

**Methadone Exemption
Clinical Training Session**

Goal of the clinical training session: to allow new methadone prescribing physicians to practically interpret and apply the methadone maintenance treatment guidelines in a supervised clinical setting and to take this learning and apply it to their medical practice with opiate dependence.

Patient initiation

- 1. DSM4 criteria for Substance Dependency should be met before methadone is initiated**
 - Identify someone who is not appropriate
 - CPSO forms
 - Cover template in guidelines

- 2. Initial urine drug screen should be collected and interpreted to verify patient self-report of drug use.**
 - Why do this
 - What to do if negative for opiates
 - What are you looking for in urines

- 3. If patient is an adolescent documentation that other treatment options were explored and offered and refused or determined to be inappropriate.**
 - Consider specialist referral
 - Give other options to methadone - medical detox, inpatient treatment

- 4. Initial psychosocial assessment and focused physical is completed prior to methadone initiation as per Guidelines**

- 5. Patient chart reflects Informed Consent and Treatment Agreement obtained and documented**
 - Review other options as above
 - Informed consent includes risks, benefits and side effects of methadone explained to patient (copy should be given to patient)

- 6. Screening bloodwork should be done in a timely fashion (HIV, Hep C, Hep B, pregnancy test, LFTs; TB if high risk)**
 - Issues of management
 - Pregnancy testing
 - Primary care or specialist

- 7. Charting should identify high-risk behaviours and interventions (e.g. safe needle use, safe drug use counselling, safe sex counselling and assessment for suicidality).**

8. **The patient chart identifies reported illicit drug use of the patient and urine drug screening results.**
 - **Drug history of other drug use**
 - **Psycho-social assessment issues**

Patient stabilization and maintenance

- **Any dose change requires reassessment**
 - **Special case transfers - prisons, inter-office**
9. **Initial methadone dose is less than or equal to 30 mg, and 10-20 mg for high risk patients (refer to Guidelines) (Medical assessment completed, opioid dependence established).**
 - **Risks during early stabilization phase and how to reduce them**
 10. **Stabilization Phase: dose increases are 5-15 mg every 3-4 days until a dose of 80 mg is reached, and/or the patient reaches maintenance phase. Dose increases require physician assessment, clinical justification and documentation (refer to Guidelines)**
 - **Identification and assessment of withdrawal symptoms**
 - **Frequency of visits**
 11. **Maintenance: Dose increases are 5-10 mg every 5-14 days after the dose of 80 mg is reached and/or if the patient is in the maintenance phase. All dose increases require a physician assessment, and clinical justification for any dose increase is documented (e.g. specific cluster of opiate withdrawal symptoms identified, opiate cravings, and/or opiate use.)**

Adherence to Methadone Maintenance Guidelines

12. **Criteria for high range doses greater than 120 mg are met (e.g. specific cluster of opiate withdrawal symptoms identified, and/or on-going illicit opiate use). A second opinion from an experienced Methadone provider (formal or informal) is obtained and there is clinical justification.**
13. **Missed Doses - Where the record indicates that the patient misses 3 consecutive methadone doses there is a reassessment recorded before continuing methadone treatment.**
14. **Carry Schedule - No carries are given in the first 2 months of treatment. Patient meets criteria for clinical stability when carries granted and during the acquisition of carries. The carry schedule is followed, and carry reductions and/or reinstatements are appropriate. Exceptions for extenuating circumstances are appropriate and should be documented in file.**
 - **Informed consent**
 - **Carries agreement**
 - **Locked box**

15. Urine drug screening performed in accordance with Methadone Maintenance Guidelines

- Clarify random vs. fixed
- Supervised screens
- Reliability of specimens
- Frequency of testing

16. Criteria met with chronic prescribed benzodiazepines in patients that receive greater than one carry. Patient is clinically stable, diagnosis and second opinion documented, less addictive medications attempted first, and controlled dispensing and possible tapering attempted.

17. Requirements for counselling have been assessed and implemented

- Resources - CAMH, Addiction Clinical Consultation Service, CPSO

18. Involuntary Discharge - Have criteria been met?

Documentation

- Recordkeeping
- Chart notes
- Reporting obligations to CPSO
- Documenting stepping outside the MMT guidelines

Other

Physical set-up - what works and what does not

Medical assessment form

Safety in office

Physician back up

Pharmacy issues

Special areas of practice – corrections