m.i.n.e. offers should be explained during or shortly after your assessment.*

Third, clients in Canada see the need for more educational and peer groups within the context of the methadone programs. Fischer et al. (2002) reported that the “availability of on-site support services such as counseling, skills training, education, and peer support groups was stated as necessary for good treatment programs” (p. 509). A few m.i.n.e. clients also mentioned the desire for such groups.

*I would like to see an ongoing methadone group (maybe methadone anonymous) one evening or weekend-day a week because our experience is different from most N.A. members.*

*More groups. And training things Eg. Computers, education, etc.*

*I liked the group they used to hold here.*

Finally, Fischer et al. (2002) reported that a majority of the participants in their study were dissatisfied with the methadone program staff. In contrast, m.i.n.e. clients in Winnipeg were generally pleased with the staff. As described above, at least half the m.i.n.e. clients felt that the staff provided the program ingredient that helped them the most. Program staff play an essential role in program and client success, and this was supported even by the participants in the Fischer et al. study. Thus, the m.i.n.e. program may be one of the better methadone programs available in Canada from the point of view of client satisfaction.

*It is a very well run program. I have been on methadone programs in Sask and Alberta and this is the best run of all of them. And all the staff are very nice people who seem to actually care about you as a person and have a good understanding of peoples situations. Very good work.*

*This program has helped me a lot more than the program in B.C. You get more one on one counselling here.*

In summary, many clients expressed appreciation for the m.i.n.e. program and were not hesitant to offer suggestions for program improvements. The clients’ willingness to answer

the open-ended questions shows their comfort with and investment in the program, as well as providing valuable information in the program evaluation.

## **PARTNERSHIPS WITH PHARMACIES**

As the number of potential clients of the m.i.n.e. program has increased over the past few years, there has been a focus on creating and expanding an outreach component of the program. One type of partnership in the outreach component is that formed with local pharmacies in the delivery of methadone. This is one of the more recent innovations, and since the last evaluation of m.i.n.e., when 20 urban and rural community pharmacies were part of the m.i.n.e. program (Wenger, 2002), the program has expanded to include 57 pharmacy partners, with 27 (47%) located outside the city of Winnipeg.

A sample of pharmacists ( $n = 6$ , 11%) from these partner pharmacies were contacted by the AFM research team regarding their involvement with the m.i.n.e. program. The pharmacists were asked questions regarding (a) their satisfaction with the operation of the m.i.n.e. program as far as their involvement, (b) what things they would like to see improved, given unlimited time and resources, (c) any problems they had with the m.i.n.e. clients, and (d) whether they would be willing to accept more clients.

The pharmacists expressed their appreciation for the m.i.n.e. program. For example, one pharmacist appreciated that the m.i.n.e. program provided counselling along with the methadone, because while the methadone helps to stop the need to obtain other opiates, the counselling helps the clients deal with other aspects of their lives. Another pharmacist who provided methadone to clients of other methadone programs in the province felt that the m.i.n.e. program was the best.

When asked what things they would like to see improved, the answers were of a similar nature to those of the clients. Some pharmacists would like to be able to contact the m.i.n.e. physicians and counsellors after hours and on weekends, when the pharmacies are open and may be seeing the clients, but the m.i.n.e. Misericordia site is closed. Another pharmacist suggested that more information could be provided to some clients, which was also recommended by the clients. Specifically, the pharmacist suggested that some clients may benefit from more information regarding voluntarily weaning from methadone, because they may feel frustrated and think they need to take methadone for the rest of their lives.

All pharmacists were satisfied with the operation of the program as far as their own involvement with it and while most pharmacists reported that they had had problems with some of the clients, all pharmacists were enthusiastically willing to accept more m.i.n.e. clients. Thus, given the pharmacists' overall positive response about the program and the fact that 74% ( $\pm 8\%$ ) of clients received their methadone from community pharmacy sites of the m.i.n.e. program, the partnerships with pharmacies appear to be working very well.

## SUMMARY AND RECOMMENDATIONS

### SUMMARY

In summary, this evaluation shows that the m.i.n.e. program has met some of its goals, made progress toward others, and made a positive impact in the lives of numerous clients.

