

# **Methadone Maintenance Treatment Policies and Procedures**

**For**

**New Brunswick Addiction Services**



March 2006

## TABLE OF CONTENTS

<b>PURPOSE</b> .....	3
<b>FUNCTION AND ACTIVITIES</b> .....	4
<b>GOALS AND OBJECTIVES</b> .....	5
<b>REFERRAL PROCESS</b> .....	5
<b>ADMISSION CRITERIA</b> .....	6
<b>ADMISSION PROCEDURE</b> .....	7
<b>INTAKE POLICY AND PROCEDURE</b> .....	7
<b>THE NEW BRUNSWICK MODEL OF MMT PROGRAM</b> .....	9
<b>ASSESSMENT</b> .....	11
<b>METHADONE DOSING ISSUES</b> .....	12
<b>CARRY POLICIES</b> .....	14
<b>CARRY SCHEDULE</b> .....	17
<b>URINE DRUG SCREENING</b> .....	18
<b>MANAGING RELAPSE</b> .....	18
<b>INVOLUNTARY DISMISSAL FROM CARE</b> .....	19
<b>DISCHARGE CRITERIA</b> .....	19
<b>COMPLETION OF METHADONE TREATMENT</b> .....	20
<b>COUNSELLING</b> .....	21
<b>PROGRAM EVALUATION</b> .....	21
<b>TREATMENT OF PREGNANT CLIENTS</b> .....	21
<b>METHADONE AND ACUTE PAIN</b> .....	23
<b>ADDENDUM</b> .....	24

# **Methadone Maintenance Treatment Policies and Procedures**

## **PURPOSE**

The primary goal and objective of the Methadone Maintenance Treatment Program is to reduce harms associated with illicit drug use by providing access to methadone, counseling, primary health care and other community-based services. In doing so the vision is to improve the health and wellness of opiate dependent persons by providing an accessible service, which will enable them to return to being a productive member of the community.

## **Specific Benefits**

- **Methadone is the most effective treatment for opiate addiction.** Compared to the other major drug treatment modalities - drug-free outpatient, therapeutic communities, and chemical dependency treatment – methadone is the most rigorously studied and has yielded the best results.
- **Methadone is effective HIV/AIDS prevention.** MMT reduces the frequency of injecting and of needle sharing. Methadone treatment is also an important point of contact with service providers and supplies an opportunity to teach drug users harm reduction techniques such as how to prevent HIV/AIDS, hepatitis and other health problems that endanger drug users.
- **Methadone treatment reduces criminal behaviour.** Drug-offence arrests decline because MMT clients reduce or stop buying and using illegal drugs. Arrests for predatory crimes decline because MMT clients no longer need to finance a costly opiate addiction, and because treatment allows many clients to stabilize their lives and obtain legitimate employment.
- **Methadone drastically reduces, and often eliminates, opiate use among addicts.** Treatment Outcome Prospective Study (TOPS) – the largest contemporary controlled study of drug treatment – found that clients drastically reduced their opiate use while in treatment, with less than 10% using opiate weekly or daily after just three months in treatment. After two or more years, heroin use among MMT clients declines, on average, to 15% of pre-treatment levels. Often, use of other drugs – including cocaine, sedatives and even alcohol – also declines when an opiate addict enters methadone treatment, even though methadone has no direct pharmacological effect on non-opiate drug craving.

- **Methadone is cost effective.** In Canada, it is estimated it costs approximately \$6,000.00 (includes such costs as medication, urine testing and physician, nursing and counselling staff) on an annual basis to maintain a client on methadone treatment while the untreated opiate user can cost society on average \$49,000.00 per year.

Criminal activities related to heroin use resulted in social costs that were four times higher than the cost of methadone maintenance treatment (Harwood et al., as cited in NIDA, 1995, 1-47). In addition, for every dollar spent on methadone maintenance treatment, there is a savings to the community of between US \$4-\$13 (results of CALDATA study, as Stoller and Bigelow, 1999, 24).

For **Practitioners** involved in treatment delivery, methadone maintenance treatment is an opportunity to:

- Provide an important component of medical and public health care;
- Develop partnerships and linkages with other service providers and provide clients/families with a range of service and supports;
- Establish positive, supportive therapeutic relationships with, and learn from people who are dependent on opioids;
- Contribute to an educational and therapeutic process that can lead people who are dependent on opioids to gain a new perspective on themselves and their use of drugs, and make changes in their lives.

## **FUNCTION AND ACTIVITIES**

The New Brunswick Methadone Maintenance Treatment Program will provide a confidential and comprehensive community based service, which will include a client centred approach, accessibility, wide range of services and support through integrated community services; medical care, mental health, substance abuse treatment, professional counselling and support and health promotion, disease prevention and education.

### **This will be accomplished by:**

- 1) Fostering healthy lifestyles by eliminating or reducing the harmful impact of opiates dependencies on individuals/families and the community.
- 2) Emphasizing the mobilization of individuals and communities to promote dependence-free lifestyles. Treatment requires a growing commitment by the individual and society to change attitude, behaviour and lifestyle. Treatment is client centred, decentralized, comprehensive, innovative, evidence based and monitored.
- 3) Providing a full range of services, along with flexibility, to adapt to ever changing needs because of the complex nature of opioid dependency. These services are delivered by qualified and competent professionals guided by a Code of Ethics and adherence to the principle of confidentiality.

