



# Methadone News

College of Physicians and Surgeons of Ontario

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Dr. Steve Bodley  
Methadone Committee Chair

## Word from the Chair

I am pleased to introduce myself as the new Chair of the Methadone Committee. I am an Anesthesiologist and Director of the Pain Management Clinic at the North Bay Regional Health Center. I have been on Council since 2009.

In my new role as Chair I wish to acknowledge a few people. I would like to thank Dr. Michael Franklyn, Committee Chair since 2009, for his excellent leadership and for making the work of the other committee members so seamless. Dr. Franklyn will remain a member of the committee in 2012. Thanks also to Dr. El-Tantawy Attia who has served on the Committee as a public member since 2009. Welcome to our new member, Dr. Karen Jones, who is a family physician and a member of the College's Quality Assurance Committee. Welcome back to Drs. Gupta, Gillmore and Kahan and to public member Diane Doherty.

As a Committee member, I have seen the value of this program to the provision of MMT in Ontario. Here are a few comments which demonstrate this:

"I am very pleased with the process and it has helped me to increase my confidence."

*"Very professional and knowledgeable – helpful suggestions – would appreciate more web presence of the Methadone Program"*

*"...this assessment was truly a "peer" assessment, compared to past years."*

I'm looking forward to my new role as Chair and contributing to the ongoing work of this Committee. I hope to meet some of you at the 2012 Prescribers' Conference.

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## Combined Opiate Prescriptions

Prescribers are sometimes asked to accept the transfer of a patient who has a combined script for opiates (e.g. methadone and the duragesic patch, or, methadone and Oxycontin or morphine). Although the physician should be sensitive to the chronic pain issues which affect a large proportion of the methadone population, physicians who monitor patients under the rubric of methadone maintenance for addiction are not obligated to manage chronic pain.

The combined scripts of chronic opiates and methadone make monitoring the addiction illness difficult if not impossible. Methadone alone can be effective in managing patients who have both addiction and chronic pain, but the methadone prescriber's role is managing addiction in the methadone maintenance program.

Therefore, if the new prescriber is uncomfortable with the present prescribing practice, he or she is not obligated to continue chronic opiates, or give carries to patients on the combined opiates. If the physician feels that chronic pain is the main problem in a patient who has no active addiction, as an alternative, the physician may choose to manage the patient under a pain license for methadone, and remove the patient from the methadone maintenance registry.

## Moving beyond the methadone clinic and into primary care: the challenge for long term methadone patients

**Justyna M Bartoszko and Carol J Strike, University of Toronto**

While 50 years of evidence shows that methadone maintenance treatment (MMT) is effective, most of the research is about patients within the first few years of treatment. In Ontario, the patient population is changing and many patients remain in treatment for many years.

However, the research literature does not provide much evidence about this population of MMT patients and if their needs with respect to methadone and other health services change with increasing years in treatment. Working with the Patient Advisory Group at the CPSO, we focused on this issue. To do so, we interviewed 21 methadone patients in treatment for 5 or more years across 3 geographic regions in Ontario and, also, 13 with methadone prescribers.

MMT patients in our study were very satisfied with their relationship with their methadone prescribers, but expressed dissatisfaction with the structure of health care accessibility and delivery. The MMT patient population is diverse and includes many who were keen to cut ties to the drug scene and regain what was lost as a result of addiction (e.g., employment, housing, family life).

Almost all patients received the MMT at a large practice setting where they interacted with other patients at various stages of recovery. Many participants noted that this was problematic for their recovery because mandatory attendance requirements led to fre-

quent exposure to the drug scene, despite treatment being seen as a pathway away from this very lifestyle.

*“You don't like going to the clinic, because you're surrounded by exactly what you're trying to get away from... The talk, the motions, the people high, the people sick. Every week, you deal with that. And you're not strong to begin with, because you wouldn't be on methadone if you were strong.”*

Many patients had a strong desire to be seen in an inconspicuous general practice setting both to avoid triggers for relapse and the stigma of being labelled as someone on methadone. Their desire for a “normal doctor's” office was related to their attempts to fully integrate into society and to have a long-term, multi-faceted relationship with their doctors in situations where they felt their needs were understood, their privacy and confidentiality were ensured and triggers for relapse were avoided.

For most patients, their MMT practice provided few primary care services. Participants told us there were few primary care settings where MMT was prescribed. Patients identified an inherent contradiction in the design of MMT service: most MMT physicians are also primary care physicians but few provided these services to their MMT patients.

*“I think they should be able to get their primary care in one place. It's often artificial to say ‘Go to your regular doctor. Don't come to me.’ They're running around enough as it is. So being sick and then having to show up at doctors and drugstores, and need toilets regularly. It consumes people's lives and energy.” – Physician*

Our findings suggest the need for the need for improved access and integration of primary care services into MMT. Internationally, there have been movements to facilitate increased provision of MMT by general practitioners, as data indicates it to be more cost-effective overall, less stigmatizing than receiving care within a specialized addictions clinic, and, it results in higher patient satisfaction and improved care for physical health.