*The day I started mine my drug problem was under control.*

*It has helped me in leaps + bounds. I'm not stressed out like I was and now I can see the light at the end of the tunnel. Everything has changed for the good, drastically!*

*The mine program probably saved my life.*

The conclusions drawn from this evaluation are based on only those clients who completed the survey. Thus, it is important to review the similarities and differences between surveyed and non-surveyed clients. Table 1 showed that surveyed and non-surveyed clients were similar in age and gender distributions, education, income, and employment status, but differed in marital status: a higher percentage of surveyed clients were married/common-law and a lower percentage were single compared to non-surveyed clients. As discussed in the *Method* section, both groups of clients had similar drug use patterns at intake, and fewer surveyed than non-surveyed clients had committed and been charged with crimes. Surveyed clients reported statistically similar levels of problems in social functioning compared to non-surveyed clients, but in every case, a slightly lower percentage of surveyed clients reported the problem. Thus, overall, surveyed and non-surveyed clients were similar, but differed in a few areas. The differences may mean that non-surveyed clients would have different outcomes, because as presented in the introduction, outcomes are generally better for clients who have intact social networks and have committed fewer crimes, among other things. However, given that there were similarities in a majority of areas compared, non-surveyed clients may also show outcomes similar to the surveyed clients.

Data obtained from the surveyed clients were used to assess whether m.i.n.e. was reaching its program goals. In summary:

1. The first goal of reducing the harm of opiate use and improving the health of clients was well met, as opiate use declined from the time of intake to the time of the survey, and clients reported improvements in eating habits, physical health, and mental health.
2. The evaluation of the second goal, providing clients access to other services, was inconclusive, as some clients used services more and some clients used services less after starting m.i.n.e. However, determining whether each client was accessing the services that he or she needed was not addressed by the current questionnaire. Future work should explore how this goal can be better assessed.

3. The m.i.n.e. program is making progress toward its third goal of reducing the spread of infectious diseases: injection drug use decreased in m.i.n.e. clients and most clients were tested at least once for HIV and Hepatitis C; however, further testing should be encouraged for some clients.
4. The goal of m.i.n.e. to reduce crimes associated with opiate use was supported by the decline in the percentage of clients with court appearances pending, who are on probation, or who are on parole. Further evaluations of outcomes related to this goal were not as easy to interpret because of differences in the way the data were collected at intake and in the survey. However, information from the survey can provide a baseline measure for the next evaluation of the m.i.n.e. program.
5. The fifth goal of m.i.n.e. is to improve the social functioning of clients. This evaluation showed that some clients reported fewer problems in the areas of education and employment, and roughly half of the clients reported that their social and family relationships had improved since starting m.i.n.e. However, many clients reported ongoing problems in social functioning; thus, this area should continue to be a focal area for the program staff.

Overall, m.i.n.e. is making excellent progress toward most of its program goals. This evaluation presents data that show where future efforts may be focused, either in altering the program to better reach the goals, or in revising the goals to better define the expectations of the program. Selected suggestions for doing so are offered below.

## **RECOMMENDATIONS**

The recommendations that arise from this evaluation include both those for the program staff and administrators, as well as for the next evaluation of the m.i.n.e. program.

- *Identify the clients who are at risk and have not yet been tested for HIV or for Hepatitis C and encourage them to be tested*

As shown in Figures 6 and 7, some m.i.n.e. clients have not been tested for HIV or for Hepatitis C since starting the program. Encouraging these clients to be tested is an important prevention step. If any of the clients test positive for HIV, they will likely adopt behaviours that will reduce further spread of the disease, and if any clients test positive for Hepatitis C, they can be assisted in seeking treatment.

- *Concentrate effort toward reducing clients' criminal activities (related to opiate use or otherwise)*

The survey showed that approximately 30% of clients had committed a crime in the six months before the survey. We could not determine whether this was a reduction in crime, because of differences between questions at intake and those on the survey. Nonetheless, this percentage of clients committing crimes suggests that further efforts toward reducing criminal activity are warranted. A future evaluation could examine in more detail the circumstances around this criminal activity.

- *Work with clients to continue to improve their social relationships*

Almost half of clients reported that their social relationships had improved, but many still reported problems (e.g., arguments with family and friends). M.i.n.e. staff should therefore continue to help the clients to improve the quality of their personal relationships.

