METHADONE MAINTENANCE GUIDELINES

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Ontario College of Pharmacists

These guidelines are in effect as of October 1, 2001.

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Preface

In 1996, following program changes made by the Bureau of Drug Surveillance (Health Canada), the College of Physicians and Surgeons entered into a formal partnership with the Ontario Substance Abuse Bureau of the Ministry of Health through a funding agreement to administer the provincial methadone program. The mandate of the College's program since 1996 has been to improve the quality and accessibility of methadone maintenance treatment in Ontario. This has been accomplished in conjunction with the Centre for Addiction and Mental Health (CAMH) and the Ontario College of Pharmacists (OCP). The profile of methadone treatment in Ontario has been enhanced through the outreach activities and the recruitment of individual physicians to prescribe methadone in the treatment of opioid dependence.

The guidelines are intended to reflect the general standard of practice in Ontario for prescribing methadone in the maintenance treatment of opioid dependence. At this time in Canada, methadone remains the only opioid approved for long-term (greater than 180 days) treatment of opioid dependence. These guidelines are not intended to substitute for sound clinical judgment. In a specific instance where the individual circumstances of a patient provide clinical justification for deviation from the guidelines, a member may do so. However, it is expected that the physician will balance the risks and benefits to the patient and document any deviation from the guidelines in the patient's medical record with an indication of the clinical reasons for the deviation. In difficult or complex cases physicians should consider seeking assistance by referral, consultation or informal consultation with a physician knowledgeable in addiction medicine.

For a comprehensive physician reference, please also see Methadone Maintenance: A Physician's Guide to Treatment, CAMH, 1998.

These guidelines are approved by the College of Physicians and Surgeons of Ontario for members of the College and they replace the August 1996 Methadone Treatment Guidelines and the earlier 1992 publication of Health Canada entitled "The use of opioids in the treatment of opioid dependence". Methadone maintenance treatment (MMT) is regulated by each province and treatment guidelines may vary between provinces.

Introduction

Methadone is a synthetic pure mu opioid agonist with good oral bioavailability, and a long duration of action. Methadone prevents withdrawal symptoms and helps reduce drug cravings in opioid dependent individuals. It also blocks the euphoria produced by short acting opioids. This collection of attributes makes this drug an appropriate choice for opioid maintenance therapy.

Methadone was developed in Germany before the Second World War and was used as a substitute analgesic for morphine. Early research in the late 1940's showed that it could also be used to treat withdrawal symptoms in heroin dependent individuals. In the early 1960s, Dole and Nyswander demonstrated the feasibility of using methadone as maintenance medication although it was actually a Canadian researcher, Dr. Robert Halliday, who set up what may have been the first methadone maintenance treatment program in the world in British Columbia in 1963.

Methadone maintenance typically involves the daily oral administration of methadone over an extended period of time as a substitute for heroin or other short acting opioids to opioid dependent individuals. Once an individual has been stabilized on a dose of methadone, subsequent daily doses should not cause sedation, analgesia or euphoria. Methadone is long acting; it can prevent the occurrence of withdrawal symptoms or cravings when a patient receives an optimal dose. This enables individuals to function normally and to perform mental and physical tasks without impairment. In sufficient doses, cross-tolerance to other opioids develops i.e. methadone "blocks" the euphoric effects of self-administered illicit opioids.

Numerous studies have shown that maintaining opioid dependent individuals on methadone has many benefits including: (1) reduced illicit drug use, (2) improved health status as a result of access to treatment, (3) decreased transmission of HIV and HCV, HBV, (4) decreased illegal activity, (5) increased employment (6) decreased cost to society and (7) decreased mortality. Further, one of the indirect benefits of methadone treatment is that patients come into contact with other services – counseling, vocational services, and needle exchange programs.

Pain Management

Patients being treated with methadone for the management of pain are not subject to the recommendations contained in the Ontario Methadone Guidelines. However, where there are individuals who meet the DSM IV criteria for substance dependence that is complicated by chronic pain, methadone maintenance practice should adhere to the recommendations of these guidelines. In complicated cases, it is recommended that a physician should consider seeking assistance by referral, consultation or informal consultation with a physician knowledgeable in pain management and addiction medicine. ***For a complete reference, please see "Evidence Based Guidelines for the Management of Chronic Non-Malignant Pain" available from the College of Physicians and Surgeons [also available from CPSO website – www.cpso.on.ca].***

(DSM IV criteria-Appendix A)

Criterion for Admission

Individuals requesting admission to a Methadone Maintenance Treatment Program meet the DSM-IV criteria for substance dependence (opioid).

General Considerations

- Previous methadone treatment does not exclude a patient from further methadone treatment.
- If a patient is at risk of relapse following a previous course of methadone treatment, they should be readmitted to MMT at their request.
- **Adolescents:** Those of a younger age may be considered in special circumstances. In cases where a physician considers it appropriate that an adolescent should be offered methadone maintenance treatment, it is recommended that the physician consider seeking assistance by referral, consultation or informal consultation with a physician knowledgeable in addiction medicine.

- **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. Clinicians are expected to stabilize opioid dependent pregnant women on methadone without delay. These are high risk pregnancies. Referral to, or guidance from a physician experienced in managing the care of the pregnant opioid dependent patient is strongly advised. A list of physicians who are experienced in this area is available from the CPSO or alternatively a physician can contact the ACCS (Addiction Clinical Consultation Service 1-888-720-ACCS)

- **High Risk of Relapse**: An exception to the general criteria for admission applies for patients who have been opioid dependent in the past but who are not currently using opioids and are at a high risk of relapse. The most common application will be for patients who are incarcerated within the provincial or federal correctional system and who have had a prior diagnosis of opioid dependence. Documentation of the specific reasons for initiating the patient not currently using opioids is essential. Added caution in determining the methadone dose is advised. (Refer also to section on Corrections)

ASSESSMENT

A focused medical and psychosocial assessment should be completed prior to the beginning of treatment. The purpose of the assessment is to document the patient's dependence on opioids, evaluate the complications related to drug use and other medical conditions, and assess psychiatric problems and high-risk behaviour in order to recommend a comprehensive and practical treatment plan. The assessment process consists of the following steps:

I. Document the patient's history

II. Explain Treatment Options

III. Treatment Agreement (Plan) - Informed Consent

IV. Explain exceptions to doctor-patient confidentiality

I. Document the patient's history. This must include:

1. Reason(s) for presenting at the current time
2. History of use of drug(s) of choice and the amounts taken, route of administration and duration of dependency
3. History of use of other drugs including tobacco and ethanol use
4. Past addiction treatment, outcomes of treatment – i.e. successful
5. High risk behaviours eg. unsafe sex, injection practices, criminal involvement, alcohol consumption, tattooing, body piercing
6. Medications, primary pharmacy
7. Allergies
8. Past medical history
9. Contraceptive practices
10. Past psychiatric history, including current suicidal ideation
11. Social history including custody of children and partner's substance use history
12. Family history, including medical and addiction history of family members
13. Vocational/Educational history
14. Legal problems
15. DSM IV criteria review

Given laboratory testing limitations and staff resources, it may be difficult to obtain supervised urine samples. In such cases, caution should be exercised when relying on the results to assess patient stability.