- 4) Monitoring service and continuously evaluating to ensure high standards of quality care and cost effectiveness. It is recognized that a variety of outcome measures are necessary for appropriate evaluation of the services offered.

## **GOALS AND OBJECTIVES**

- 1) To provide a safe, effective and efficient stabilization and maintenance treatment program.
- 2) To provide an environment conducive to the treatment and rehabilitative process.
- 3) To respond supportively to the clients' immediate needs and social pressures through situational and/or crisis counselling.
- 4) To implement a learning process that will involve the client and/or significant other in recognition of his/her condition.
- 5) To encourage the client to take primary and personal responsibility for his/her behaviour and recovery.
- 6) To encourage family participation in the entire process.
- 7) To encourage the clients' active participation in consolidating and accepting a treatment plan.
- 8) To initiate and implement a thorough, ongoing assessment process that includes relevant past and current data throughout the term of client contact, for utilization in treatment and rehabilitation planning. This process involves a collaborative approach with community partners.
- 9) To function within guidelines of treatment standards, best practice and protocols.

## **REFERRAL PROCESS**

- Clients may be self-referred, or referred by physicians, addiction counselors or other agencies.
- Regardless of source of referral, client must contact the program to confirm their interest in MMTP.
- Clients will be assessed to determine eligibility under the admission criteria
- Clients who meet the admission criteria will be accepted in the MMTP
- Clinic staff will provide an initial assessment and develop a treatment plan and refer to the appropriate team member for service
- All referrals will be prioritized using a risk assessment scale developed for that purpose.

## **ADMISSION CRITERIA**

There shall be clear criteria for admission to the MMTP. All clients will be assessed against the criteria, which will include:

- Validated history of opioid dependence; clients meet the DSM criteria for opioid dependence.
- Opioid dependant for at least one year
- Triage using some risk assessment scale that addressed relative risk to self and/or others
- Clients complete intake procedures
- Past treatment failures (desired, not required)
- Previous methadone treatment does not exclude a client from further treatment
- Willingness to comply with treatment; signs and abides by a treatment agreement
- Willingness to participate in all aspects of the MMTP included in the treatment plan, including admission to Addiction Services Inclient Services (Detox) if required, drugs screening, counselling (group or individual), consent to release of information.
- Must be able to access all clinic appointments, daily dispensing (at pharmacy or clinic) and all clinical interventions.
- Must be willing to attend the clinic on a weekly basis.
- Client must be medically manageable as determined by the physician.
- Clients at high risk of relapse following a previous successful course of methadone treatment should be readmitted at their request (i.e. those client who have successfully and voluntarily tapered off methadone, then present as a high risk for relapse)

### **Special Populations:**

**Adolescents:** Generally persons < 18 years of age should not be admitted. Exceptions may be made in those instances where the youth is already well known to Addiction Services and is considered appropriate by their youth counsellor.

**Pregnancy:** A number of deleterious effects for the woman and the fetus can be avoided or reduced if a pregnant opioid dependent woman is provided MMT, thus this should be done wherever possible.

**High risk of relapse:** An exception to the general criteria for admission applies for clients who have been opioid dependent in the past but who are not currently using opioids and are at high risk of relapse (e.g. clients who are incarcerated).

## **ADMISSION PROCEDURE**

When the client's information is obtained from all sources, including lab results, the individual's case will be reviewed and assessed by the regional MMTP Team. The team will make a decision regarding the client's acceptance into the clinic, or referral to another program resource such as In-client Addiction Services Treatment (Detox or other Residential Treatment), Outpatient Counselling, or other treatment options as appropriate. In some individual cases, where deemed appropriate, clients with co-existing physical or mental illness; and/or where social conditions warrant may be referred to Inclient Addiction Services or Mental Health Services or other health professionals.

If accepted into the clinic, she/he will be contacted and provided an appointment date and time to meet with the physician at the clinic to be given instructions, prescription for Methadone and next scheduled appointment for group counselling and/or 1:1 counselling and physicians visit. Based on team decision, it maybe necessary for the client to be admitted to Addiction Services In-patient Services (Detox) for stabilization.

If not accepted into the clinic, at this time, she/he will be contacted and provided with the referral information to another program for either other treatment options or admission to In-patient Addiction Services, as appropriate.

Clients are required to consent to all treatment agreements.

The procedures for notifying the client's identified pharmacy of choice will be developed and followed

Family physicians of clients who have been admitted to the clinic will receive a faxed copy of a letter requesting that the family physician **NOT** prescribe any benzodiazepines or narcotics for their client while he/she is on the Methadone, without consultation with a regional MMTP physician. At the discretion of the particular clinic, the family doctor may also be sent a copy of the client's methadone prescription. A similar letter may be forwarded to ER Dept., Addiction Services, Health Clinics and community Pharmacies and other appropriate stakeholders, on a "need to know" basis.

## **INTAKE POLICY AND PROCEDURE**

### **Policy**

New clients will be considered for admission into the regional MMTP on a regular basis, if there is space available, unless they fall into the exempt criteria. An intake assessment shall be completed prior to being considered for admission.

