Opioid prescribing challenges doctors

There are no straightforward, off-the-shelf solutions to mounting concerns in Canada about prescription opioids.

The challenges are varied: how to ensure appropriate pain management, how to reduce rates of addiction and how to provide effective treatment options for addicts.

Many solutions, meanwhile, hold the risk of unintended consequences. For example, a simple crackdown on opioid prescribing could leave some patients in pain and force those already addicted to seek other drugs.

The prescription opioid addiction problem presents "such a challenge" because it is so very different from other types of substance abuse, observes Beth Sproule, pharmacist scientist at the Centre for Addiction and Mental Health in Toronto, Ontario. "We need to have the prescription drugs available for medical use, so any control has to be very careful."

Experts agree on the need for balance and caution: "It's a double-edged sword with narcotics because there is a certain amount of underprescribing and you don't want to create narcophobia," says Doug Spitzig, a pharmacist who works part-time with the College of Physicians and Surgeons of Saskatchewan scrutinizing prescribing patterns. At the same time, "it is a matter of appropriate utilization …and the need to stop diversion."

Dr. Robert Vroom, deputy registrar of the College of Physicians and Surgeons of British Columbia, puts it bluntly: Prescribing opioids for chronic, noncancerous pain is a "big sinkhole for physicians."

Doctors receive very little education about prescribing these drugs, he adds. "Most physicians are compassionate and, in prescribing opioids for chronic noncancer pain, compassion often trumps caution. Nobody wants to challenge their patient saying, 'You're an addict'."

As well, Vroom says, fee-for-service and volume pressures "are not conducive to optimal treatment. … These patients need a lot of time and it is a lot easier to continue mal-prescribing."

Roger Collier

The Ottawa Clinic is one of 25 clinics operating in Ontario that offer a methadone maintenance treatment program for opiate addiction.

On the other hand, Vroom acknowledges that fear of regulatory scrutiny "sometimes scares many doctors from providing optimal therapy. … So we see many walk-in clinics with signs that say 'no prescription opioids' on the door, and that is completely inappropriate because people do go to clinics for acute pain situations."

Brent Taylor, spokesperson for Unified Network of Drug Users Nationally, warns that if doctors simply stop prescribing opioids "it would bring on chaos. More drug stores would be robbed."

"And more heroin, coke and speed would be moved in for users, and these are crazy drugs," adds Deborah Breau, also with the network. At least with prescription drugs, addicts who buy on the street know what dose they are getting, the pair argue.

Compounding the problems is the lack of hard information about opioid use and treatment.

Canadian research in the field of substance abuse "has focused on alcohol, tobacco and illicit substances," states a discussion document Sproule authored for a Health Canada-sponsored workshop.

As a result, there is less awareness and more uncertainty about the link between prescription and addiction, and the scope of the problem.

Sproule, who is also studying the "pathways" to opioid addiction, says her research indicates many patients enrolled in her centre's methadone maintenance treatment program "reported initially being prescribed opioids for pain and had then progressed to opioid dependence" (*Drug Alcohol Depend* 2004;73:199-207).

Hard data on the national scope of the prescription opioid problem is difficult to obtain because Canada has not followed the lead of countries such as France and the United States and specifically mandated organizations to monitor prescription drug abuse.

Only British Columbia and Saskatchewan have databases that allow them to track opioid prescribing and identify high prescribers and

patients who seek prescriptions from multiple doctors.

But the impact of these programs on opioid prescription abuse is unknown, says Sproule. The systems, which are often coupled with attempts to restrict use, have been studied "only in a very limited way."

Moreover, "we don't really have a good evidence base of knowledge about what the best treatments are," says Benedikt Fischer, a research chair in applied public health at the Centre for Applied Research in Addictions and Mental Health at Simon Fraser University in Burnaby, British Columbia.

"We assume methadone works for heroin, but there are not a lot of studies about the best treatment for prescription drugs," says Fischer.

Methadone is now the main substitution treatment for opioid addiction and its use across the country is highly regulated. But a 2007 Ontario task force found that patients taking methadone expressed "overwhelming frustration" that physicians were not helping them taper their methadone use.

The issue of tapering is "definitely on the radar" of the College of Physicians and Surgeons of Ontario's planned revision of methadone use guidelines, expected to be completed in 2010, says Wade Hiller, manager of government programs (independent health facilities and methadone) for the college.

Taylor, who is himself an addict, argues that the two most pressing needs in resolving the prescription opioid problem are treatment for addicts and better prescribing so fewer addicts are created. "We hear people say, 'I just want to get on a program that helps me get my life together. I want to be out of this craziness'."

He decries the limited treatment options in Canada — primarily detox or the substitution treatments methadone or buprenorphine and naloxone combination (Suboxone), as compared with some European countries, where morphine and heroin maintenance are available. Taylor also says opioid tapering approaches should be more widely adopted and available to those patients who would prefer such an approach.

The "street drug scene here only exists because addicts can't be maintained unless they go on methadone," Taylor says. "Where their addiction problem is pharmaceuticals, why not say to them, 'The drugs will be provided to you, if you are already wired'."

Recently published Canadian research concluded that injectable diacetylmorphine (the active ingredient in heroin) is more effective than oral methadone in treating opioid-addicted patients in terms of the likelihood of patients remaining in treatment (87.8% compared to 54.1%) and refraining from taking illicit drugs or engaging in illegal activity *(N Eng J Med* 2009; 361[8]:777-86). A follow-up study is now being funded by the Quebec government.

The need to improve treatment has also prompted efforts to create a National Opioid Treatment Association, which is awaiting incorporation. Guy Pierre Levesque, general manager of Méta d'Âme, a 10-year-old, user-run support service in Montréal that operates a drop-in centre for addicts, says it will "look at standards about treatment, confidentiality, training," share best practices, and try to bring some standardization to treatment across Canada. — Ann Silversides, *CMAJ*

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