A focused physical examination should be performed prior to starting a patient on methadone. Special attention should be given to: signs of opioid withdrawal, malnutrition, jaundice, hepatosplenomegaly, presence or absence of heart murmurs, pupil size, tattoos, body piercing, signs and symptoms of chronic liver disease, signs of untreated H.I.V infection, needle tracks, and abscesses.

A urine drug screen is to be completed during the assessment phase, the results of which must be interpreted prior to initiation of MMT. As a general rule, the validity of the urine screen increases if the sample collection is done under supervision. Initial testing should include TB skin testing, HIV, Hepatitis B and C serology, liver function tests such as albumin and INR, liver enzymes, and a BHCG where indicated. For a more complete discussion on assessment considerations see "Methadone Maintenance: A Physician's Guide to Treatment". Please refer to the sample assessment form in Appendix B.

II. Explaining Treatment Options

After the assessment is completed, the patient should be given information about the treatment options that are available. These may include tapering, medical detoxification (using clonidine and other medications including opioid agonists), admission to a withdrawal management centre, mutual help groups, drug and alcohol treatment programs (residential and non-residential) or methadone. It is recommended that a treatment plan be developed and agreed upon between the physician and the patient. Whenever it is most appropriate in the doctor/patient relationship, the treatment plan should be in writing and signed by both parties.

Assistance for special needs that have been identified during the assessment should be arranged. These include: medical care, treatment for concurrent psychiatric disorders, relationship and parenting issues, housing needs and vocational assistance.

III. Treatment Agreement (Plan) - Informed Consent

In order to ensure that all patients receiving methadone have a clear understanding of MMT, it is recommended that each physician (or program) use a Treatment Agreement. This agreement confirms the patient's consent and commitment to MMT. This agreement should take into consideration the patient's goals and be individualized to each patient in treatment. The agreement should include relevant information about methadone treatment that will satisfy the patient being able to provide informed consent to treatment. The agreement should also include a consent for a release of information between the pharmacist and the physician. It is recommended that the treatment plan be clearly communicated, preferably in writing.

IV. Explain exceptions to doctor-patient confidentiality.

A physician should explain to a patient the circumstances under which an exception to the doctor-patient expectation of confidentiality will occur prior to obtaining a history from the patient. Please refer to Appendix B for sample form.

A comprehensive treatment agreement should include the following sections:

1. Informed consent (signed agreement and/or information sheet)

2. Consents

3. The Physician's obligations to his/her patients

4. Program Rules

1. Informed Consent

The following acknowledgements/statements should be discussed and agreed to in a comprehensive treatment agreement and are the basis of informed consent for a patient.

- The patient has considered the treatment options for opioid dependence (other than methadone maintenance) as explained by the physician, and that these options have been unsuccessful or are unacceptable to the patient.
- Methadone is an opioid that the patient will become physically dependent on, and if the patient abruptly discontinues the medication, withdrawal symptoms will result.
- Methadone maintenance is generally a long-term (or life time) treatment option.
- During the stabilization period, sedation and/or withdrawal symptoms may be present. Driving an automobile or operating machinery during the stabilization period of methadone maintenance may be dangerous. These dangers can also arise again during dose adjustments or periods of instability.
- Illicit drug or ethanol use with methadone can be dangerous. The use of other substances including prescribed or non prescribed medications while taking methadone should be discussed with your physician, as drug interactions may occur. For example, some HIV medications cause withdrawal.
- For reasons of safety, the methadone dose may be withheld if patient appears to be intoxicated.
- After three missed days of methadone, a patient needs to be reassessed by the physician because of the risk of overdose if the original prescribed dose is given at this time.
- Methadone maintenance assists in the stabilization of the patient physically and emotionally so that the counseling and lifestyle changes necessary for recovery may occur.
- The average daily dose of methadone may result in death if taken by a person not dependent on opioids.

- Side effects from methadone maintenance can include constipation, sweating, fatigue, decreased libido and weight gain.
- Fertility frequently improves with stabilization on methadone, so patients should consider this factor during family planning.
- A baby born to a mother on methadone maintenance may experience symptoms of opioid withdrawal after birth; neonatal opioid withdrawal may be delayed 1-2 weeks postpartum. The symptoms are treatable and have not been shown to result in long-term developmental or physical problems.
- The law of Canada places a duty on patients to inform any physician if they have received a narcotic from another physician within the preceding 30 day period - otherwise a patient will have committed the offence of double doctoring.
- The patient may voluntarily withdraw from the methadone treatment program at any time.

2. General Consents

The patient consents to:

- The physician reporting to the College of Physicians and Surgeons of Ontario the patient's name, date of birth, OHIP number, City of Residence, the name and phone number of the pharmacy that will dispense their methadone and the date methadone was initiated and completed.
- The patient consents to the exchange of information and communication between the physician and the pharmacist.
- Allow the College of Physicians and Surgeons of Ontario or its designate permission to review the patient's chart. This is done to assess the care provided by the patient's physician. (The patient may decline to consent to their name being provided in a review of their chart, but their chart may still be reviewed with the identifying information removed. If the patient does not consent to their name being provided – this will have no impact on any decision made with respect to the individual care of a patient.)

3. The Physician's obligations to his/her patients

1. To provide professional, respectful and reliable services to patients.
2. To provide back-up coverage for holidays and periods when the physician is on vacation or unavailable.
3. To provide appropriate notice to the patient should a physician choose to leave this area of practice. The physician should assist in the transfer of patients to other methadone prescribing physicians to ensure continuity of treatment.
4. To either provide or facilitate patient access to services related to recovery. This includes counseling, vocational support services, primary health care, etc.
5. To remain current in practices and standards for MMT and the treatment of opioid dependence.

4. Program Rules

When a physician or program requires that a patient sign a treatment agreement, it is important that the patient receive clear information about the program rules and expectations. Issues such as carry policy, urine screens and appointment frequencies should be specified. The reasons for discontinuation of methadone, should it become necessary, are to be specified. It is important to advise patients about the services or resources that are available to them either in the program and/or the community in conjunction with the prescribing of methadone.

Please see a copy of a sample agreement in appendix C.

METHADONE DOSING ISSUES

"start low – go slow"

1. Methadone must be dispensed in a vehicle that does not lend itself to injection (e.g. Tang) to a volume of 100ml
2. Methadone/Tang must be consumed under the direct supervision of a health professional

Methadone Initiation

The initial dose of methadone is administered after the medical assessment has been completed and a diagnosis of opioid dependence has been established. The following protocol is suggested:

- ***The initial dose should be 15 - 30 mg of methadone per day for the first three days***

During the initiation phase, a physician should not prescribe short acting opioids such as codeine.

To over estimate tolerance exposes the patient to the risks of inadvertent single-dose toxicity, and certainly increases the risk of the more common problem of associated accumulated toxicity given the relatively long elimination half-life of methadone. Similarly, to underestimate tolerance puts the patient at increased risk for ongoing use of illicit substances due to inadequate methadone levels, and prolongs both the withdrawal and/or stabilization period.

Three days represents the average time taken for an individual being dosed daily to reach 87.5% of steady state for a drug with an elimination half-life of 24 hours.

In single-dose overdose cases, death has been reported with methadone doses as low as 50 mg in non-tolerant individuals. Methadone blood levels continue to rise for five days after starting or raising a dose. Death by accumulated toxicity may result from increasing a dose before the full effect of the current dose is known. It is important to remember that there is no clear relationship between reported "heavy use" of heroin and the final dose of opioid dependent patients.