## **Procedure**

- 1) The individual will be contacted with a date and time for a comprehensive biopsychosocial assessment.
- 2) The client must complete the following:
  - a) A supervised urine drug screen.
  - b) A full intake biopsychosocial assessment.
  - c) One individual counselling session to include review and completion of the Client Initial Assessment and the Narcotic Assessment Tool if necessary.
  - d) Attend an individual or group session, in which the treatment guidelines of the clinic will be reviewed. Discussion will occur concerning the need for sharing information about the client's history with other community agencies. Authorization for release of information will be obtained from the client and forwarded to appropriate community partners, i.e. RCMP, Provincial Addiction Services, other Methadone Clinics, City Police, Mental Health, Dept. of Public Safety, FCS, First Nations, Corrections Canada, Family Physicians, Pharmacies and anyone deemed appropriate to substantiate or advocate for their need.
- 3) The client will be provided with an appointment at the appropriate hospital for urinalysis and pertinent lab work. Admission screening should include but not necessarily be limited to Tb skin testing; HIV, HBV, HCV serology; liver function (albumin, INR, AST, ALT, GGT, alkaline phosphatase) and serum BHCG where indicated. Any or all of the above that have been obtained within the preceding 6 months, may suffice, unless otherwise clinically indicated. Baseline ECG is recommended and indicated in any client on a methadone dose > 150 mg.
- 4) The client will be required to sign two copies of a contract that reflects the rules and regulations of the program (Methadone Treatment Agreement) and any other forms as developed by the regional clinic. One copy will be filed in the client's confidential file and the other given to the client.
- 5) The client will be counselled concerning harm reduction and safety issues until they are admitted to the program.
- 6) Clients who are on the list and are being assessed for admission to the clinic will lose their position on that list as a result of activities that indicate a lack of motivation or cooperation. For example, missing appointments can result in that individual being replaced by the next person on the list.
- 7) Family members of clients will be recommended to attend Family Intervention Program or 1:1 counselling at Addiction Services to deal with co-dependency issues.



## **THE NEW BRUNSWICK MODEL OF MMT PROGRAM**

Although time frames for the stages of recovery are very individualized, working through the stages of recovery occurs over a period of years. Clinical experience and knowledge suggests that stabilization tasks take around 18 months from the time that the individual actually starts in recovery.

### **Phase 1: Stabilization**

Individuals in this phase of treatment often struggle with the recognition of the need to abstain from all mind-altering chemicals. Providing methadone maintenance treatment services may help an individual in this phase. Individuals prescribed methadone may struggle with continued use of opioids and other drugs. Counseling should address these issues as a normal part of this treatment phase.

MMT team members may provide education on:

- Methadone maintenance treatment – dispel myths and understand the treatment process that includes prescribed methadone (i.e., daily attendance at a pharmacy/clinic)
- Attempts to control use
- Denial/taking ownership of addiction
- Breaking the addiction cycle/lifestyle
- Sleep, exercise, nutrition
- Stress management
- Needle exchange and safe needle use
- Blood born pathogens – especially HIV and hepatitis testing and treatment, as well as hepatitis A & B immunization

The stabilization phase usually may consist of weekly physician appointments, group and individual counseling, and weekly/random drug screening. This phase consists of a minimum of six (6) weeks in duration.

### **Phase 2: Transition**

Individuals in this stage of recovery need to learn to manage episodes of possible acute withdrawal from non-opioid drugs, post-acute withdrawal symptoms, as well as develop hope and motivation about treatment.

MMT team members may provide education on:

- Methadone maintenance treatment regulations
- Dispelling myths
- Community based support programs (e.g. cultural supports, spiritual supports/affiliations)

- Post acute withdrawal, assessing relapse triggers, managing cravings and euphoric recall
- Grief and loss of former friends/networks and development of new social contacts
- Substance affected family/friends/associates and boundary information
- Problem solving (e.g., addictive lifestyle, relationships involving strategies/techniques such as time management, containment and journaling)
- Cognitive skills development (e.g., planning, memory, problem solving)
- Blood-borne pathogens

The transition phase usually consists of:

- Physician appointments every two (2) weeks
- Focus on the Determinants of Health; the social and economic environment, the physical environment and the person's individual characteristics and behaviors (Public Health Agency of Canada)
- Group and individual counseling
- Weekly/random drug screening
- Access to community resources/referrals

During this phase, services are provided for a minimum of six (6) weeks.

### **Phase 3: Community**

Individuals in this phase of treatment develop short-term stability, understand the impact of addiction, learn non-chemical stress management and develop a recovery-centered value system. They also establish lifestyle balance, resolve social damage resulting from substance use, and learn to manage change.

MMT team members may provide education on:

- The development of an individualized treatment value system
- Financial Management
- Boundaries in relationships
- Vocational counseling/school/work/volunteer
- Parenting, self image
- Resolving outstanding legal issues
- Containment/stabilization strategies for people showing signs/symptoms of trauma
- Relapse prevention

MMT team members may provide information on:

- Renewing or establishing social contacts/outlets
- Family communications, parenting
- Accessing services at other agencies regarding marriage/couple issues, career changes, reaching goals, managing change, recognizing and achieving lifestyle balance

The community phase usually consists of:

- Physician appointments every three (3) to four (4) weeks
- Carries possible
- Ongoing assessment
- Group and individual counseling
- Weekly/random drug screening
- Support
- Evaluation
- Access to community resources/referrals
- Clients remain on Methadone Maintenance

During this phase, services are provided for as long as the client remains in the Methadone Maintenance Treatment Program.