- *Maintain and enhance supportive and non-judgmental characteristics in current and future m.i.n.e. staff members*

Based on the positive responses regarding the staff at m.i.n.e., it is important to maintain and enhance the characteristics of program staff that the clients appreciate. Further, given that the clients provided these positive responses about the current staff, staff retention should be supported and promoted. When additional staff members join the m.i.n.e. team, measures should be taken to ensure that the new staff members are as supportive and non-judgmental to the clients as the current staff are.

- *Consider client suggestions for improving the program. For example:*
  - *provide more flexible hours of operation based on client input*
  - *ensure that every client is provided with information about all aspects of the program and what to expect while taking methadone*
  - *establish a “methadone anonymous” or other peer support group*

The above recommendations for improving the program come from clients’ suggestions, which are important to consider because m.i.n.e. operates under the philosophy of client-centered care. Implementation of these recommendations should occur only after feasibility assessments have been done to assess whether m.i.n.e. has the capacity to implement the recommendations appropriately and consistently. For example, for the suggestion of providing more flexible hours of operation, questions should be answered regarding whether current staff will be able to work different hours, or whether more staff members would be required for different hours of operation. Before changing the hours, it’s also important to consider client interest and what they may gain. For example: How many clients would be interested in different times to receive their methadone? Would different times allow more clients to hold full-time jobs?

- *Ensure that questions on the intake and assessment forms include time frames. For example, instead of asking if the person has ever injected drugs, ask the time frame of most recent injection drug use with an option of “never”.*

This recommendation is one example of the improvements that can be made during the revision of the MIS forms, which is currently underway. Some information from the current MIS forms was used in this evaluation, but the MIS data have potential to be even more valuable in future evaluations of AFM programs. This should be considered by the teams revising the MIS forms.

- *Between now and the next evaluation, review and clarify program goals and objectives, by answering questions such as:*
  - *What is the definition of harmful use of opiates?*
  - *How does reducing harmful use improve the health of users?*
  - *Can the health of users improve without reducing the use of opiates?*
  - *Should m.i.n.e. be more concerned with clients' knowledge of available services, rather than the clients' access to the services?*
  - *Should m.i.n.e. be more concerned with clients' use of safe injection and sexual practices than with reducing the spread of infectious diseases?*
  - *What crimes are associated with opiate use?*
  - *How are the crimes associated with opiate use identified?*
  - *Should m.i.n.e. clients reduce all criminal activity or only that associated with opiate use?*
  - *How do we know if the social functioning of clients has improved?*
  - *What specific aspects of social functioning should the m.i.n.e. program affect?*

This recommendation arises mainly from the challenge in assessing the current goal of providing “a doorway through which clients can access other services”, but as can be seen from the list of questions, all goals should be reviewed and clarified. Clarified program goals will support a more meaningful evaluation of the program next time.

- *Based on the revised goals and objectives, create outcome indicators that can be measured in a future evaluation survey.*

While reviewing the program goals and objectives, specific outcome indicators should be created. These indicators are important for helping to guide the next evaluation study.

- *The next evaluation should specifically measure the new outcome indicators.*

The current evaluation was an improvement over the previous evaluation, and the next evaluation should improve on this one. The next evaluation should more closely assess whether specific program objectives were met. For example, the survey used in the current evaluation did not ask clients about their criminal activity *related to opiate use*. Rather, the survey asked about criminal activity in general. After the crime-related goal is clarified, a new survey should address the specific aspects of crime that are of interest to the program.

- *Include a process evaluation in the next evaluation to determine why or how the m.i.n.e. program is making a difference in clients' lives*

For the next evaluation, specific information should be gathered to answer questions about *how* or *why* the m.i.n.e. program changes clients' behaviours. The survey used in the current evaluation can provide some information as a starting point. For example, from the survey, we know that the clients reported changes in their physical

and mental health such as fewer illnesses, more energy, and improved concentration. The next evaluation should try to determine how the program leads to these changes in the clients' health.

- *Add questions to the survey questionnaire regarding:*
  - *the timeframe of most recent drug use*
  - *positive relationship experiences (e.g., increased trust, honesty), and more detail about negative relationship experiences*
  - *why clients are not getting tested for HIV and Hepatitis C*
  - *client satisfaction with the m.i.n.e. program (e.g., are they empowered by having methadone carries? Do they appreciate receiving methadone at a community pharmacy? What aspects of the program make them stay?)*

After conducting the current evaluation, we see that much more can be learned in the next one, and the questionnaire should be revised to gather better information. Adding questions regarding most recent drug use will improve comparisons to the urine test results. Questions about positive relationship experiences and more detailed questions about negative experiences may help to determine why almost half of the clients reported that their relationships had improved. For example, although arguments continued to occur, perhaps they happened less often. "Why" questions are important to help program staff identify what can be done to further help the clients. For example, finding out why clients are not getting tested for HIV or Hepatitis C will help the staff find a way to help the clients who haven't yet been tested. Finally, questions regarding overall client satisfaction with the m.i.n.e. program may provide more specific information regarding which aspects of the program work well and which ones could be improved.