Methadone maintenance treatment patients who consistently use benzodiazepines, cocaine or other psycho-stimulants are at risk for significant complications and often have a poorer prognosis. In addition, the combination of alcohol, sedatives and/or short acting opiates (such as oxycodone or hydromorphone) significantly increases the risk of overdose death. For these reasons, physicians should be particularly cognizant of safety considerations with respect to methadone dose and take home privileges in patients where methadone may be combined with other drugs.

Methadone Dose Stabilization

- ***Criteria for dose increases include: (a) signs and symptoms of withdrawal (objective and subjective) (b) amount and/or frequency of opioid use not decreasing (c) persistent cravings for opioids***

- ***Dose adjustments should not be made more frequently than every 3 – 4 days***

In terms of dosing increments during initiation and stabilization - "start low – go slow". Dose adjustments during the stabilization period are typically in the 5 to 15mg range while changes during maintenance are in the 5 to 10mg range.

Withdrawal Symptoms

Objective findings of withdrawal include nausea, vomiting, piloerection, pupil dilation, tremor, runny nose, teary eyes, sweating and signs of autonomic instability.

Subjective findings include dysphoria, edginess, lack of energy, insomnia, craving and emotional lability. While the latter are more difficult to quantify, these are reasonable grounds to upwardly adjust a patient's dose. During the stabilization phase, adjustments no more frequently than every three to four days are recommended. Because of the long half-life, inadvertent, toxic methadone accumulation can occur even one to two weeks after treatment initiation. Once a daily dose of 60 – 80mgs has been reached dose increases in the 5 to 10mg range with reassessment as required.

Optimal Dose:

The optimal methadone dose is that dose which relieves withdrawal symptoms, blocks the euphoria from short acting opioids and drug cravings without sedation or other significant side effects. With experience, the optimal dose for the majority of patients can be established within two to six weeks of methadone initiation; a dose above 120 mg per day is considered to be in the high range. If the physician has difficulty in stabilizing the patient's dose above this level, it is recommended that a physician should consider seeking assistance by referral, consultation or informal consultation with a physician knowledgeable in addiction medicine.

Typical reasons for dose increase include:

1) Signs and symptoms of withdrawal
2) Amount and/or frequency of opioid use not decreasing
3) Persistent cravings for opioids
4) Failure to achieve a dose that blocks the euphoria of short acting opioids

It has been reported that the most common reason for methadone overdoses has been overly aggressive prescribing during the first two weeks of treatment. The combination of overestimated tolerance and underestimated accumulation are the main factors at work. After stabilization, the most common reason for overdose is Drug-Drug interactions, typically with sedatives and /or hypnotics.

In recent reports, methadone doses many times greater than average have been cited, especially in those individuals with concurrent immune compromising illness such as HIV infection. More research in this area is required.

Missed Doses and Loss of Tolerance:

A clinically significant loss of tolerance to opioids may occur with as little as three days without methadone. For this reason, after a period of three days without methadone, it is recommended that the physician consider reducing the methadone dose to ensure any loss of tolerance does not result in a "single-dose" overdose of methadone. After tolerance to that first dose of methadone is demonstrated, the dose can be rapidly increased over a period of days to the previous dose for that person. After missing five or more days of methadone the body has eliminated the drug, and so the most prudent course is to restart methadone at 30 mg or less. After assessing response to that initial dose over three days, the dose may be safely increased relatively quickly toward the previous stable dose of methadone.

If an individual receiving a relatively high dose of methadone, with a high level of carries, suddenly encounters a forced consumption of their daily dose of methadone (i.e. incarcerated or hospitalized patients) he/she is at risk for overdose and death if medication has not been consumed as ordered. This is particularly dangerous for a patient who has been diverting a substantial portion of his/her prescribed methadone. Similarly, if a person has a significant drop in their carry status, for example to daily dispensing consumption at a clinic or pharmacy, caution should be exercised in case the patient is no longer tolerant to their full dose of methadone and could be at risk for accumulated toxicity.

Vomited doses

In certain situations a recently ingested dose may be lost through emesis. If the emesis was witnessed by a health professional or member of staff, the dose may be replaced as follows:

- Emesis < 15 minutes after consumption, – replace full dose
- Emesis between 15 to 30 minutes after consumption, replace 50% of dose
- Emesis >30 minutes after consumption - no replacement

As it is impossible to completely empty the gut with even violent emesis, repeated dose replacement can lead to unexpected overdose. The underlying cause needs to be sought.

Frequency of Visits

When a patient is initiated on methadone, they should be seen every 3 – 4 days to adjust their methadone dose. After a stable dose has been reached, it is recommended that the patient and the physician [or other member of the treatment team] meet every one to twelve weeks depending on the patient's stability. The patient should see a physician more frequently during times of relapse or unusual stress.

An intoxicated patient should never be medicated with methadone.

The combined use of sedative prescription drugs such as benzodiazepines, and barbiturates, with opioid agonist therapy is to be avoided.

Intoxicated Patients

In most reviews of methadone related deaths, concurrent use of sedatives such as benzodiazepines and alcohol were found to play a contributory role. For this reason, intoxicated patients should not be medicated with methadone until they have been reassessed and found to be unimpaired. In the case of alcohol abuse or dependence, routine breath alcohol determinations prior to being medicated can be helpful.

URINE DRUG SCREENING

Results of urine drug screens may provide valuable information and can be used as an aid in:

- Documenting baseline drug use and periods of abstinence
- Verifying self report of drug use
- Aiding in assessing functional stability
- Minimizing possible drug interactions
- Assisting in evaluating compliance with methadone by detecting presence or absence of methadone parent and/or metabolite
- Assisting in assessing appropriate carry status
- Adjusting methadone dosage
- Reevaluating treatment goals

The design and implementation of urine collection, testing and interpretation should be done in a way that maximizes patient retention, compliance monitoring, positive treatment outcomes, and the safety of the patient and others. Results of the urine drug screens should be interpreted by the physician in conjunction with functional stability. Patients not willing to comply with urine testing as directed should be carefully assessed with respect to carry privileges.

Urine Collection

Ideally, urine samples should be obtained on a random schedule under the direct observation of personnel trained in the collection of urine samples. The validity of a test can be increased further by measuring the temperature of the sample immediately after collection, having patients remove obstructing clothing, bluing of the toilet water and ensuring no access to running water in the collection area. It is important that personnel act in a professional and respectful manner towards patients and that sensitivity and privacy be exercised during the urine collection process. If direct observation is not possible or if there is any question about the reliability of the urine drug screen results, other methods should be employed. If tampering is suspected the physician should be notified and whenever possible a second sample should be collected the same day so results can be compared. As well, laboratory measures, such as those described in the appendix can be used to increase reliability.

Frequency of Urine Testing

At least one urine drug screen must be collected and interpreted prior to initiation onto methadone. Thereafter, urine testing should be done on a random schedule wherever possible. During the stabilization period, a urine drug screen should be assessed at least once weekly. After six months of negative screens urine can be collected biweekly to monthly.

Ongoing reassessment of the frequency of urine screens is based on the physician's assessment of the patient and their pattern of drug use, validity of the patient's self-report and functional stability. It is important the urine drug screening results not be utilized in a punitive manner.