## **ASSESSMENT**

Thorough assessment should include:

### **Documentation of the client's history**

- Document dependence on opioids
- Evaluate the complications related to drug use and other medical conditions
- Assess psychiatric problems
- Assess high-risk behaviours

### **Explanation of treatment options**

- In-patient Addiction Services Treatment (Detox)
- Outpatient Detox (using clonidine) (See Addendum)
- Mutual help groups
- Out Patient Counselling
- Residential treatment
- Methadone Maintenance Treatment

### **Treatment agreement/informed consent**

### **Exceptions to professional-client confidentiality**

### **Included in the intake process are:**

- Medical assessment plus biopsychosocial assessment
- Documentation of client's history
- Reasons for requesting admission at the time of the request
- History of use of other drugs including tobacco and alcohol use
- Past addiction treatment, outcomes of treatment
- High-risk behaviours - unsafe sex, injection practices, criminal involvement, alcohol consumption, tattooing, body piercing
- Medications
- Allergies

Past medical history  
Contraceptive practices  
Past psychiatric history, including suicidal ideation  
Social history including medical and addiction history of family members  
Vocational/educational history  
Legal problems  
DSM IV criteria review

**Physical examination should pay special attention to:**

Signs of opioid withdrawal  
Malnutrition  
Jaundice  
Hepatosplenomegaly  
Presence or absence of heart murmur  
Pupil size  
Tattoos  
Body piercing  
Signs and symptoms of chronic liver failure  
Signs of untreated HIV infection  
Needle tracts and  
Abscesses

## **METHADONE DOSING ISSUES**

### **Initiation/Stabilization:**

- 10-30 mg of methadone/day for the first 3 days

Starting at a low dose puts the client at increased risk for ongoing use of illicit substances due to inadequate methadone levels and prolongs both the withdrawal and/or stabilization period. It must be acknowledged that with starting doses in the above range, the client will most likely need to "top up" their dose and accommodation should be made for this initially.

### **Criteria for dose increases:**

- Signs and symptoms of withdrawal (objective and subjective)
- Amount and/or frequency of opioid use not decreasing
- Persistent cravings for opioids
- Failure to achieve a dose that blocks the euphoria of short acting opioids

Dose adjustment should not be made more frequently than every 3-4 days

Adjustment during stabilization period	5-15 mg
Adjustments at doses < 60 mg:	5-15 mg
Adjustments during transition phase	5-10 mg
Adjustment in daily doses above 60-80mg	5-10 mg

### **Optimal dose:**

The optimal dose of methadone is that dose which relieves withdrawal symptoms, blocks the euphoria from short acting opioids and drug cravings without sedation or other significant side effects.

The optimal dose for the majority of clients can be established within 2-6 weeks.

A dose above 100 mg is considered in the high range. Should a physician have difficulty in stabilizing the client's dose below this level, it is recommended that a second physician involved in methadone be consulted. In doses above 150 mg, strong consideration should be given to obtaining a methadone serum half -life (or peak/trough ratio).

Drug craving alone is an inadequate reason to increase doses above 120 mg. The requirement for further dose increases should be manifested by the presence of a constellation of withdrawal symptoms, both physiological and psychological, that occur at a predictable time at the end of a dosing interval

Methadone dosing should not be used in a punitive manner. Actions such as missed appointments, inappropriate behavior, "dirty urines" should have clearly defined consequences that are enforced. Such actions should not be responded to by adjusting the methadone dose until such behavior is corrected.

Once the optimal dose is reached, further dosage adjustment should not be necessary. Factors that may cause a client to complain of a recurrence of withdrawal symptoms are:

- Relapse to opioid use
- Increased metabolism of methadone; may occur in the third trimester of pregnancy, or when another medication is added to the therapy
- Withdrawal of other drugs such as cocaine or benzodiazepines
- "Pseudowithdrawal" - depression, anxiety, and situational crises can also lead the client to experience withdrawal symptoms. Increasing the dose in this situation may give the client the message that more methadone is the solution to their problems. The next time they are in crisis, they will be conditioned to ask for another increase.

### **Split dosing**

More than daily dosing may be clinically indicated in clients who

- are rapid metabolizers
- are on medications known to increase methadone rate of metabolism
- pregnant clients in their last trimester, on doses > 100 mg.

In instances where rapid metabolism is suspected, consideration should be given to obtaining methadone serum half-life or methadone peak-trough levels.

**Missed doses and loss of tolerance:**

A clinically significant loss of tolerance to opioids may occur with as little as three days without methadone.

- Missed 1-2 doses: give usual dose
- Missed 3-5 doses: give 1/2 usual dose, assess tolerance, increase 15 mg /day back to usual dose
- Missed >5 doses: start over @ 30 mg or less, assess tolerance, increase 15 mg/day back to usual dose

**Unless extenuating circumstance, consider the client to have withdrawn from the program after 3 consecutive missed doses.**

\*\*If an individual is hospitalized or incarcerated, particularly if they are on relatively high doses, extra care must be taken in dispensing their medication if there have been any missed doses.

