Methadone treatment for patients who use fentanyl: Plain language summary

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INTRODUCTION

Opioid agonist therapy, or OAT, is opioid medication that is used to control withdrawal—dope-sickness and cravings—so that people don't have to take other opioids. Methadone is the oldest and most common drug used for OAT. Other medications used include buprenorphine (Suboxone) and slow-release oral morphine (Kadian).

Methadone is a very strong opioid and can potentially be dangerous, so policies were created for Ontario prescribers to follow when prescribing methadone (like starting at a low dose and raising the dose slowly) in order to keep their patients from overdosing. However, these policies were made before high-grade opioids like fentanyl were available, and while people were more likely to be taking heroin or prescription opioids like Percocet, Dilaudid, or OxyContin. In the last few years, more fentanyl is in the street drug supply. Because fentanyl is so much stronger than these other opioids, people who use it often have very high tolerance, meaning they have to take more opioids in order to keep from getting dope-sick. When methadone is prescribed according to these policies to someone who uses fentanyl, the dose usually isn't enough to help with withdrawals and cravings, especially in the early part of treatment. As a result, someone might feel they have to keep taking fentanyl in order to keep from getting sick, even if they don't want to.

Because of this, a group of Ontario doctors decided to write some new guidelines for prescribing methadone. The goal of these guidelines is to make it easier for people who use fentanyl to stay in methadone treatment if that's what they want. There are several reasons this is important:

- Taking methadone helps people take fentanyl if they choose to, not because they feel like they have to. This may help people reduce their consumption or consume opioids in safer ways.
- People who take methadone are less likely to die of a fentanyl overdose than people who are using opioids and aren't on OAT.
- Being on methadone treatment has been shown to improve people's health; people on methadone are more likely to get other health treatments that they need, like flu shots and treatment for diseases like HIV and Hep C.
- Taking methadone has been shown to improve people's lives in other ways: People get arrested less, go to the ER less, have better relationships, and are healthier overall.

The authors of these new guidelines are all methadone doctors who work with people who use fentanyl. The recommendations are based on their experiences combined with a review of scientific articles about methadone and methadone guidelines from other parts of Canada and the United States. The new

guidelines will not be rules that prescribers have to follow, but suggestions to help prescribers across Ontario adjusting their current practices. The guidelines were reviewed by people who work in health care and by people with lived expertise of being on OAT. The authors are grateful to everyone who gave feedback on this document.

Below is a summary of the new guidelines being suggested. It includes the new suggestion and how it is different from the previous methadone policies.

GUIDELINES

1. When to start a patient on methadone

   (a) When someone wants to start treatment, prescribers should offer them a choice of medications. Methadone could be a better choice than buprenorphine if methadone has worked before for them and they felt well on it, or if they have tried buprenorphine before and it didn't work for them. This is different from current recommendations that say that buprenorphine should be the first choice for people wanting to start treatment.

2. Methadone doses

   (a) Prescribers should try to get patients to a comfortable dose of methadone safely and quickly.

   (b) For people who use fentanyl, the prescriber should start the methadone at 30mg, the highest starting dose allowed in Ontario. This is different from current practice, which is to usually start people between 15–25mg.

   (c) Prescribers should increase the methadone dose by 10–15mg every three to five days up to 80mg and then 10mg every five to seven days days, as long as the patient is responding positively and it's safe; people on benzos or alcohol should be increased more slowly. This is different from current practice, which is to usually increase by smaller amounts.

   (d) When someone is first starting on methadone, prescribers can also prescribe slow-release oral morphine (Kadian) to help work with the methadone. This is a new recommendation to help get the overall dose of opioids high enough to make more of an impact on withdrawal symptoms sooner.

   (e) If a patient misses doses, their dose shouldn't be lowered unless they've missed four days in a row. This is different from recommendations that say that the dose should be lowered after missing three days in a row. The recommendation to lower doses is because people could overdose if they lose tolerance to methadone and take a dose that is too high for them.

   (f) People who are using fentanyl or heroin regularly might need higher doses of methadone than prescribers are used to (100mg or higher). In the past, 60–80mg was considered an average effective dose and doses over 100mg were considered high.

   (g) The dose of methadone can be increased over 150mg without getting an ECG, except for people who have other risks for a heart problem. This is different from recommendations that say that patients must have an ECG before their dose can be raised over 150mg. The previous recommendation was made because of the risk of developing a dangerous heart rhythm at high doses of methadone; this is very serious when it happens, but it happens very rarely.

(h) For people taking benzos, methadone should be started and adjusted at the usual rates unless someone is at high risk of overdose from the combination of benzos and methadone. This is different from past recommendations that methadone should be started at lower doses and increased more gradually in people taking benzos.

3. Harm reduction and helping patients stay in treatment

(a) Prescribers should find ways to help people stay in treatment. Examples would be phone appointments instead of in person appointments, extending prescriptions for someone who misses an appointment, and leaving prescriptions for 30mg of methadone at the pharmacy so a person can restart without seeing a prescriber if they've been out of treatment for a while. This is different from recommendations that say that patients must see the prescriber in person before a dose increase or before a restart.

(b) Prescribers can start giving patients take-home doses of methadone ("carries") after at least one month of observed daily doses. Carries can be given based on how stable someone is and whether they can manage them. This is different from recommendations that say that people shouldn't get take-home doses until they have had two months of daily observed doses and are not using any substances other than their prescribed medicines.

(c) Urine tests should be used along with an overall assessment to look at a patient's stability. This is different from thinking that a urine test fully shows whether a person is using substances or not as the basis for deciding whether someone should get carries.

(d) When setting a schedule for appointments and urine tests, prescribers should think about the effect the schedule will have on the patient's life and how it helps treatment. This is different than having a fixed schedule for appointments or urine samples that applies to everyone on methadone, without regard to their personal situation.

(e) Prescribers should treat or refer patients for any other mental health and/or substance use problems they have. Many prescribers already do this, but some prescribers don't deal with mental health issues or refer their patients to other services instead of trying to combine care of substance use and mental health.

(f) Prescribers or peers in house should give patients take-home naloxone and advice on lowering their overdose risk.

4. Patients in the hospital

(a) Prescribers who are not addiction experts should offer methadone to patients who use fentanyl who are in the hospital. This is different because in the past methadone was only prescribed by doctors with a methadone "license".

5. Pregnancy and methadone

(a) Prescribers should start pregnant patients who use fentanyl on methadone as soon as possible. It's best if this is done in the hospital, because the dose can be raised faster than usual. Talk to experts on methadone and pregnancy to get advice, and make sure the team that will deliver the baby is involved as early as possible. This is not really different than previous guidelines but encourages prescribers to increase the methadone dose faster for people who are pregnant.