Urine Toxicology

Some drug elimination is pH dependent. Methadone in alkaline urine is reabsorbed so commonly not found. EDDP is not pH dependent.

Typically urine specimens are initially screened using an enzyme immunoassay. Ideally, urine screening should include: opioids, benzodiazepines, cocaine and methadone. Depending on local drug use patterns and clinical judgement the screen may also include amphetamines, barbiturates, cannabinoids, and ethanol.

A more specific test using gas, thin layer or high pressure liquid chromatography will identify specific drugs of abuse, as well as the presence of the methadone metabolite. The frequency of testing for methadone metabolite should be individualized based on the clinical setting. The absence of the methadone metabolite in a urine specimen may indicate that the patient had tampered with the sample or that methadone has not been consumed as directed.

COUNSELLING

Studies have shown that patients will have increased success in MMT when they receive appropriate counselling.

Access to counselling should be an integral part of methadone maintenance treatment. Patients will have increased success in MMT when they receive appropriate counselling. It is important that patients have input both into where and what counselling services they receive. It is expected that where physicians are unable to provide counselling services directly, they would be familiar with the resources that are available in their community. This information can be obtained through DART (Drug and Alcohol Treatment Registry) at 1-800-565-8603, the CPSO (416) 967-2661 (or 1-800-268-7096 Ext. 661)) or by calling OSAB (416) 327-7432.

Counselling can be structured around the following areas:

- Securing basic necessities such as housing, food, clothing
- Legal issues
- Life skills
- Coping with stress
- Identification and treatment of concurrent mental illness
- Issues of abuse – physical, sexual, emotional
- Parenting and family counselling
- Education about harm reduction
- Stopping drug use and preventing relapse

CARRY POLICY

Most people who die with methadone in their system are found to have ingested methadone that has been diverted.

In order to safely prescribe carry medication, three questions must be answered:
1) is it safe for the patient?
2) is it safe for the public?
3) what is the risk of diversion?

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.

1. Clinical stability - the patient demonstrates **clinical stability** when:

- The patient's dose has reached a stable level.
- The patient 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, support system and activities and regular attendance at pharmacy and doctors appointments.

2. The length of time in methadone treatment - Carries are not recommended during the first two months of treatment. (See chart page 24)

- Pharmacies may not be open on Sunday and the patient may need to use an alternate pharmacy on Sundays. It may be appropriate or necessary for the patient to receive a Sunday carry. It is recommended that the physician involve the regular dispensing pharmacy in making any accommodations to a patient's carries. If alternate arrangements cannot be made and there is not a pharmacy open to dispense methadone, the physician can call the Ontario College of Pharmacists (OCP), Pharmacy Practice Department (416-962-4861, ext. 236) to get the name of a local pharmacy that dispenses methadone on weekends.

3. Ability to safely store medication.

- Patients with unstable living arrangements, such as those living on the street or in hostels without storage facilities may not be appropriate to receive carries.
- Patients should be informed that a locked container for their carries is advisable in situations where other individuals (especially children) may have access to the carries or in the circumstance of shared accommodation with other drug users.

Reassessment and/or Reduction of Carry Privileges

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

- Patient has failed to maintain clinical stability as previously outlined.
- Continued problematic drug or alcohol use with extra caution exercised with the patient's use of cocaine or other stimulants.
- Patients 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.
- Patient is not meeting agreed upon goals and objectives.
- Patient has failed repeatedly to leave a urine sample for drug screening in the required manner as agreed upon in the treatment plan.
- Patient 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).
- Patients have tampered with their urine sample.
- Patients consume carries early, report lost or stolen carries, or vomit carries should have their level of carries re-assessed.

Giving, lending or selling methadone is considered diversion and is trafficking in a controlled substance.

Physicians must consider the increased mortality associated with patents who use alcohol, and benzodiazepines within MMT.

Lost or stolen carries should be reported to the police by the physician or staff. It is not required that the patient's name be disclosed although it is recommended that the patient report the incident and obtain a occurrence reference number from the police.

Exceptions to Carry Policy

All exceptions to the carry schedule must have clear documentation of their necessity.

1. Patients 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 warrants the use of the medication to treat the symptoms of the condition.
- The patient is clinically stable and meets other carry criteria.
- Consideration given for a referral to a physician knowledgeable in addiction medicine who has supported the use of the medication.

Examples -

a) Chronic benzodiazepine use as second line drugs for treatment of panic disorder or specific anxiety disorders.

b) Stimulant use for ADHD. (ie. Ritalin)

c) Opioid use for conditions of chronic pain.

- For prescription drugs it is important that the physician prescribing has full knowledge of the current prescribed medications and the patient's past addiction history.
- Benzodiazepenes generally have a mild to moderate abuse liability. The risk of abuse, however, is increased in a patient who has already demonstrated a history of substance abuse and/or dependence.
- Physicians must recognize that it is difficult to monitor supplemental and non-prescribed drug use in a patient to whom a drug with abuse potential has been prescribed.

2. Medical disability.

- A physician may decide to initiate or increase carries to a patient 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 requirement for carries should be re-assessed once the patient'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 physician must carefully decide whether the benefits of carries for the patient outweigh the risk of further destabilizing the patient.
- Carry exceptions should most commonly be seen as a trial and as such, require frequent reassessment.

3. Compassionate basis

- Patients 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 patient's dosing observed (ie. at a local pharmacy).
- Additionally the physician should assess the mental status of the patient to be satisfied that the provision of carries through the crisis will not compromise the safety of the patient or other persons.

4. Job or Vacation

Patients who have been deemed appropriate for a high level of carries (ie. attends the pharmacy once or twice weekly) may be granted a higher number of carries for reasons such as travel and employment opportunities. The physician can contact the CPSO Methadone Program for information about the services available for the area to which the patient is traveling. In certain circumstances, temporary arrangements for pharmacy dispensing can be made. The patient should provide the physician with verification of the travel plans (eg. plane ticket, letter from work).

Process Considerations

In general, the practitioner must weigh the benefits of prescribing a given drug with the risks involved. It should be understood that the presence of any illicit drug or medication in a urine drug screen is indistinguishable from whatever 'prescribed' quantity of drug is present.

Initiating Carries:

Prior to initiating carries it is important that informed consent related to safety and responsibility is discussed with the patient. If practical, a spouse or significant other should be in attendance on initiation of carries. The physician should advise the patient of the potential danger of methadone consumed by the opiate naïve, and particularly children, and the advantage of storing the carries in a locked container.

Prescription Issues:

The dose, start and stop dates of the prescription and the frequency of carries, must be clearly documented both on the prescription and on the patient chart.

Clear documentation of this information will decrease the likelihood that prescriptions will overlap. It will also be essential in the event that another clinician will be required to manage the care of that patient based on the original physician's records. Carbon copy (duplicate) prescriptions kept in the patient's chart can facilitate documentation.

SAMPLE Methadone Prescription Form

Valid only at:
(specify pharmacy)

____

____

____

Name	Date	File #

Rx Methadone _________mg   ____________________

p.o. dispensed daily mixed in orange drink   Dose in words

Start Date:_________________ End Date:____________________ Inclusive

Drink observed in the pharmacy on days circled:

Mon Tues Wed Thur Fri Sat Sun

The following doses are to be dispensed **as take home doses:**

Mon Tues Wed Thur Fri Sat Sun

Special instructions:

Contact prescriber before filling this prescription if dose is increased by more than 15mg., unless noted above. Hold prescription if more than three consecutive doses are missed, and contact prescriber. Notify the pharmacy if a dose is missed. Fax a copy of this prescription if there are any concerns about this prescription.