**Vomited doses:**

If a health professional or member of staff witnesses emesis, the dose may be replaced as follows:

- |                                      |                         |
|--------------------------------------|-------------------------|
| Emesis <15 minutes after consumption | replace full dose       |
| 15-30 minutes after consumption      | replace 50% of the dose |
| >30 minutes                          | no replacement          |

**Intoxicated clients:**

Intoxicated clients should not be medicated with methadone until they have been reassessed and found to be unimpaired.

Each regional clinic must establish protocols with their corresponding hospital/ER so as to ensure continuity care and treatment philosophy for MMTP clients.

**CARRY POLICIES**

The following three criteria should be assessed prior to initiating carries. These criteria should be re-assessed regularly with regards to continuing carries and/or increasing/decreasing the level of carries.

Clinical stability: The client demonstrates clinical stability when:

- The client’s dose has reached their optimal level.
- The client demonstrates the social, cognitive and emotional stability necessary to assume responsibility for the care of the medication and to use it as prescribed. Social stability can be demonstrated by stable housing, stable support system and activities and regular attendance at pharmacy, counselling and doctors appointments.

- Clients must be demonstrating no evidence of problematic use of any drug or alcohol.

The length of time in methadone treatment:

- Carries are not recommended during the first 3 months of treatment:

NB: Pharmacies may not be open on Sunday and the client may need to use an alternate pharmacy on Sundays. It may be appropriate or necessary for the client to receive a Sunday carry. It is recommended that the physician involve the regular dispensing pharmacy in making any change to a client's carries.

Ability to safely store medication:

- Clients with unstable living arrangements, such as those living on the street or in hostels without storage facilities may not be appropriate to receive carries.
- Clients should be asked to demonstrate to the physician the locked box that they have agreed to keep carries secured in.

Reassessment and/or Reduction of Carry Privileges:

A reassessment and possible reduction of a client's carry privileges should be undertaken when the client engages in risky behavior that is not consistent with recovery from addiction. For example:

- Client has failed to maintain clinical stability as previously outlined.
- Continued problematic drug or alcohol use.
- Clients who are experiencing withdrawal, cravings or continued drug use or who are requesting an increased methadone dose may be at risk of consuming their carry dose earlier than indicated.
- Client is not meeting agreed upon goals and objectives.
- Client has failed repeatedly to leave a urine sample for drug screening in the required manner as agreed upon in the treatment plan.
- Client has either diverted their methadone or there is a strong suspicion that methadone has been diverted or used in an inappropriate way (not as prescribed).
- Clients have tampered with their urine sample.
- Clients who consume carries early, report lost or stolen carries, or vomit carries should have their level of carries re-assessed.
- Failure to return carry bottles intact to pharmacy or clinic.

Exceptions to Carry Policy:

All exceptions to the carry schedule must have clear documentation of their necessity. Carry exceptions should most commonly be seen as a trial and as such, require frequent reassessment.

1) Medical Disability:

Clients showing sustained use of medications with abuse potential may receive more than one carry per week if the following conditions are satisfied:

- A specific medical diagnosis has been made that has evidence-based substantiation for the use of that medication to treat the symptoms of the condition.
- The client is clinically stable and meets other carry criteria.
- The team may decide to initiate or increase carries to a client who otherwise does not qualify if they suffer from a medical condition that significantly interferes with their ability to attend the pharmacy.
- Every effort should be made to have some supervision of the methadone consumption in these cases.
- For medical conditions of a temporary nature, the requirements for carries should be re-assessed once the client's ability to attend the pharmacy is established.
- It should be recognized that the medical condition that necessitates carries might involve pain and clinical situations that trigger increased substance abuse. The team must carefully decide whether the benefits of carries for the client outweigh the risk of further destabilizing the client.

2) Compassionate Basis:

- Clients who have not satisfied all of the other criteria may be provided short term carries on a compassionate basis in cases of personal or family crises or bereavement.
- Physicians should verify the extenuating circumstances and be satisfied that there is no other way to have the client's dosing observed.
- Additionally the physician should assess the mental status of the client to be satisfied that the provision of carries though the crisis will not compromise the safety of the client or other persons.

3) Job or Vacation:

Clients who have been deemed appropriate for a high level of carries (i.e. attends the pharmacy once or twice weekly) may be granted a higher number of carries for reasons such as travel and employment opportunities. In certain circumstances, temporary arrangements for pharmacy dispensing can be made. The client should provide the physician with verification of the travel plans (eg. plane ticket, letter from work).



## CARRY SCHEDULE

Suggested schedule:

- I. Treatment 3 months;  
Functionally stable for the last month: 1 take-home dose
- II. Treatment 3 months; no unauthorized drug use for the last month;  
Functionally stable for four weeks: 3 take-home doses
- OR  
Treatment 6 months, occasional non-problematic drug use  
Otherwise stable: 3 take-home doses
- III. Treatment 6 months; no unauthorized drug use;  
Otherwise stable 5 take-home doses
- OR  
Treatment 12+, occasional non-problematic drug use,  
Otherwise stable: 5 take-home doses
- IV. Drug free for 12+ months; functionally stable: 6 take home doses

The risk of abuse of any drug is increased in someone with a known history of substance abuse or dependency.