- *Consider in-person interviews for the next evaluation.*

Because some clients may have trouble reading and understanding a questionnaire, in-person interviews should be considered for the next evaluation. However, this option should be researched to determine whether the benefits outweigh the costs (e.g., some clients may be more honest when answering a questionnaire).

- *Conduct a more extensive survey for the partner pharmacies.*

Only six pharmacies were surveyed in the current evaluation, but valuable information about what works and what could be improved may be gained by surveying all of the partner pharmacies. As well, both pharmacists and pharmacy technicians could be surveyed, as they may have different views of the m.i.n.e. program and clients.

Following these recommendations will likely improve the m.i.n.e. program and the next evaluation of m.i.n.e. Further, the improved evaluation will lead to further improvements of m.i.n.e. and suggestions for the next evaluation. Such an ongoing cycle of improvements will create the best situation for the program and more importantly, for the clients.

## References

- Bell, J. (1998). Delivering effective methadone treatment. In J. Ward, R. P. Mattick, & W. Hall (Eds.), *Methadone maintenance treatment and other opioid replacement therapies* (pp. 161-175). Amsterdam: Harwood.
- Brands, B., Blake, J., Sproule, B., Gourlay, D., & Busto, U. (2004). Prescription opioid abuse in patients presenting for methadone maintenance treatment. *Drug and Alcohol Dependence*, *73*, 199-207.
- Broome, K. M., Simpson, D. D., & Joe, G. W. (2001) Relapse to opioid and cocaine use following methadone treatment. In F. M. Tims, C. G. Leukefeld, & J. J. Platt (Eds.), *Relapse and recovery in addictions* (pp. 334-354). New Haven, CT: Yale University.
- Centers for Disease Control and Prevention (1998). Recommendations for prevention and control of Hepatitis C Virus (HCV) infection and HCV-related chronic disease. *Morbidity and Mortality Weekly Report*, *47*, 1-39. Available (cited 10 July 2005): <http://www.cdc.gov/mmwr/preview/mmwrhtml/00055154.htm>
- Centers for Disease Control and Prevention (2000). Adoption of protective behaviors among persons with recent HIV infection and diagnosis – Alabama, New Jersey, and Tennessee, 1997-1998. *Morbidity and Mortality Weekly Report*, *49*, 512-515. Available (cited 10 July 2005): <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4923a2.htm>
- Epstein, D. H., & Preston, K. L. (2003). Does cannabis use predict poor outcomes for heroin-dependent patients on maintenance treatment? Past findings and more evidence against. *Addiction*, *98*, 269-279.
- Farrell, M., Ward, J., Mattick, R., Hall, W., Stimson, G. V., des Jarlais, D., Gossop, M., & Strang, J. (1994). Methadone maintenance treatment in opiate dependence: A review. *British Medical Journal*, *309*, 997-1001.
- Fischer, B., Chin, A. T., Kuo, I., Kirst, M., & Vlahov, D. (2002). Canadian illicit opiate users' views on methadone and other opiate prescription treatment: An exploratory qualitative study. *Substance Use & Misuse*, *37*, 495-522.
- Gates, J. (Ed.). (2002). *Canadian Community Epidemiology Network on Drug Use: Winnipeg 2002 report*. Winnipeg, MB: Addictions Foundation of Manitoba. Available (cited 10 July 2005): [http://www.ccsa.ca/ccendu/pdf/report\\_winnipeg\\_2002.pdf](http://www.ccsa.ca/ccendu/pdf/report_winnipeg_2002.pdf)
- Hall, W., & Solowij, N. (1998). Adverse effects of cannabis. *The Lancet*, *352*, 1611-1616.
- Health Canada (2002). *Literature review: Methadone maintenance treatment* (Cat. H49-162/2002E). Ottawa, ON: Author.