____________________   ____________________ M.D.

Signature   Print Name

Prepared by	Date	Dispensed by

The physician should indicate on the prescription the start and stop dates, the number of carries to be dispensed per week and/or the days of the week the patient receives carries and/or the dates the patient is to receive carries. If there is some reason why prescription dates overlap, an explanation should be included to cancel the previous prescriptions (e.g. in cases of change of dose prior to end of previous prescription). Methadone is diluted in a suitable drink e.g. Tang to discourage injection. This should also be stated on the prescription.

There is a risk to the patient when methadone dispensing is split between two or more pharmacies. This practice increases the possibility that the patient could be inadvertently dosed twice on a single day. Additionally, one pharmacy may not be aware of missed doses that occurred at the other pharmacy. Communication between physician and pharmacy as well between the two pharmacies is very important in this situation. (Refer to "Methadone Maintenance: A Pharmacist's Guide to Treatment", CAMH, 2000.)

There is no one right way to handle the reduction or resumption of carries. Adequate documentation and good clinical judgment are key. Carry reductions must not be used as a punitive measure.

In general, a gradual return to the previous level of carries is recommended. In certain cases, the gradual loss of carries will not be appropriate; care must be exercised to avert intoxication or overdose when carry levels are adjusted downward.

Managing Relapse

A relapse to mood altering substances indicates reduced stability in the patient and the level of carries must be reviewed. (Refer to the examples of "risky behaviour" page 19.) A physician may consider not reducing the level of carries following a single episode of drug use (a "slip" or "lapse") if the episode appears to be over and the patient does not demonstrate other signs of instability. It is recommended that the physician increase the frequency of clinical re-assessments (ie. office visits, urine drug screens) following a lapse.

A proposed schedule for carries during a sustained relapse is:

- Reduce one carry per week for each positive urine sample (typically tested once per week) if the patient remains clinically stable.
- Patients who demonstrate continued risk behaviours should have all carries discontinued.
- Return carries to the previous level of carries at a rate no greater than an increase of one carry per week for each negative urine sample (typically tested once per week), provided that the patient is otherwise stable and meets the criteria.

Lapse vs. Relapse

A lapse is defined as a return to unhealthy behaviour regarding drugs that may include use of the drug for a period not lasting more than 24 hours. A relapse is defined as a return to drug use along with a corresponding loss of social support.

CARRY SCHEDULE

In general, methadone patients who are clinically stable and meet the criteria described on page 18, # 1 – 3 can receive each month after the first two months in treatment, one additional carry per week, to a maximum of six carries per week (one witnessed dose in the pharmacy, 6 take away "carry" doses). Patients who have occasional drug use or, in some circumstances, sustained drug use may be appropriate to receive carries (although the number and progression of "carries" would be reduced from the schedule) if they are determined by the physician to be clinically stable and able to safely store their medication. Physicians should clearly document these exceptions.

When a patient demonstrates risky behaviour (examples found on page 19) the prescribing physician must reassess the progression of carries and/or level of carries. The decision to give carries must take into consideration both patient safety and public safety.

When a patient has a sustained relapse:

- Reduce one carry per week for each positive urine sample (typically tested once per week) if the patient remains clinically stable.
- Patients who demonstrate sustained use and/or clinical instability should have all carries discontinued.
- Return carries to the previous level of carries at a rate no greater than an increase of one carry per week for each negative urine sample (typically tested once per week), provided that the patient is otherwise stable and meets the criteria.

Carry Criteria:
refer to page 18

Criteria	# of Carries
Meets carry criteria #1- 3 and, - Has been on methadone for at least **2** months	**1**
Meets carry criteria #1 – 3 and, - Has been on methadone for the past **3** months	**2**
Meets carry criteria #1 – 3 and, - Has been on methadone for the past **4** months	**3**
Meets carry criteria #1 – 3 and, - Has been on methadone for the past **5** months	**4**
Meets carry criteria #1 – 3 and, - Has been on methadone for the past **6** months	**5**
Meets carry criteria # 1 – 3 and, - Has been on methadone for the past **7** months	**6**

INVOLUNTARY DISMISSAL FROM CARE

While a comprehensive treatment system attempts to provide options and levels of care that are appropriate for the diverse range of individuals who are opioid dependent, physicians have the right to determine who they can properly treat and to discharge or to transfer a patient to another program or physician if deemed necessary.

The Code of Ethics of the Canadian Medical Association provides that the ethical physician, having accepted professional responsibility for a patient, will continue to provide services until they are no longer required or wanted, until another suitable physician has assumed responsibility for the patient or until the patient has been given adequate notice that the physician intends to terminate the relationship. The Regulations governing medical practice in Ontario provide that it is professional misconduct to discontinue professional services that are needed unless the patient requests the discontinuation, alternate services are arranged or the patient is given a reasonable opportunity to arrange alternate services. If it is necessary to inform a patient that Methadone Maintenance Therapy must be terminated, the timeline for this discharge from treatment must be clearly stated when the decision is communicated to the patient. If transfer of care is not possible in the circumstances, there is no alternative but to institute a slow taper which should follow the guideline found in Methadone Maintenance: A Physician's Guide to Treatment; published by the Centre for Addiction and Mental Health, 1998.

Whether a patient on Methadone can be transferred to another program or must be tapered, the goal is to end the relationship in a way that will minimize the risk or discomfort to the patient.

Contraindication of methadone:

If it is felt by the physician following a thorough assessment and using all available resources that, in the interest of the patient's safety, methadone treatment is not currently appropriate, it is appropriate for the physician to discharge the patient from MMT. The clinical reasoning involved should be carefully documented.

It is important that information about any patient behaviour that may give rise to discharge from the program come from reliable sources. Unreliable hearsay* or rumour is not an appropriate basis upon which to discharge a patient from therapy.

*Hearsay implies information passed verbally from unreliable sources. Anonymous sources are not adequate, regardless of source.

Appropriate reasons to terminate Methadone treatment may include:

a) **Threats:** The patient has made a threat to the safety or well-being of a staff member or another patient or someone related to them;

b) **Disruptive behaviour:** The patient has engaged in disruptive behaviour on the methadone program premises;

c) **Violent behaviour:** The patient has engaged in violent behaviour towards a staff member, a patient or another person.

If a patient on methadone feels that he/she has been wrongfully dismissed, they will have the option of addressing the decision through the complaints process set out under the Regulated Health Professions Act, 1991. The potential for dispute will be reduced if the program rules and the circumstances which may give rise to dismissal from the program are made clear at the commencement of the treatment. A sample treatment agreement which makes these points is in Appendix B.

MMT IN A CORRECTIONAL FACILITY – FEDERAL OR PROVINCIAL

Introduction

Methadone treatment in correctional settings involves unique issues. The controlled environment, imperatives for security and the governance of correctional policy may affect the physician's ability to provide patient-centered care at community standards. The trusting therapeutic relationship between physician and patient must remain the focus of treatment.