Caution must be exercised when contemplating the awarding of carries to anyone known to be using other chemicals, regularly or sporadically. The decision to give carries must take into account both individual and societal safety.

### Rationale for Carry Policy:

#### 1) Benzodiazepines:

Benzodiazepines should always be the medication of last resort with documented failure of other medication to treat the same disorder. There is no scientific evidence to support the long-term use of Benzodiazepines in any medical condition. In contrast, there is ever increasing evidence that the combination of benzodiazepines and methadone significantly enhance the risk of sleep apnea and sudden death. Hence because of the degree of medical risk, wherever possible clients should be weaned off of benzodiazepines prior to being allowed carries.

#### 2) Cocaine/Methamphetamine:

Continued use of illegal stimulants illustrates significant continued involvement in the culture of substance use and identifies the client as psychosocially unstable. Clients known to be opiate dependent are at high risk to developing a stimulant addiction.

#### 3) Marijuana:

Continued use of illicit products documents ongoing involvement in the culture of substance use. Regular marijuana use may result in psychosocial instability, with impaired judgement and problem solving abilities.

## **URINE DRUG SCREENING**

The physician should interpret the results of the urine drug screen in conjunction with functional stability. It should be clearly understood by all involved that these are screening, not confirmatory tests; they do not meet forensic requirements and are not sufficient for a court of law.

As a minimum, specimens should be screened for: opioids, benzodiazepines, cocaine, THC, amphetamine and methadone

- Should be obtained on a random schedule.
- Should be collected under the direct supervision of a treatment team member, who has the authority to request a second specimen if deemed necessary.
- No children will be permitted into the collection area.
- Clients should not be allowed to take any bag, jacket/coat, purse or similar into the collection area.
- Heat strips can be used to determine temperature of the specimen.

Validity of test can be increased by:

- Measuring the temperature of the sample immediately after sampling.
- Having clients remove obstructing clothing, and turning all pockets inside out.
- Having patients leave all handbags, etc. outside the collection area.
- Bluing of the toilet water.
- Ensuring no access to running water in the collection area.

If tampering is suspected the physician should be notified and whenever possible a second sample should be collected the same day.

Frequency of testing:

At a minimum testing should be done:

0-6 months weekly

If stable (biopsychosocially and optimal dose)

6-12 months q2weeks

>12 months monthly

## **MANAGING RELAPSE**

Program response to relapse must be clearly defined and enforced

- A relapse to mood altering substance indicates reduced stability.
- Re-evaluate frequency of counselling, focus of counselling.
- Consider increase frequency of urine screening.
- Consider increase frequency of medical appointments.
- No response may be required following a single episode of drug use.
- Consider referral to in-client detox.

## **INVOLUNTARY DISMISSAL FROM CARE**

The Code of Ethics of the Canadian Medical Association provides that the ethical physician, having accepted professional responsibility for a client, will continue to provide services until

- 1) They are no longer required or wanted
- 2) Another suitable physician has assumed responsibility for the client or
- 3) The client has been given adequate notice that the physician intends to terminate the relationship.

Clients who are being discharged involuntarily should be tapered at a rate of no more than 5 mg every 3-4 days. Clonidine may be used in the last one to two weeks to relieve withdrawal symptoms, at a rate of 0.1 mg po tid-qid. If indicated the client may be referred to in-client detox for withdrawal and referral for ongoing counselling.

## **DISCHARGE CRITERIA**

- 1) Upon admission to the MMTP all clients will be given a three-month “grace period” to allow for stabilization, prior to the commencement of any administrative sanction (warning letters or discharge). At the end of that three months, the team may review the situation and authorize an additional three month stabilization period. (Maximum of 6 months stabilization allowed before commencing administrative sanctions.)
- 2) The philosophy of the Methadone Maintenance Treatment Program is one of harm reduction and every effort will be made to retain the client in the program.
- 3) It is important that information about any client behavior that may give rise to discharge from the program come from reliable sources.
- 4) Discharge will be a collaborative decision of the Treatment Team.
- 5) Discharge may occur if there is a continued failure to meet conditions and expectations of the program and the Treatment Team determines that the risk of continuing Methadone maintenance outweighs the benefits. Any decision should take into account, but not be limited to, the following:
  - Missing appointments without making prior arrangements (this includes appointments with RN, Social Worker, physician, other community partners); (eg 3 within a 2- month period. After stabilization)
  - Producing urines that contain cocaine, narcotics or benzodiazepines, (eg 3-5 in any 2 month period after stabilization)
  - Soliciting urine from other clients or being caught or suspected of tampering with urine specimens in some way.

- Acting in an abusive, disrespectful or threatening manner towards other clients, their families or treatment team (to include all clinic staff, physicians, nurses, social workers, pharmacists, administrative staff other community partners)
- Loitering on premises without having a reason to be present in the area.
- Being implicated in or having evidence found of illegal behaviours, including but not limited to, shoplifting, breaking and entering, drug dealing and/or threatening clinic staff, pharmacies, physicians or health care professionals.
- Missing 3+ methadone doses
- Soliciting or selling illicit drugs on the clinic premises as verified by clinic staff.

