Treatment of Opioid Addiction

Introduction

As most physicians are aware, a number of guidelines have been developed regarding the appropriate practice of Opioid Substitution Therapy (OST). These have been developed by provincial regulators and other agencies and, in some cases, enforced as the standards by which all therapy should be provided (see appendix).

The College in New Brunswick was reluctant to arbitrarily select one approach over the other, even granting the similarities. It was felt appropriate to allow physicians to adopt one of these established approaches to guide them. They could then modify their approach as they gain experience. That said, for the sake of some consistency, the College can point to the most recent guidelines from Nova Scotia (http://www.cpsns.ns.ca/Portals/0/PDFprograms/Methadone%20Maintenance%20Treatment%20Handbook.pdf) for guidance in English, as well as guidelines from Quebec (http://www.cmq.org/Public/profil/commun/APropos Ordre/Publications/~/media/4CF7E2D1B394417D91B8AC7767D00976.ashx?71015) as the only current source of guidance in French.

In any case, when reviewing a guideline from elsewhere, physicians should be cognizant of special circumstances in New Brunswick, such as the current lack of a monitoring system. In addition, such guidelines should be read in context with the remaining remarks in this document as the standard by which such physicians should practice.

While this document will refer repeatedly to methadone, it should be remembered that there are alternative opioid substitutes, including Buprenorphine (Suboxone). This latter medication is legally different and does not require direct approval from Health Canada or the College for the physician to prescribe it. Perhaps more importantly, it is clinically distinctive from methadone and must be used in a different way. Nevertheless, many of the contexts discussed here will be applicable.

Prescriber Qualifications

In some provinces, physicians are expected to undertake a professional development program prior to being allowed to prescribe methadone. Others also require a period of mentoring with another physician. It has been suggested that such requirements may present a barrier to physicians taking on this practice. Others note that many physicians have been prescribing methadone treatment for many years and should not arbitrarily be required to undergo additional training. Finally, many have pointed out the paradox that there is no training required to prescribe the opioids which are the source of this issue in the first place.

Physicians must apply for an exemption from Health Canada to prescribe methadone. Each exemption must be approved by the College. Exemptions must be renewed every three years. In order to ensure that practice meets the highest contemporary standards, physicians who are applying to prescribe methadone for the first time are expected to demonstrate recent appropriate training experience. Such could consist of a formal in-person program, an online program, or a mentoring process with an experienced prescriber. Similarly, while not required at each

application, those seeking renewal of methadone prescribing privileges should be able to provide evidence of an appropriate training experience within the previous five years.

While prescribing Suboxone does not require formal approval, evidence of training may be similarly requested. Finally, it should be noted that the background of knowledge necessary to provide an effective methadone treatment program is not simply regarding the protocols for treatment, but in fact, to demonstrate a solid understanding of all aspects of the problem of addiction.

Criteria for Treatment

Many guidelines recommend that the patient be able to demonstrate the criteria for opioid substance abuse disorder, as defined by the most recent Diagnostic and Statistical Manual (DSM).

Alternatively, many practitioners feel that such requirements may be overly narrow. There are a number of reasons why the patient may have significant issues and not fulfill a particular criteria. For that reason, physicians can only be admonished to be as satisfied as possible that the patient does have the condition for which treatment is being initiated.

Other specific criteria have also been advocated. Some programs insist that the patient demonstrate, through a positive urine test, the presence of opioids. Others suggest that the patient should have a documented history of at least one year of addiction. There must also be previous treatment failures. The College does not consider these to be absolute requirements. As with all situations, each case must be judged on its own particular set of facts. In other words, patients can have a significant issue warranting treatment without meeting each and every specific criteria.

Many guidelines also suggest that physicians should be reasonably satisfied that the patient will benefit from methadone treatment. Nevertheless, it is often pointed out that it may not be possible to have any certainty on this point. Methadone essentially treats only opioid addiction, not all aspects of the patient's life. It is argued that these other aspects may influence the physician to prejudge the matter.

Nevertheless, it can be useful to determine whether the patient will be prepared to make the significant long term commitment necessary to continue the treatment. Ongoing clinical assessment, pharmacy visits, and possibly ancillary services, must be attended over an extended period of time. Geography and the patient's resources may have a negative impact on their ability to meet these requirements.