There is significant intravenous opioid use within correctional facilities, often accompanied by high-risk behaviour. The prevalence of HIV and viral hepatitis is high in the prison population and needle sharing is common. Incarcerated opioid dependent individuals should be offered ongoing methadone maintenance or initiation of methadone, as this is the current standard of care.

Issues regarding physician qualifications, assessment, initiation and other areas of MMT common to both community and federal/provincial correctional facilities should be consistent with current CPSO Guidelines.

Issues unique to providing MMT in Correctional Facilities

Dosing on Admission

Confirmation must be obtained about whether a patient is on a MMT program upon their admission to prison prior to dispensing the first methadone dose. The previous provider and/or pharmacy should be contacted to determine the dose and the date/time of the last dose received.

Current Ontario Provincial Corrections policy - There is provision for a 30mg 'holding dose' for those inmates who are known to be on methadone, but where the pharmacy or provider is not available to confirm the current dose.

Methadone brought with an inmate

Methadone accompanying any inmate should be discarded unless continuity of handling can be proven, such as in a transfer from another facility. Please refer to institution correctional policy for the protocol for the discarding of narcotics.

Treatment planning for release

It is necessary to make arrangements in advance of an inmate's discharge from a correctional facility with an appropriate community methadone provider so that an inmate will be able to continue on methadone. It is expected that medical records and/or relevant clinical information be provided in advance of any discharge to the receiving physician. A list of providers may be obtained from the CPSO. Arrangements should be made so the discharged inmate may pick up methadone at a local pharmacy, although not all pharmacists dispense methadone. If assistance is requires in finding a local pharmacy that dispenses methadone, the facility can contact the Ontario College of Pharmacists at (416) 962-4861, extension 236. The pharmacy should be contacted and, if possible, the prescription faxed directly to the pharmacy rather than being provided to the inmate.

If an inmate is going to a community with no methadone provider, the inmate will require a slow withdrawal from methadone prior to discharge from prison/jail. This should be done only as a last resort and only with the inmate's informed consent.

Reporting to CPSO

The CPSO requires an initiation form upon incarceration or release from prison or jail. It is not necessary to re-initiate and cessate inmates when moving from one institution to another. At the time of initiation in jail the physician previously prescribing should also be faxed the initiation form and faxed the cessation form on discharge.

In cases of intermittent sentencing or in very short sentences other procedures may be more practical. An example would be an inmate serving weekends only. In some of these instances the community physician may agree to continue the prescription rather than to transfer care to the correction's physician.

Treatment Agreement

Treatment agreements should be signed and medical records obtained from previous providers. Information discovered while obtaining a treatment agreement and medical history should be kept as part of the medical file. Patient confidentiality must be strictly observed.

Urine Toxicology Screening

It is essential that urine toxicology screening used in MMT in jails and prisons are clearly a part of the medical record and not available to security or administration for any reasons. Frequency of urine testing while a patient is incarcerated can be varied and may be done less frequently than the guidelines specify.

Approach to Treatment

Inmates may have difficulties involving trust. A treating physician's primary concern should be for the patient's medical care and every effort should be made to foster a trusting relationship. It must be clear that the interests of the patient are the priority of the physician. A multidisciplinary approach to the provision of MMT programs is essential in a prison setting including clinical staff, substance abuse counseling and parole officers.

It is not uncommon for methadone maintenance patients to be under considerable pressure from other inmates to divert their medication. Adequate steps to protect the patients from other inmates are critical to ensure institutional safety.

Confidentiality and honesty are extremely important in a jail or prison system as in all medical interactions. Conflicts are often avoidable when the structure of the treatment is conveyed to both inmates and the staff. Program rules and expectations should be in writing and verbally described to each inmate. Dispensing times should be clearly defined. Expectations regarding provision of urine samples, physicians' appointments and general behaviour should be clearly described at the onset of treatment. Inmates that arrive late for dispensing or who vomit doses should not have these doses replaced unless extraordinary circumstances exist.

Dispensing

Traditional lack of access to MMT in prison has created a situation where demand usually exceeds supply. For this reason attention to dispensing matters is of paramount importance so that methadone is not diverted.

1. Each inmate should be segregated from the general population while he/she is ingesting the methadone dose.
2. Each inmate must be properly identified prior to the methadone being dispensed. This should include asking the inmate's name, birth date and comparing with the unit card photograph.

3. Check the name, date and dose on the label of the methadone bottle.

4. It should be verified that the inmate has completely swallowed the dose so that there can be no regurgitation or oral diversion.

5. Records should be kept clearly verifying dose administration.

6. The health care nurse should observe the ingestion of methadone in an area isolated from other inmates. A glass of water should be ingested after the methadone and the inmate should be kept for observation in the area for about 20 minutes.

7. Methadone cannot be left unattended unless it is secured either in a locked refrigerator or safe. The drug storage area should not be accessible to inmates.

Accidental Overdose of Methadone

Jails and prisons should have available to all healthcare staff protocols involving acute opioid overdose. If the jail or prison does not have the facilities and staff to treat and observe a methadone overdosed patient for at least 24 hours, the patient should be transferred to another suitable facility.

Initiating inmates in a methadone program while in a correctional facility

If an inmate is not receiving methadone at the time of incarceration, the following conditions should be met:

1. The inmate must meet or have met in the past the DSM IV diagnostic criteria for substance dependence (opioid).

2. A urine drug screen must be interpreted and a complete assessment performed prior to initiation.

3. The usual reporting procedure to the CPSO is followed.

4. Inmates not currently using opioids but where their documented history clearly shows a pattern of long term opioid dependence continuing until the time of incarceration should be considered for initiation on methadone while in the correctional facility.

5. Pregnant inmates currently using opioids must be offered MMT while incarcerated. Patients suffering from HIV infection, or viral hepatitis should be made a high priority for being offered methadone treatment while incarcerated.

Involuntary Discharge

As a last resort when the risks of providing methadone outweigh benefits, a patient may be considered for involuntary discharge from MMT. Involuntary discharge from MMT should not be used for behavioural management. Patient retention is a major goal of MMT and it is essential that the corrections systems MMT program strive for this.

Carries

Carries should not be provided in jails and prisons. In very limited and unusual circumstances and by physician prescription only, on an individual case by case basis, limited carry or take home medication may be allowed.

Appendix A

Diagnostic Criteria for Substance Dependence

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Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:

   a) the need for markedly increased amounts of the substance to achieve intoxication or the desired effect
   b) markedly diminished effect with continued use of the same amount of the substance

2. Withdrawal, as manifested by either of the following:

   a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
   b) the same (or a closely related) substance is taken to relieve (or avoid) withdrawal symptoms

3. The substance is often taken in larger amounts or over a longer period than was intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain smoking), or recover from its effects.

6. Important social, occupational or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was worsened by alcohol consumption).