## Methadone Q & A

**Q. I have a few patients who will not show up for appointments. How do I deal with this? Can I cover patients week after week?**

**A.** The answer to this question is different for different stages of treatment/recovery. Some patients have legitimate reasons for missing appointments such as work, family or transportation problems. The physician may want to reflect on their own practice to determine whether they need to reduce the frequency of visits for certain patients who continually miss appointments to maintain retention on the methadone program.

A new patient should be seen at least once a week and will require close monitoring given the risks of methadone, especially in the first few weeks of treatment. For this patient, you may choose to cover for a day or two until he/she can see you or another physician. If you have concerns about giving another dose of methadone before assessment and the patient can see you or another physician the next day then you are not obliged to extend the prescription of methadone. Practice in a way that you feel is safest for that patient.

Patients in the maintenance phase, who are otherwise stable on carries, or, not on carries, can be covered or you can extend their prescription on their present carry status, depending on the individual circumstance, until you can see them next if you choose to do so.

Carries for patients who continually miss appointments can be held with the prescription extension because missing frequent appointments may deem them unstable. Monitoring is an essential component of methadone maintenance treatment and important to maintain safety for the patient and the public.

If the patient does not have any carries, you can develop a policy about only extending the prescription once or twice and then no additional extensions until he or she can see a doctor. If these policies are shared early on in the treatment program, the patients are less likely to miss appointments.

Remember, you are the prescribing physician, and if you are uncomfortable or have safety concerns about extending the prescription without assessment, you are not obliged to do so.

**Q. My patient was previously on four carries, and lost his carries seven months ago due to a cocaine relapse. He is back on track, has a job, and is now leaving drug free urine samples. How can I reinstate carries?**

**A.** Based on the new guidelines, the carries may be reinstated at a rate of one carry per week back to the previous carry level, if the relapse has been less than one year. After 4 carries have been reinstated for this individual, carries should then be reinstated at a rate of one carry per month.

When the relapse lasts for a one year period or longer, the carries can only be reinstated, after the relapse is over, at a rate of one carry per month.

Studies suggest that patients tend to be motivated to maintain abstinence with take home doses of methadone if a contingency approach is being followed. If the patient has been inconsistently drug free during the carry acquisition phase of carry reinstatement of one carry per week, then the physician may choose to slow down the carry acquisition phase to one carry per month to demonstrate more consistent abstinence.

The rate of carry acquisition should be based on good clinical judgment, motivation of the patient to remain abstinent, work issues and other social issues related to the patient's recovery.

**Annual Methadone Prescribers' Conference**

The Annual Methadone Prescribers' Conference was held on October 28, 2011. This year we had a record number of 256 attendees encompassing both physicians, pharmacists, and case managers.

Thank you to all who completed the evaluation forms. Our results indicate that the attendees were overall pleased with the event and the variety of topics that were presented throughout the day. There were also a number of comments concerning the venue and we will use this information for planning next year's event.

The CPD certificates have been prepared and have been mailed out. Family physicians will receive 5.5 Mainpro-M1 credits and Royal College Physicians will receive the "Accredited Group Learning Activity Section 1 by Maintenance of Certification Program".

If you do not receive your certificate by January 1, 2011 please contact Ms. Tracey Marshall at 416-967-2600 ext. 223.

**Correction!**

**MMT Program Standards and Guidelines**

In the Prescribers' Conference Q&A session on MMT Program Standards and Guidelines, prescribers identified an inconsistency in the direction for missed doses. **As a result of this, we have corrected section 6, pg 36 – Dosing During Initiation, Stabilization and Maintenance to read:**

"The MMT physician shall reduce the dose by 50% or to a dose of 30 mg or less when a patient has missed 3 consecutive days during the late stabilization and maintenance phases."

This will be corrected on the electronic version of the MMT Program Standards and Guidelines available on the CPSO website [View here](#)

**Program Assessments**

Over the past three years the methadone program, in response to recommendations of the coroner, increased the frequency of assessment of physicians to once every 3 years. This was done with the intention of reviewing it. In it's December, 2010 meeting, the Methadone Committee concluded that there was little if any benefit from the increased frequency of assessments and that the program should revert to its 5 years cycle which is in line with other CPSO assessment and inspection programs.



**Nurse Practitioner Prescribing Authority**

As of Oct 1, patients will benefit from the removal of restrictions to Nurse Practitioners prescribing. NPs are now able to prescribe the most appropriate medication for the patient. The exception is all controlled medications, such as narcotics and benzodiazepines. These are federally regulated and at this time NPs are not able to prescribe them, As always, NPs remain accountable to their patients and the College of Nurses of Ontario to ensure they have the knowledge, skill, and judgement to prescribe specific medication.



**Recruitment Events**

Between January and March 2012, the Methadone Program will host speaker's bureau events in **Thunder Bay, Sault Ste. Marie and Ottawa**. These will focus on recruiting new prescribers and supporting current prescribers. If you or people you know would like to attend please let us know.

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