There will be **Zero Tolerance** for any act of violence (including verbal and/or physical threats) directed towards staff or other clients while on the clinic premises.

Depending on the discretion of the staff, the police department will be called to assist in removing the client from the premises for any of the above violations.

**NB: The pharmacy is considered an off-site department of the clinic. Any actions there will be addressed as if they occurred in the clinic proper. Clients should be made aware that they are responsible for the actions of anyone accompanying them to clinic or pharmacy that should not be there in their own right.**

## **COMPLETION OF METHADONE TREATMENT**

Clients leaving methadone treatment have a high relapse rate, however, those who leave treatment because they have done well and are “ready” have a better prognosis.

The ideal candidate for methadone cessation is:

- 1) Socially stable
- 2) Supportive relationships with non-drug users
- 3) Discovered alternative ways of dealing with the precipitants to drug use
- 4) Confident and motivated to taper
  - Clients who are doing well and do not wish to discontinue should not be pressured to do so.
  - Clients should be advised against tapering if the physician feels they are not ready, but ultimately it is the client’s decision to make.
  - Clients who relapse after tapering should be offered re-entry into methadone treatment

Voluntary taper:

- 1) Taper rate should be a maximum of 5 mg/week
- 2) Pace to be determined by the client and should be halted or reversed at the client’s request.
- 3) Tapering may have to proceed more slowly when the dose falls below 20 mg

- 4) Tapers as slow as 1-2 mg every 1-2 weeks have been used successfully
- 5) Tapers should be placed on hold or reversed if the client experiences severe withdrawal symptoms or drug cravings or restarts drug use.

## **COUNSELLING**

Counselling is a mandatory component of the MMTP and may be provided in an individual or group format.

## **PROGRAM EVALUATION**

Program evaluation shall be an essential component of the Methadone Program in all regions. Each region will keep appropriate documentation and required data including the following indicators:

Some suggested indicators to follow:

- 1) Use of opioids and other drugs
- 2) Clients' self-reported criminal activity
- 3) Decrease in drug related criminal behaviour as evidenced by RCMP and police statistics
- 4) Retention, discharges, leaves against medical advice and readmissions to the program
- 5) Wait times for program admission, number of participants in the program and on waiting list
- 6) Number and type of health issues
- 7) Changes in employability status
- 8) Changes in social functioning
- 9) Client retention
- 10) Decrease in overall drug use
- 11) Decrease in intravenous drug use and other infection related risk behaviours (decrease in discarded needles).
- 12) Decrease in incidence of HIV, Hepatitis B and Hepatitis C.
- 13) Decrease in mortality and morbidity due to drug related illness and death including overdoses and suicides
- 14) Increase in employment status and social functioning.
- 15) Improved pregnancy outcomes.
- 16) Increased community awareness of the benefits of Methadone Maintenance Programs.
- 17) Improvement in family life of substance abusers as evidenced by FCS statistics.

## **TREATMENT OF PREGNANT CLIENTS**

It is known that any use of alcohol during pregnancy may have a detrimental effect on the baby. Therefore, MMTP staff has a responsibility to address the special concerns posed by alcohol use, abuse, and dependence for pregnant women and their children.

### The Goals and Benefits of Methadone Use during Pregnancy:

Methadone is the drug of choice in the management of the opioid dependant woman. While Methadone does carry the risk of triggering neonatal abstinence syndrome, this is a relative risk and overcome by the fact that in this population neonatal caregivers are aware of the risk and can monitor more effectively.

In addition to the standard goals in MMTP of reducing cravings, and blocking euphoria of opioid use, the desired goal of methadone maintenance during pregnancy is to prevent the mothers' experiencing withdrawal, the stress of which may be sufficient to induce spontaneous abortion in first trimester pregnancies and premature labor in last trimester pregnancies. Methadone maintenance provides a "steady state" of opiate levels, thus reducing the risk of withdrawal to the infant. Methadone also reduces the use of street opiates, and thus decreases the risk of problems such as hepatitis, HIV, other infections, prostitution, criminal activity, and the general life disruption associated with opiate dependence. Methadone can be taken orally, lacks impurities, costs less, and can be carefully regulated. Methadone also allows for the engagement of the woman in a treatment program, providing daily contact with a health care provider. Methadone dispensing for pregnant women should occur in the context of a comprehensive MMTP program that includes prenatal care. In this type of program, women receive almost daily care or contact with their healthcare provider when they receive their methadone dose.

Administration of methadone and determination of methadone dose during pregnancy involves a balancing of considerations for the mother and fetus. While methadone administration reduces many of the risks associated with opioid use, it has also been associated with longer and more severe neonatal abstinence than short acting opioids exposure due to methadone's longer half-life. Neonatal abstinence syndrome may occur in between 60-80% of babes born to methadone maintained moms. Some authors have reported a relationship between methadone dose and the severity of neonatal withdrawal, while others have not found a similar relationship.

Detoxification from methadone is not generally recommended during pregnancy. Methadone and clonidine should not be used together because of the sedative effect. If detox is going to be attempted, ideally, this should occur during the second trimester, when the pregnancy is the most stable.