Specify if:
With Physiological Dependence: evidence of tolerance or withdrawal (i.e. either Item 1 or 2 is present)

Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e. neither Item 1 nor 2 is present)

Diagnostic Criteria for 292.0 Opioid Withdrawal

A. Either of the following:

1. cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer)
2. administration of an opioid antagonist after a period of opioid use

B. Three (or more) of the following: developing within minutes to several days after Criterion A:

1. dysphoric mood
2. nausea or vomiting
3. muscle aches
4. lacrimation or rhinorrhea
5. papillary dilation, piloerection or sweating
6. diarrhea
7. yawning
8. fever
9. insomnia

C. The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

D. The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Suggested Criteria for Methadone Treatment

1. Opioid use (track marks and a urine drug screen that is positive for opioids)
2. Physical dependence, as evidenced by symptoms or signs of opioid withdrawal
3. Psychological dependence
    - Regular daily use
    - Social consequences: financial and legal difficulties; difficulties with employment and relationships
    - Physical consequences such as hepatitis C
    - Inability to discontinue use
    - Neglect of major social responsibilities due to drug use
    - Preoccupation with the drug: acquiring it, using it, recovering from its effect
4. Small likelihood of benefit from non methadone treatment
    - Past history of treatment failures
    - Opioid dependence for at least one year
5. Agreement to terms and conditions of the treatment program

Appendix B

Sample Methadone Assessment Form

This assessment form will assist your doctor in determining what type of treatment will best serve your needs.

Methadone maintenance is a regulated form of treatment, and there are guidelines that we follow in order to select patients who are appropriate for treatment. A thorough assessment of every patient is required prior to initiating methadone treatment. This assessment typically includes interviews with a doctor, a physical exam with appropriate blood work (eg. HIV and hepatitis testing), supervised urine drug testing, as well as a review of records from previous treatment centres you have attended.

You cannot expect a prescription for methadone after your first visit and it may not be possible for the physician to give you an exact time when methadone therapy will be available to you. Please be aware that completing an assessment does not guarantee you a position on our methadone program.

About Confidentiality:

Everything that you tell the clinic staff is confidential, although it is important to realize that under exceptional circumstances we can be obliged to report something you tell us to the appropriate authority. This can occur under the following conditions:

1. If we suspect that a child is being abused, under the Child Welfare Act, it is the law that we report this information.
2. If you reveal to the staff that you intend to harm another person, we will be obliged to protect that person by notifying the appropriate authority.
3. If your chart is subpoenaed by a court we must release it to the party that requests it.
4. If you are dangerously suicidal, homicidal, or are unable to take care of yourself due to a psychiatric condition, you might be held to be assessed by a psychiatrist against your will.
5. If it is suspected that you are unable to drive an automobile due to a medical condition (which includes intoxification from alcohol or drugs), we are obliged to notify the Ministry of Transportation of this.
6. Certain infectious diseases, when detected, are reportable to the Public Health Department. Examples of these infections are tuberculosis and H.I.V.
7. If you are started on methadone, we must register your name with the College of Physicians and Surgeons. This is done to prevent people from joining more than one methadone program at a time. This is a confidential list and the College will not release your name to any party.

Patient Initial Assessment Form

ABOUT YOURSELF:

Please complete the following questionnaire as accurately and honestly as possible so that we can determine what kind of treatment would serve you best.

NAME________________________________ ________________________________

(last) (first)

DATE____________________________

HEALTH CARD #________________________________ VERSION CODE: _________

DATE OF BIRTH____________________________

(year/ month / day)

ADDRESS____ APT #_______

CITY_________________________________ POSTAL CODE ______________________

PHONE (day) ( )________________ (evening) ( )___________________

CONTACT IN CASE OF EMERGENCY(state relationship)

____

CONTACT'S PHONE ( )____________________

WHO REFERRED YOU HERE ?____

YOUR AGE __________ YOUR GENDER : ❑ male ❑ female

PRESCRIPTION MEDICATIONS :

(any medications you regularly take or are prescribed, amount and frequency): none or, give details:

Are you now or have you ever been prescribed narcotics (eg. Tylenol #3, Percodan, Percocet, Dilaudid, Talwin, morphine) for an extended period of time (eg. for more than four weeks?)

yes / no narcotic name____

Amount prescribed______________________For how long?_______________________

(per week / month) (weeks / months / years)

For what reason was it prescribed?

If it has been discontinued, when and why?

DRUG ALLERGIES: none or, give details:

____

(any medications you can't take, and WHY NOT?)

PAST MEDICAL HISTORY: (circle and give year)

hepatitis A....... neg / pos / never tested / don't know

hepatitis B........ neg / pos / immune / vaccinated / carrier /never tested / don't know

hepatitis C........neg / pos / never tested / don't know

HIV.................. neg / pos (______________)/ never tested / don't know
date of last test

Tuberculosis skin test....... neg / pos (____________)/ never tested / don't know
date of last test

For the above questions, where was the test done, and where are the results now?

Year of first i.v. drug use.. ______/never
History of needle sharing......... yes/no
(including cotton, spoons, filters etc.)

Overdoses.................... yes/no

asthma......................... yes/no

seizures........................ yes/no

operations.................... yes/no
(give year and type):

migraines...................yes/no
back problems............yes/no

ulcers........................yes/no

heart problems...........yes/no

car accidents.............yes/no

other:

Name and address of your family doctor:

Is your doctor aware of your drug problem?.............. ❑ yes ❑ no

WOMEN ONLY:

1. When was the first day of your last menstrual period ? ______
2. Current method of contraception ? The Pill condoms other:
3. Is there any chance you might be pregnant ? ❑ yes ❑ no

EMOTIONAL HEALTH:

Have you ever been treated by a family doctor or psychiatrist for:

anxiety? ❑ yes ❑ no

depression? ❑ yes ❑ no

Have been admitted to a psychiatric facility? ❑ yes ❑ no

Received treatment for any other emotional problems? ❑ yes ❑ no

Were you abused? (mentally, sexually or physically?) ❑ yes ❑ no

Have you ever attempted suicide? ❑ yes ❑ no

Are you currently depressed or suicidal? ❑ yes ❑ no

FAMILY HISTORY :

(any family history of medical problems like alcohol or drug abuse, depression, heart disease etc.?)

mother:______________________________ father: _______________________________

(age) (age)

brothers, sisters, others____

DRUG TREATMENT PROGRAMS:

(including attempts at detox), program name, when, how long did you stay clean?/ why failed?

1.____

2.____

3.____

SOCIAL HISTORY

married / single / separated / divorced / common-law / widowed

Children?______________________ Whose custody are the children in? __________

Who lives in your household?________________________________

Do they abuse alcohol/drugs? ❏ yes ❏ no

Are the people close to you aware of your drug problem? ❏ yes ❏ no

Usual occupation: __________________ Are you currently employed ? ❏ yes ❏ no

Last job held: ________________________ From when ______ to ______

Highest level of education:

Are you receiving: welfare / FBA / pension / UI / none / other?

Do you drive a car? ❏ yes ❏ no

LEGAL STATUS:

1. Are you currently on probation or parole? ❏ yes ❏ no
   if yes, until when ?
2. Is treatment a condition of your probation? ❏ yes ❏ no
3. Do you have any court dates pending? ❏ yes ❏ no
   if yes, When ?
4. Do you have previous convictions? ❏ yes ❏ no
   if yes, for what ?
5. Have you been incarcerated? ❏ yes ❏ no
   if yes, for what ?
6. How long have you been in jail for in total? ____________
7. Have you been charged with impaired driving? ❏ yes ❏ no
8. Have you been charged with a crime that included a weapon or violence?
   ❏ yes ❏ no

About your addiction:

In the last 12 months:

Do you need more and more of the drug you are using to get the same effect? ❑ yes ❑ no

Describe what symptoms you experience if you suddenly stop taking the drug:

Do you frequently take more drugs than you planned, or use it for longer than you planned to? ❑ yes ❑ no

Have you had many unsuccessful attempts to cut down on your drug use? ❑ yes ❑ no

Do you spend a lot of your day getting, using, and recovering from the effects of drugs? ❑ yes ❑ no

Have you given up work, social or other things you used to do because of your drug use? ❑ yes ❑ no

Do you keep taking drugs, despite the harm and problems it is causing you? ❑ yes ❑ no

Why have you come for treatment at this time?