- Joe, G. W., Simpson, D. D., Greener, J. M., & Rowan-Szal, G. A. (1999). Integrative modeling of client engagement and outcomes during the first 6 months of methadone treatment. *Addictive Behaviors, 24*, 649-659.
- Loughlin, A. M., Schwartz, R., & Strathdee, S. A. (2004). Prevalence and correlates of HCV infection among methadone maintenance attendees: Implications for HCV treatment. *International Journal of Drug Policy, 15*, 93-101.
- MacMaster, S. A. (2004). Harm reduction: A new perspective on substance abuse services. *Social Work, 49*, 356-363.
- Millson, P., Myers, T., Calzavara, L., Wallace, E., Major, C., & Degani, N. (2003). Regional variation in HIV prevalence and risk behaviours in Ontario injection drug users (IDU). *Canadian Journal of Public Health, 94*, 431-435.
- Patton, D., & Lemaire, J. (2002, July). *A preliminary evaluation of the AFM Methadone Maintenance Program (MMP)*. Winnipeg, MB: Addictions Foundation of Manitoba.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114.
- Seivewright, N. (2003). Methadone treatment outcomes appear mainly unaffected by cannabis use. *Addiction, 98*, 251-252.
- Stevens, K. (Ed.). (2003). *Canadian Community Epidemiology Network on Drug Use: Winnipeg 2003 report*. Winnipeg, MB: Addictions Foundation of Manitoba. Available (cited 10 July 2005): [http://www.ccsa.ca/ccendu/pdf/report\\_winnipeg\\_2003.pdf](http://www.ccsa.ca/ccendu/pdf/report_winnipeg_2003.pdf)
- Stevens, K. (Ed.). (2004). *Canadian Community Epidemiology Network on Drug Use: Winnipeg 2004 report*. Winnipeg, MB: Addictions Foundation of Manitoba. Available (cited 10 July 2005): [http://www.ccsa.ca/ccendu/pdf/report\\_winnipeg\\_2004.pdf](http://www.ccsa.ca/ccendu/pdf/report_winnipeg_2004.pdf)
- Wenger, L. (2004). *Methadone intervention & needle exchange program: Moving best practices into action*. Winnipeg, MB: Addictions Foundation of Manitoba.
- Wodak, A. (2002). Methadone and heroin prescription: Babies and bath water. *Substance Use & Misuse, 37*, 523-531.

**Appendix A**  
**Questionnaire**



7) Do you visit a family doctor other than the m.i.n.e. doctor more or less often than before starting m.i.n.e.?

More     Less     About the Same

8) Since starting m.i.n.e., have you received care from a dentist?

No     Yes

↓

Why?

- I can't afford it / don't have coverage.
- I don't have a dentist.
- I have an appointment scheduled.
- I have not been able to get an appointment.
- I don't have any dental problems.
- Other reason (explain): \_\_\_\_\_

9) Do you visit a dentist more or less often than before starting m.i.n.e.?

More     Less     About the Same

10) In general, how have your eating habits changed since starting the m.i.n.e. program?

Improved     Stayed the same     Got worse

↓

↓

What aspects of your eating habits have changed? \_\_\_\_\_

11) In general, how has your overall physical health changed since starting the m.i.n.e. program?

Improved     Stayed the same     Got worse

↓

↓

What aspects of your physical health have changed? \_\_\_\_\_

12) In general, how has your overall mental health changed since starting the m.i.n.e. program?

Improved     Stayed the same     Got worse

↓

↓

What aspects of your mental health have changed? \_\_\_\_\_

13) Since starting m.i.n.e., have you received care from a psychologist?

No     Yes

↓

Why?

- I have an appointment scheduled.
- I have not been able to get an appointment.
- I don't have any mental health problems.
- Other reason (explain): \_\_\_\_\_

Continue ►

14) Do you visit a psychologist more or less often than before starting m.i.n.e.?

More     Less     About the Same

15) Since starting m.i.n.e., have you received care from a psychiatrist?

No     Yes

↓

Why?

- I have an appointment scheduled.
- I have not been able to get an appointment.
- I don't have any mental health problems.
- Other reason (explain): \_\_\_\_\_

16) Do you visit a psychiatrist more or less often than before starting m.i.n.e.?

More     Less     About the Same

17) Please indicate which of the following services you used before starting m.i.n.e. and which you have used since starting m.i.n.e. Please indicate all that apply.