Initiation of methadone in the pregnant client should be done on an in-client basis. Dose adjustment should be as follows:

- At the first sign of withdrawal, (NAT>4-5) commence 10 mg methadone. Supplement this dose by 5 mg q6h for NAT>5. On day 2, give total of first day's dose as single AM dose, supplement 5mg q6 h. Client is considered stable when no further supplementation is required. (Usually 35-60mg)
- Dosage adjustments during pregnancy should occur no more than every 2-3 weeks, 5 mg/adjustment.

- There may be a requirement to slightly increase the dose during third trimester as with metabolic changes, women may metabolize methadone at a faster rate. Doses over 100 mg should be administered as a split dose.

Women on methadone who become pregnant should have their dose adjusted downward to as low a dose as possible, remembering it is better to have the client at a higher dose than risk relapse.

Breast-feeding is not contraindicated. With doses below 20 mg it is not a concern. With higher doses, the best time to feed is just before the next dose. Feeding should not take place within two hours of dosing and at around 6 months the infant should be weaned or the methadone discontinued.

## **METHADONE AND ACUTE PAIN**

Clients on long-term methadone therapy have a lower pain threshold, and are tolerant to the analgesic effects of other opioids. There is no evidence that opioid use for acute pain increases the risk of relapse. Indeed, some have argued that under treatment of acute pain can cause relapse by forcing the client to self-medicate.

Ideally, any opioid dispensed for pain should be dispensed on the same schedule as the methadone. In injection drug users, acetaminophen-opioid combinations are preferred because they are more difficult to inject. If possible, choose opioids with a lower abuse liability (codeine, morphine) over opioids with greater liability such as oxycodone or hydromorphone. Scheduled, rather than PRN dispensing is preferred for constant pain. The physician may start the client at a dose that would normally be prescribed for a non-addicted client with a similar condition, with upward titration if necessary.

As an alternative to adding an opioid, a temporary increase in the methadone dose of 10-15 mg may be considered as a temporary split dose. The dose should be reduced after the acute pain has resolved.

### **Management of Methadone clients with acute pain**

- Use non-opioid alternatives along with (or instead of) the opioid.
- Clients on stable doses of methadone often require higher or more frequent opioid doses for acute pain than other clients. Initiate treatment at doses usually used to treat clients with a similar condition. Titrate upwards, if necessary.
- The opioid should be dispensed along with the methadone (i.e. daily, if the client has no methadone carries).
- The prescribing physician should avoid prescribing opioid agonist-antagonists
- Acetaminophen-opioid combinations are preferred for injection drug users
- Where possible, the physician should avoid prescribing short-acting opioids with a higher dependence liability, such as oxycodone or hydromorphone

- Alternatively, a 10-15 mg increase in methadone dose may be considered as a temporary titrated dose. The dose should be reduced after the acute pain has resolved.
- For constant pain, scheduled use is preferred to PRN use.
- The physician should address any client concerns about inadequate pain control, and the risk of relapse.
- The physician should be alert for signs of relapse, such as continued use of short-acting opioids long after the pain should have resolved, excessive use, and unwillingness to share information with the prescribing physician
- Opioids should generally not be given for more than two weeks for acute pain, and a re-evaluation of the client's pain should be made with the appropriate referrals. Avoid prescribing the opioid the client was originally abusing.

## **ADDENDUM**

### **Opioid Detoxification Protocol Using Clonidine**

#### Outpatient dosing

Clonidine 0.1 mg po bid –tid

- May increase to 0.2 mg bid-tid after 1st day
- Continue bid-tid for 3-5 days then prn for 3-5 more days

#### Additional treatment options:

- NSAID or acetaminophen for myalgias
- Loperamide for diarrhea
- Gravol or other antinauseant
- Trazodone 50-100 mg hs for insomnia

#### Precautions:

- Don't prescribe clonidine if BP , 90/60, client pregnant, on antihypertensives or has heart disease
- Warn clients about postural symptoms and drowsiness. Postural symptoms are dose-related, so be cautious with higher doses
- Warn about mixing with opioids, or having prolonged hot bath (both can cause hypotension)
- Don't prescribe for longer than 2 weeks (rebound hypertension)
- Warn clients they're at risk for overdose if they relapse to their usual dose; always combine clonidine protocols with a documented treatment plan
- A follow-up with the client should be made in 3-5 days and the client should be assessed for an aftercare program.



**Admission Risk Assessment Scale:**

All admissions will be prioritized using a risk assessment scale developed for that purpose, (i.e. pregnant women). It is recognized that certain medical and/psychosocial conditions enhance the risk associated with substance use. The scale developed is not meant to be all-inclusive, but rather seeks to point the relative risk of the most common presenting issues.

This scale prioritizes admission based on high risk using a Laskey Scale with 10 being the highest risk and 1 being the lowest risk. This scale has not been validated and is only intended for use in conjunction with a complete clinical assessment.

1	Referral from Corrections Canada
2	
3	
4	
5	IV Drug use, History of non-compliance with treatment
6	Recovery (Without Methadone) and at Risk of relapse
7	
8	IV Drug Use, History of completing treatment available
9	HIV/VCV Stable but significant health problems Children at risk
10	Pregnant