

Tighten Ontario's methadone program states inquest

Ontario's methadone maintenance program needs additional funding and more precise treatment guidelines for physicians, a coroner's jury has concluded after investigating 4 deaths related to the program.

The Office of the Chief Coroner's month-long November inquest found that physicians treating patients in methadone maintenance deviated from current guidelines by allowing patients an excessive number of "carries" (take-home methadone) and not following guidelines for initiating patients into therapy.

The jury's 46 recommendations also identified systemic problems, including stagnant funding despite a growing number of patients and a lack of access to information about the number of deaths specifically related to methadone maintenance.

Since 1996, when provincial colleges of physicians and surgeons took over methadone maintenance from Health Canada, Ontario's program has grown to 11 147 registered clients and 182 trained physicians (from 474 patients and 40 physicians). Initially designed for people addicted to heroin, the program now serves more people addicted to prescription opiates.

Despite the escalating number of clients, the percentage of methadone-related deaths since 2000 has remained about the same: 0.7% (37 deaths) in 2000 and 0.85% (79 deaths) in 2003. "We'd like to take credit for that," said Wade Hillier, who administers the program for the Ontario College of Physicians and Surgeons.

Dr. Mark Latowsky, a former member of the College's expert committee on methadone maintenance, says "We've done a good job expanding," but increasing patient loads have presented problems. "It's left up to the practitioner to deal with these complex patients, and most are inexperienced," says Latowsky. "There's not a lot of support."



The majority of patients in Ontario's methadone maintenance program used to be addicted to heroin; now it's prescription opiates.

The inquest was called due to concerns about methadone-related deaths in some cities between 2000 and 2003. During that time there were 20 such deaths in Oshawa, 10 in Windsor and 34 in Hamilton. The coroner selected 4 methadone maintenance-related deaths representing various aspects of the problem, said Dr. William J. Lucas, the regional supervising coroner who presided over the inquest.

"We're not critical of the merits of methadone maintenance, but let's tighten it up because people should not be dying on the program or in the community," said Lucas. Here are the 4 Oshawa-area cases:

Diverted carries: Craig Beers, 17, was not in the program but died July 13, 2003 of an overdose of methadone that he obtained from a program client. Lucas said a "significant source" of methadone in the community comes from programs, but how much is diverted is unknown.

Although the coroner's office knows from autopsy reports whether a person died of methadone overdose, it doesn't know whether the methadone came from the maintenance program, was prescribed for pain or was obtained illegally.

"We need to know which [deaths] are related to MMT,"

said Dr. Jim Cairns, deputy chief coroner of investigations. That information would provide "a better statistical analysis leading to program tweaking. We're trying to prevent deaths."

Before 2000, the College identified any deceased individuals in treatment to the coroner's office, to allow tracking of the number of patients in the program who overdosed. Since 2000, that information has been deemed private. The jury recommended changes to privacy legislation and that the coroner's office pursue a legal challenge to obtain the data.

Excessive carries: Steven Pidgeon, 48, was enrolled in the program for 3 years but continued to use a variety of other medications. He died on July 16, 2003. An autopsy revealed "markedly elevated" levels of methadone as well as oxycodone and diphenhydramine in his blood. Pidgeon was sometimes allowed up to 17 carries due to travel distances to the clinic.

Pidgeon's doctor deviated from program guidelines, which state that only clinically stable clients should get carries, and should receive no more than 6 at a time. In practice, doctors provide them "much more liberally," said Lucas. The jury recommended that no one using

opiates, benzodiazepine or illicit substances be given carries.

Initiation risks: David Stevenson, 28, had recently returned to the program when he died of an overdose on Nov. 12, 2002. The inquest found that due to a prescription error, Stevenson received an excessive dose of methadone. The jury recommended “more stringent and precise guidelines during the initiation phase.”

Dr. Graeme Cunningham, the former chair of the College’s methadone governance committee and director of the Home-wood Addiction Centre in Guelph, said updated College guidelines (coming Mar. 31) reflect this concern.

Lucas said it is “not uncommon” for doctors to exceed the recommended initiation dose. Latowsky finds this unacceptable. “I can’t think of any circumstances where deviation [from this guideline] would be justified. Certain aspects of the guidelines should be more like standards.”

The jury also recommended more education for physicians and reassessment every 3 years, rather than only at the end of their first year.

Cunningham believes physicians also need broader training in addiction. “It’s like teaching doctors about diabetes, but only talking about insulin,” he said. “Doctors are naive and in some cases enabling. It’s a huge problem.”

Lack of integration: Judith Jenkins, 42, had been in treatment for 10 months when she died Sept. 21, 2003, of “combined drug toxicity.” Jenkins was also seeing a psychiatrist, who was unaware that she was taking methadone and prescribed other drugs, including diazepam.

“The left hand didn’t know what the right was doing,” says Lucas.

The jury recommended random urine screening throughout treatment.

Many of these recommendations will require increased funding. The budget has re-

mained stagnant for 3 years at \$225 000 annually, while the number of clients has nearly doubled, says Hillier. “Funding has to be addressed.”

Practitioners are often left to manage “on their own,” says Latowsky. “There’s no money for case management, rehabilitation, psychiatric care, etc. If more services were available, generally these people would do better.”

The jury recommended that funding be based on the number of clients.

The College will study all 36 recommendations pertaining to its management of the program, but Latowsky is worried that neither the College nor the province will act on the recommendations. “As long as there’s a perception of a safe program and reasonable recommendations, then everyone’s happy — though nothing may happen. It’s much harder to have recommendations followed through with real action.” — *Barbara Sibbald, CMAJ*

LEGISLATION

Privacy versus public safety: reporting of gunshot wounds

Alberta politicians want to amend the Health Information Act to force doctors to tell police when they are treating a gunshot victim and to disclose that patient’s health status.

Currently, doctors are prohibited from providing that information unless the police have a court order, the victim is in grave condition, there is an immediate threat to public or individual safety, or the patient con-

sents. Patient privacy concerns have been at the root of the prohibition until now.

But that protection makes it difficult for investigators to do their jobs, says Tory MLA Thomas Lucaszuk. “Police services are experiencing difficulty obtaining information [about] individuals who go into emergency with wounds indicative of criminal activity, or [from] those they’ve lost custody of, say, after a car accident,” says Lucaszuk, a member of the all-party committee reviewing the legislation.

Critics of the proposed legislative changes say some victims may not seek treatment if police and physicians cooperate in this way.

“That is not a concern I share,” says Lucaszuk. “If they have something to hide and choose not to go, that’s their choice. My job is to protect law-abiding Albertans.”

Although no Canadian jurisdiction currently requires physicians to report gunshot wounds to police, Ontario has introduced legislation that requires public hospitals and health care facilities to report patients with gunshot wounds to the police (*CMAJ* 2004;170:780). The Mandatory Gunshot Reporting Act, which is at the committee stage in the Ontario legislature, is expected to pass this spring, says Adrian Dafoe, a spokesman for Community Safety Minister Monte Kwinter.

“Although individual doctors have expressed certain opinions, medical bodies overall are highly supportive,” Dafoe says.

In most provinces, physicians are justified in contacting police only when there is an imminent threat to the victim, to the public, or if the victim is near death. — *Lisa Gregoire, Edmonton*

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Alberta may require emergency staff to report gunshot wounds.

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