	Before starting m.i.n.e.	After starting m.i.n.e.
<b>Medical</b>		
Hospital	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>	<input type="checkbox"/>
HCV Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Other Medical (e.g., obstetrics, specialist care, lab work)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Social Services</b>		
Social assistance	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Child care support	<input type="checkbox"/>	<input type="checkbox"/>
Training	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other substance use treatment</b>		
Narcotics Anonymous (N.A.)	<input type="checkbox"/>	<input type="checkbox"/>
Other (e.g., withdrawal management [detox], outpatient/patient, residential)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Counseling and support</b> (e.g., individual, group, women's, couple, family)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Health promotion, disease prevention and education</b> (e.g., public health, community health centres, nutrition, HIV prevention, HCV prevention)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Child, youth, family services</b> (e.g., child welfare, child care, youth services, parenting programs)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Legal/justice</b> (e.g., victims' services, legal services)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Education</b> (e.g., literacy, academic courses, life skills programs)	<input type="checkbox"/>	<input type="checkbox"/>

Continue ►

	Before starting m.i.n.e.	After starting m.i.n.e.
<b>Employment</b> (e.g., vocational skills training, employment services/programs, employee assistance)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Resources</b> (e.g., shelters, food banks, spiritual/ethnocultural organizations, recreational, community advisory groups, service groups, women's services, friendship centres)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Outreach &amp; advocacy</b> (e.g., street workers, peer-based services)	<input type="checkbox"/>	<input type="checkbox"/>

**18) What is the highest education level you have obtained?**

- |   |   |
|---|---|
| <input type="checkbox"/> Less than grade 9      | <input type="checkbox"/> Some college, university or other training beyond high school          |
| <input type="checkbox"/> Incomplete high school | <input type="checkbox"/> Completed college, university, or trades school certificate or diploma |
| <input type="checkbox"/> Completed high school  | <input type="checkbox"/> Completed university Bachelors degree or higher                        |
|   | <input type="checkbox"/> Other: _____   |

**19) Since starting m.i.n.e. have you completed any schooling or training?**

- No  Yes → Please describe briefly: \_\_\_\_\_

**20) Since starting m.i.n.e. have you returned to a previous job you left?**

- No  Yes

**21) Since starting m.i.n.e. have you started a new job?**

- No  Yes

**22) What is your current employment status?**

- |   |   |                                    |                                       |
|---|---|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Employed full-time | <input type="checkbox"/> Unemployed       | <input type="checkbox"/> Student   | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Employed part-time | <input type="checkbox"/> Leave of absence | <input type="checkbox"/> Retired   |                                       |
| <input type="checkbox"/> On E.I.            | <input type="checkbox"/> Disability leave | <input type="checkbox"/> Homemaker |                                       |

**23) What is your present marital status?**

- Single  Married / Common Law  Divorced / Separated  Widowed  Other: \_\_\_\_\_

**24) How many children do you have?**

- 0  1  2  3  4  5  6 or more

**25) How many children live with you?**

- 0  1  2  3  4  5  6 or more

Continue ►



32) Please indicate how often you have used each of the following opioids in the past 6 months. Please answer for each opioid separately.

	Have never used	Not within past 6 months	Less than once a month	Monthly	Weekly	Daily	Binges/ Sprees
Morphine (M, morph, Miss Emma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine (3's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (horse, smak, junk, H, skag)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OxyContin / Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Percodan / Percocet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demerol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dilaudid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33) If you have used any of the above opioids in the past 6 months:

Did you take them by prescription?  No  Yes

Why did you use them?  Pain management  To get high

**REMEMBER: This information does NOT go to your counsellor. Please be as truthful as possible when answering.**

34) Please indicate how often you have used each of the following substances in the past 6 months. Please answer for each substance separately.