Treatment Agreements

In general it is recommended that patients sign a document, often termed a "Treatment Agreement", which outlines some of the expectations of treatment and some of the obligations the patients are expected to meet. Such an approach can be a useful part of the educational process and can focus, for patients, on the terms of the treatment which are important for the patient's safety, for example. On the other hand, the use of the word "Agreement" implies that this is a form of contract under which the patient is making a number of promises. Many argue that patients in need of treatment are not in a position to freely bind themselves in such a way. They may feel coerced if signing a document is the only way to initiate treatment. They also may, due to the effects of the illness, not be in a position to completely understand every aspect. In other words, the presenting of a document for signature may only provide later evidence that specific issues were discussed with the patient, rather than that they completely understood them.

It should also be pointed out that a previously signed agreement cannot absolve the physician of any professional obligations. A physician cannot, through a document, force a patient to waive any particular right to appropriate care. Should issues arise regarding treatment, they must be addressed in the context of the situation at the time, rather than based on provisions purportedly agreed to by the patient months, or years, in advance. The most common complaint in this regard relates to involuntary termination of therapy. A patient cannot previously agree to such occurring in response to a situation which would not otherwise allow such.

On a final point, while some colleges insist that all such agreements be formally filed with the College office, Council does not feel this would necessarily enhance the care provided to these patients.

Pre-treatment Electrocardiograms

This is a source of some controversy. Some programs insist that patients must be screened for prolonged QTc interval before treatment can begin. A more comprehensive review of the issue suggests that the scientific benefit for such is lacking. At the same time, this could be one more hurdle, even a minor one, which may deflect a patient from pursuing treatment.

For that reason, many physicians are appropriately selective in their approach to such. They will consider doing so if there is a specific clinical reason, a family history, or the patient's dosage requirements are rising above a certain level. In addition, there are other medications which are known to interact with methadone to aggravate this issue. Physicians are expected to be mindful of this.

Initiation of Therapy

Methadone has a long half-life. For that reason, the first several doses can result in high, but delayed, blood levels, which can be dangerous. Put another way, the first two weeks of therapy can be the most dangerous period of treatment for a patient. Information on specific initiating doses is available elsewhere. The important thing for physicians is to decide on a general approach to take which will create the least risk for patients. At the same time, physicians must determine the frequency of reassessments of the patient to anticipate difficulties. Whatever schedule is suggested should be based on the availability of resources. Many physicians see patients weekly during the initial phase. For that reason, physicians should not commence such therapy unless they will be available to assess the patient as required. On the other hand, physicians may practise in a context in which other health practitioners, including nurses and pharmacists, may be available

for patients to access during this, and later, periods. The availability of such alternate resources would dictate the frequency of specific oversight by the prescribing physician.

Maintenance Therapy

Many patients will need a higher dose than that which is initially provided. Physicians should expect this and be prepared to prescribe, according to prevailing guidelines, in a fashion which will allow the patient to reach a level of stability. There is evidence that success in treatment is associated with higher doses in general. Nevertheless, dosing must be individualized.

Physicians also vary in terms of the frequency in which they reassess patients who are on a stable dose. At some point, some patients may be seen only every three months, but many physicians prefer to see such patients monthly for a considerable period of time. Again, availability of alternate practitioners may influence this schedule.

Urine Drug Screening

Random, unannounced, urine drug screening for legal and illegal drugs remains a point of considerable controversy. The traditional view is that, if patients are to be treated with methadone in order to eliminate their addiction to opioids, it should logically follow that any potential issues with other drugs should also be aggressively addressed. It is only by "forcing" patients to a drug free state that they will eventually reach a status of health and productivity. Ongoing use of illegal drugs, for example, would continue to associate them with an unhealthy subculture. It would not be logical to ignore, or otherwise tolerate, ongoing use of a variety of potentially harmful medications.

In contrast, others point out that methadone treatment is really only treating a single problem, opioid dependency. It has no specific effect on the use of any other medication. Not only will patients often continue previous usage of one medication or another, but they may well be expected to do so. Nevertheless, as they become stable regarding opioid dependence, it frequently occurs that other aspects will follow suit as their general health and wellbeing improves.

The question of how the results of urinary drug screening would be used has a lot to do with how the process would be administered. Where it is going to be used in a relatively "punitive" fashion, the standards by which the screening is done (unannounced, random), do matter. If, in contrast, it is a method of ongoing assessment of the patient's lifestyle, the specifics are less important. It is, consequently, argued that a rigid approach to screening may add a further impediment to continuing Opioid Substitution Therapy (OST).