What type of treatment do you feel that you need?

What are your goals for treatment?

PHYSICAL EXAM

Name: ____________________ Date of exam: __________

GENERAL____________________________ BP__________ / ___________

HR _________ /min

PUPILS: normal / pinned / dilated FUNDI

CHEST: clear / other

CVS: murmur other

ABDO: tender enlarged liver/spleen other

SKIN: tracks abscess tattoos

piercing other

LYMPHADENOPATHY: yes no

OTHER:

ASSESSMENT:

Meets criteria for opioid dependence

Suitable for medical detoxification

Suitable for methadone

Co-morbidity:

Psychiatric: __________________________________

Medical: ____________________________________

Concurrent substance abuse: Benzo Cocaine Crack

Etoh Barbs Amp

THC

PLAN:

1.MEDICAL DETOX - discussed risks / handout given / client declined detox

2. BLOOD WORK - including pretest counselling for HIV, Hepatitis B, C

3. METHADONE BENEFITS/DRAWBACKS - discussed

4. LETTER OF UNDERSTANDING - COPY GIVEN REVIEWED SIGNED

5. URINES FOR TOXICOLOGY (L079)

6. RELEASE OF INFORMATION SIGNED

7. REFERRED FOR SECOND ASSESSMENT (if needed)

8. RETURN FOR CPE ON ____________

9. OTHER:

Physician's signature: ________________________ Date:_______________

Appendix C

Sample Methadone Treatment Agreement

Client Name: ______________________________________

I _____________________agree to enter into a program of methadone maintenance treatment offered by [NAME OF YOUR PROGRAM]. This treatment is specifically designed to help me deal with my problems of opiate dependence and will assist me in dealing with the psychological and social difficulties that often accompany problems of addiction. The main purpose of this program is to help me make positive changes in my life related to the use of opiates and other substances.

I am seeking help with reducing or stopping harmful use of illicit drugs and of substances like alcohol and prescription drugs. I am interested in gaining assistance in overcoming my problems with drug use and any associated psychosocial difficulties.

I understand [NAME OF YOUR PROGRAM] offers a range of services in conjunction with methadone maintenance treatment, which can assist me in achieving my goals. Medical care pertinent to my methadone treatment will be provided. In addition, a range of counseling services are encouraged and available on a voluntary basis. Counseling options include support groups, relapse prevention groups, individual counseling, crisis support and assistance with addressing any specific concrete needs that I have, such as financing, housing and referrals to other community services.

I understand that this treatment is likely to help me but I cannot be guaranteed that the treatment will work in my individual case. If treatment is not proving effective other clinical care will be discussed with me.

I understand that, as a participant in this treatment program, I am agreeing to the following:

1. Methadone treatment

Methadone is an opioid and, as such, its prescribing and dispensing are regulated by a number of legal guidelines. I understand that my receipt of methadone depends on the following:

- I agree to pick up my medication during pharmacy dispensing hours and to take the medicine according to the pharmacist's directions. Dispensing hours are clearly posted.
- I agree to notify program staff of all prescription and non-prescription medications that I am taking. I will bring my prescriptions or medication bottles to the pharmacy so that the exact drug and dosage can be noted. The treatment team will advise me, in consultation with my prescribing physician, of any drugs that I am taking that are inconsistent with my treatment plan. I will then refrain from taking these drugs while I am receiving treatment on this program.
- I understand that on some days I may be required to leave a supervised urine sample before obtaining my methadone dose. If I am unable to provide the required sample, staff may ask me to wait. Upon providing the urine sample, I will receive a

medication slip that I can take to the pharmacy to pick up my methadone. I understand that tampering with urine samples is a serious program violation.

- I understand that as I progress in the program, I may request methadone carries or community pharmacy pickups, which reduce the number of days I have to attend the clinic.
- I understand that I may request to have my methadone dose reduced or increased at any time by discussing this with my physician.
- I am aware that the treatment team will check to ensure that I am taking my methadone and that I am providing my own urine samples.

2. Initial Assessment/Treatment Progress Reviews

- I understand that upon entry to the program, I will receive an initial comprehensive assessment that will be used to help me develop a personal action plan based on my specific needs and goals. In the event that I am unable to attend the scheduled initial assessment meetings, I will notify the program's staff as soon as possible, preferably at least 24 hours in advance. Program staff will accord me with the same courtesy should they be unable to attend a scheduled session.
- I will be offered a range of counseling options which I can elect to engage in. I understand that the continued eligibility in most counseling services depends on regular attendance.
- I understand that I will be expected to attend periodic meetings to have my methadone prescription renewed and to review my treatment progress.

3. Medical Care

I will be provided with an initial assessment by a physician affiliated with this program. The assessment for the purpose of determining if methadone is appropriate and safe for me.

I understand that [NAME OF YOUR PROGRAM] is a specialized addictions service and not a family practice clinic. It is my responsibility to have a family physician in the community. I agree to sign a consent form allowing my family physician and program staff to exchange medical information relevant to my care. A copy of this form will be sent with me to my family physician. I understand that if I do not have a family physician, the clinic staff will assist me in finding one.

If another physician or dentist proposes to prescribe opioids (i.e. narcotics) to me I will inform him or her that I am receiving methadone. Obtaining narcotics from more than one physician or dentist could be dangerous to my health and is illegal.

4. Clinic Environment

- I understand that that [NAME OF YOUR PROGRAM] is committed to maintaining a clinic environment that is safe for clients, visitors and staff and to maintaining positive, respectful behaviour between people which does not include threats, violence or destructive behaviour. I agree to uphold these standards.
- I understand that if I have any concerns, I may approach staff immediately and if I am not satisfied with the response there is a problem resolution procedure that I may follow.

5. Confidentiality

- My privacy will be respected. Confidentiality of my health record will be protected in the same way that it is in other health facilities. No release of information from my health record will be given without my written consent or as required by law.
- I understand only in certain situations, the treatment team may be required by law to give out information without my consent. This involves situations where the treatment team perceives my behaviour to be of risk to myself or to other people (such as where child neglect or abuse is suspected).
- Because my participation in the program will bring into contact with other opiate users, I expect other clients to be respectful of my rights, confidentiality and treatment goals, and I will respect the rights, confidentiality and treatment goals of other clients.

My signature below indicates that I have discussed this treatment agreement with a counselor and understand and agree to all of the above. Should I fail to meet my responsibilities as a participant in this program, I understand that this will result in a re-assessment of the treatment plan and a consideration of my continued involvement in the program.

______________________	______________________
Witness	Signature
	______________________
	Name
	______________________
	Address
	______________________
	Date

I have been informed about methadone and have had an opportunity to ask questions and have my questions answered. I understand that I can ask the pharmacy at any time about methadone or other medications.

______________________	______________________
Signature of Client	Date
______________________	______________________
Signature of Physician or Pharmacist	Date