	Have never used	Not within past 6 months	Less than once a month	Monthly	Weekly	Daily	Binges/ Sprees
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (speed, hearts, white crosses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic Steroids/Growth hormone supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (e.g., sleeping pills: seconal, amytal, barbs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines (librium, valium, clonazepam, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cannabis: marijuana, hashish, hash oil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (powder, snow, flake)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack Cocaine (rock)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continue ►

	Have never used	Not within past 6 months	Less than once a month	Monthly	Weekly	Daily	Binges/ Sprees
Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD/Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamines: speed, crank, crystal, ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methaqualone (quaalude, ludes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methylphenidate (Ritalin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Club Drugs like Rohypnol (Roofies, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Over-the-counter products (Ephadrine, Nytol, Gravol etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phencyclidine (PCP, angel dust, love boat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psilocybin (magic mushrooms, purple passion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvents/inhalants: Gas, Glue, Hairspray, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**35) Please indicate how often you have taken drugs by injection (needle) in the past year.**

Have never injected drugs	Not within past year	Not within past 6 months	Less than once a month	Monthly	Weekly	Daily	Binges/ Sprees
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		↓	↓	↓	↓	↓	↓

Where do you get your needles?

Buy them     Needle Exchange     Friends/Family     Other

Do you use needles more than once?     No     Yes

Do you share needles?     No     Yes

Have you used the Needle Exchange at m.i.n.e.?     No     Yes

How many needles have you exchanged at m.i.n.e. in the past month?

0-4     5-9     10-14     15-19     20-24     25+

Continue ►

36) Would you like more information about safe injecting practices to be made available?

No  Yes → What additional/different information would you like?

General info  Specific info (describe): \_\_\_\_\_

37) Do you use safe sexual practices?  No  Yes

38) Do you use the condoms provided by m.i.n.e.?  No  Yes

39) Would you like more information about safe sexual practices to be made available?

No  Yes → What additional/different information would you like?

General info  Specific info (describe): \_\_\_\_\_

40) Were you tested for HIV before you started m.i.n.e.?

No  Yes → What were the results of the test?  Negative  Positive

41) Have you been tested for HIV since starting m.i.n.e.?

No  Yes



What were the results of the test?

Negative  Positive



<p>Do you think proper referrals were made for you? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>What changes to the referral process do you suggest, if any?</p> <p>_____</p>
---

42) Have you received information about HIV at m.i.n.e.?

No  Yes

43) Would you like more information about HIV to be made available at m.i.n.e.?

No  Yes → What additional/different information would you like?

General info  Specific info (describe): \_\_\_\_\_

44) Were you tested for Hepatitis C before you started m.i.n.e.?

No  Yes → What were the results of the test?  Negative  Positive

Continue ►

**45) Have you been tested for Hepatitis C since starting m.i.n.e.?**

No  Yes



What were the results of the test?

Negative  Positive  Converted from Positive to Negative

Do you think proper referrals were made for you?  No  Yes

What changes to the referral process do you suggest, if any?

**46) Have you received information about Hep. C at m.i.n.e.?**

No  Yes

**47) Would you like more information about Hep. C to be made available at m.i.n.e.?**

No  Yes → What additional/different information would you like?

General info  Specific info (describe): \_\_\_\_\_

**48) Do you have a court appearance pending?**

No  Yes



Is it related to something that happened **before** you started the m.i.n.e. program?

No  Yes

Please indicate if it is related to any of the following:

Alcohol  Opioids  Other drugs

**49) Are you currently on probation?**

No  Yes



Is it related to a crime that happened **before** you started the m.i.n.e. program?

No  Yes

Please indicate if it is related to any of the following:

Alcohol  Opioids  Other drugs

Continue ►

**50) Are you currently on parole?**

No  Yes

↓

Is it related to a crime that happened **before** you started the m.i.n.e. program?

No  Yes

Please indicate if it is related to any of the following:

Alcohol  Opioids  Other drugs

**51) Please indicate whether you have been charged with any of the following crimes in the past 6 months and whether you were high when you committed the crime. Please answer for each crime separately.**

	Charged with crime	High during crime
<b>Drug crime</b>		
Possession	<input type="checkbox"/>	<input type="checkbox"/>
Trafficking	<input type="checkbox"/>	<input type="checkbox"/>
Intoxicated in public	<input type="checkbox"/>	<input type="checkbox"/>
Driving under the influence	<input type="checkbox"/>	<input type="checkbox"/>
<b>Drug-related crime (e.g., crime to get money to buy drugs)</b>		
Break & Enter	<input type="checkbox"/>	<input type="checkbox"/>
<b>Theft:</b>		
Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>
Shoplifting	<input type="checkbox"/>	<input type="checkbox"/>
Other Theft	<input type="checkbox"/>	<input type="checkbox"/>
Fraud	<input type="checkbox"/>	<input type="checkbox"/>
Possession of stolen goods	<input type="checkbox"/>	<input type="checkbox"/>
Robbery	<input type="checkbox"/>	<input type="checkbox"/>
Assault	<input type="checkbox"/>	<input type="checkbox"/>
Prostitution	<input type="checkbox"/>	<input type="checkbox"/>