For these reasons, physicians must themselves determine how best to approach this with each individual patient.

Dispensing

In a liquid preparation, methadone is almost always dispensed directly from a pharmacy as a witnessed oral dose. Generally speaking, patients should have a choice of which pharmacy they choose to use. They should not normally be directed to a pharmacy, nor should use of a particular pharmacy be a condition of ongoing treatment. The exception to this may be if a physician feels there are particular security concerns which are relevant. In any case, for safety reasons, patients should consistently use the same pharmacy. Any wish to change pharmacies should be reviewed directly with the physician.

Carries

After patients have become stable for a reasonable, often predetermined, period of time, they may be allowed to take certain of their daily doses home in advance from the pharmacy. The minimum period of stability varies, but is generally in the order of three months. The ability to access carries is considered by some to be a privilege which must be earned. Similarly, a number of criteria may result in the withdrawal of that privilege.

In contrast, many feel that the ability to access carries has a positive effect on continuing therapy. For that reason, most patients should move toward such and only have this privilege withdrawn in unusual circumstances.

That said, physicians must acknowledge the possibility that carries do create a risk of diversion. This may be both voluntary on the part of the patient, as well as involuntary when the medication becomes accessible to children, for example. The best conclusion from this is that carries should be authorized based on individual circumstances. Physicians should feel comfortable that the patient will take the medication at home exactly as prescribed. Physicians should also feel confident that the patient will maintain the security of the medication, with a lockbox, to prevent its misuse.

Counselling

In the past, the provision of a formal counselling process to patients under treatment was considered essential to moving them towards an optimum health status. In some cases, such was considered a mandatory condition of ongoing treatment. In contrast, large reviews have questioned the benefit of counselling in terms of overall results. For that reason, they argue that the lack of availability of counselling in some situations should not preclude the commencement of Opioid Substitution Therapy (OST).

From a physician's point of view, it appears critical to realize that substance abuse is likely only one of numerous problems facing the patient. For that reason, it should never be treated in isolation, but viewed in the context of other aspects of the patient's life, for which they may need some assistance. The physician will then have to determine what resources are available to provide any additional help for which the patient may find some benefit.

Involuntary Withdrawal

No other aspect of Opioid Substitution Therapy (OST) results in more complaints. Patients are denied further involvement in therapy based on a number of factors, including inappropriate behaviour, non-compliance, and diversion. In some cases, physicians rely on pre-existing agreements to support such a decision.

For many reasons, it is not possible in a guideline to delineate all of the issues which may trigger the question of involuntary withdrawal. Physicians can consider such issues based on the context of their own practice and patients. They can, thus, predetermine the kinds of issues which may raise the question, and advise their patients accordingly in advance, but, when the actual circumstances arise, such must be considered on its own set of facts.

In contrast, others note that an involuntary withdrawal constitutes a treatment failure. As a general principle, treatment failures should be avoided in medicine. For that reason, situations where such occurs should be limited, and if possible, avoided.

It is also worth noting that, whether the behaviour is continued use of other improper substances, or aggressive behaviour in the treatment context, such can represent unresolved mental health issues. Physicians should be mindful of that and consider whether intervention in that context may be appropriate.

Patients who require Opioid Substitution Therapy (OST) have generally not been known for always making the best decisions. They may approach matters impulsively, without careful thought, or without a view to their own best interests. For that reason, any situation that arises must be appropriately assessed. If there are factual inconsistencies, these must be sorted out. If there is an alternative to discontinuing therapy, such as stopping carry privileges, this should be considered. In any case, any decision should be based strictly on issues related to the treatment program itself rather than anything external, such as behaviour in another context.

There may, however, occur difficulties which appear to be specific to the particular treatment process. In other words, this could be related to the physician, their office, or the pharmacy involved. In those circumstances, if the physician does not feel they can personally provide ongoing treatment, their first obligation would be to provide reasonable assistance in transferring the patient to another program. At the least, the patient should be advised of the existence of any alternative resources. However, it is only after the physician has confirmed that no alternatives are available to the patient, that the possibility of a weaning process be considered. It should be remembered that the physician has originally commenced methadone treatment after determining that such is in the patient's best interest. Consequently, the decision to discontinue treatment must follow a determination that Opioid Substitution Therapy (OST) is no longer in the patient's best interest. The physician must be in a position to confirm that if a dispute arises.