**52) Not including the crimes indicated above, please indicate whether you have committed any of the following crimes in the past 6 months (even if you weren't charged) and whether you were high when you committed the crime. Please answer for each crime s**

	Commit- ted crime	High during crime
<b>Drug crime</b>		
Possession	<input type="checkbox"/>	<input type="checkbox"/>
Trafficking	<input type="checkbox"/>	<input type="checkbox"/>
Intoxicated in public	<input type="checkbox"/>	<input type="checkbox"/>
Driving under the influence	<input type="checkbox"/>	<input type="checkbox"/>

Continue ►

	Commit- ted crime	High during crime
<b>Drug-related crime (e.g., crime to get money to buy drugs)</b>		
Break & Enter	<input type="checkbox"/>	<input type="checkbox"/>
<b>Theft:</b>		
Motor Vehicle	<input type="checkbox"/>	<input type="checkbox"/>
Shoplifting	<input type="checkbox"/>	<input type="checkbox"/>
Other Theft	<input type="checkbox"/>	<input type="checkbox"/>
Fraud	<input type="checkbox"/>	<input type="checkbox"/>
Possession of stolen goods	<input type="checkbox"/>	<input type="checkbox"/>
Robbery	<input type="checkbox"/>	<input type="checkbox"/>
Assault	<input type="checkbox"/>	<input type="checkbox"/>
Prostitution	<input type="checkbox"/>	<input type="checkbox"/>

53) What aspects of m.i.n.e. do you think have helped you the most?

54) What aspects of m.i.n.e. do you think need the most improvement?

55) Is there anything else you would like to tell us about your experience in the m.i.n.e. program?

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE**

**Appendix B**  
**Consent Form**

## CONSENT FORM



**Research Project Title:** Methadone Intervention & Needle Exchange Program Evaluation

**Researchers:** Dr. David Patton (944-6291)  
Dr. Jennifer Bodnarchuk (944-6243)  
AFM Research & Quality Monitoring

This consent form should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully.

---

**What is the purpose of the research?** This research has two purposes. First, to evaluate whether the m.i.n.e. program is reaching its goals. Second, to gather information that may be used to improve the program.

**What would I do?** Fill in a questionnaire and provide a urine sample. The questionnaire will ask many questions about your behaviours related to the goals of the m.i.n.e. program and will take approximately 20 minutes to complete. When you are finished with the questionnaire, you will place it in an envelope and seal it. The envelope will be sent to the AFM Research team. The urine sample you provide will be tested by a m.i.n.e. staff member and the results will be sent to the AFM Research team.

**Can I quit the project at any time?** Yes. You can withdraw from the project at any time. You can choose not to answer any questions with which you are uncomfortable. If you do not understand a question, please ask a m.i.n.e. staff member. Not participating in this research project will have no affect on your m.i.n.e. program treatment.

**Are there any risks to me?** No. Your own answers and urine test results will NOT be used to adjust your methadone dose or other parts of your individual treatment. No one will know about your answers on the questionnaire except the AFM Research team, and only the AFM Research team and m.i.n.e. staff will know about your urine test results.

**Are there any benefits for me?** Yes. After you complete the questionnaire and provide a urine sample, you will receive a \$10 coupon good for any purchase at Safeway. As well, you may benefit from improvements made to the m.i.n.e. program based on the survey results from all clients. So please provide any information on the questionnaire that you think may improve the program.

**Can I find out about the results of the project?** Yes. A copy of the final report will be made available at the m.i.n.e. office later this summer. The report will not contain any individual client's results, but will only report average, or grouped results.

If you have any concerns or complaints about this project you may contact the researchers listed on the reverse side of this sheet.

Please indicate below whether or not you agree to participate in this research project, and then sign the form. By signing this form, you show that you are satisfied with your understanding of the research project as described on the reverse side of this sheet. Signing this form does not waive your legal rights nor release AFM employees from their legal and professional responsibilities.

I AGREE to participate in this research project.

I DO NOT AGREE to participate in this research project.

---

Participant's Signature

Date

---

m.i.n.e. Staff Signature

Date