Opioid Use Disorder & Treatment in Primary Care

Faculty/Presenter Disclosure

• Faculty: Dr. Laura Evans
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Background

- Alberta Health Services
  - Addiction Inpatient Consultation Service (FMC, RGH); Medical Lead
  - Renfrew Recovery and Detox Centre; Co-Medical Lead
  - Addiction Centre Concurrent Outpatient Program (FMC)
  - Opioid Dependence Program, ODP
  - iOAT Injectable OAT Clinic
  - RAAPID ODP Tel consultation support line, eReferral consultation support service
- C.U.P.S. Medical—Primary Care Clinic
- ARCH—PLC Team: Addiction & Recovery Community Health
- Clinical Assistant Professor Department of Family Medicine University of Calgary
- Board Member, Treasurer—Canadian Society of Addiction Medicine; CSAM—SCMA

Outline—
Opioid use disorder (OUD) & Opioid Agonist Treatment (OAT) in Primary Care

- The opioid crisis in Alberta—Epidemiology & Context
- The role of primary care in the opioid crisis
  - Prescription opioids
  - Safer prescribing
  - Moving forward
- Identifying OUD in primary care setting
  - Screening & Diagnosis
  - OUD vs. chronic pain
- Approach to treatment
  - Trauma informed & patient-centered care
  - How to prescribe buprenorphine/naloxone (Suboxone®) in primary care
  - Monitoring, take-home doses/carries, urine drug screens
- Harm reduction: in clinical practice
- Resources & supports for physicians
The opioid crisis in Alberta
Epidemiology & Context

Alberta opioid report shows fentanyl deaths still on the rise

'Friends remember couple lost to suspected overdose deaths'

Kimberly Blair is mourning the loss of friends that she describes as the "give the shirt off your back" type of people.

Blood Tribe police issue warning after four fentanyl overdoses this week

Calgary police shut down fentanyl lab, seize $86,000 in drugs

Lethbridge first responders save 19-year-old after fentanyl overdose

Police officers and paramedics in Lethbridge revived a 19-year-old who had fallen unconscious after a fentanyl overdose Saturday night.
The opioid crisis in Alberta

Highlights

• 706 people died from an apparent accidental opioid poisoning (overdose) in 2017

• An average of 1.9 individuals die every day in Alberta as a result of an apparent accidental opioid poisoning (overdose)


Figure 2: Number of apparent accidental fentanyl poisoning deaths, by Zone (based on place of death) and quarter. January 1, 2016 to June 30, 2018.

• Since January 1, 2016, a total of 1,247 individuals in Alberta died from an apparent accidental drug poisoning death related to fentanyl (348 in 2016, 569 in 2017, and 330 in 2018).

• In 2018, on average, 165 individuals in Alberta died from an apparent accidental drug poisoning death related to fentanyl per quarter, while in 2017, on average, 142 individuals died from an apparent accidental drug poisoning death related to fentanyl per quarter.

Government of Alberta, 2018, Quarterly Report
Youth & the opioid crisis

• Prevalence data for OUD in Canadian youth lacking
  • 10.6% of ON grade 7-12 students report past year use of non-prescribed prescription opioids (BCCSU 2017)
  • 0.9% of ON grade 9-12 students report past year fentanyl use (Boak 2017)
  • 21% of opioid overdoses in BC youth age 10-24 in 2016 (MacDougall 2017)
  • 20.4% of opioid overdoses in BC youth age 13-29 in 2017 (BC Coroners Service 2017)

Youth & the opioid crisis

• Few adolescents receive OAT before or after non-fatal overdose (NFOD)
  • Retrospective cohort analysis of non-fatal opioid overdoses among adolescents in Massachusetts 2012-2014
    • 53% of those 11-17 with NFOD were female vs. 38% of adults with NFOD were female
    • Year prior to NFOD 11% of adolescents receive Rx opioid vs. 43% of adults
    • Year prior to NFOD ≤5% of adolescents receive OAT vs. 23% of adults
    • Year following NFOD only 8% of adolescents receive OAT vs. 29% of adults

Chatterjee et al, 2019
Pregnancy & the opioid crisis

- Prevalence of opioid use in pregnancy at Thunder Bay Regional HSC, and HC in Sioux Lookout NW ON—50% report daily use (Jumah 2017):
  - 8% in 2009
  - 18% 2011
  - 28% 2014
- 22.8% of pregnant women filled opioid Rx during pregnancy in 2007 (US data)
  
  (Opioid Use & Opioid Use Disorder in Pregnancy ACOG, ASAM Aug. 2017)

- States with highest rates of opioid Rx's have highest rates of postnatal withdrawal, or “Neonatal abstinence syndrome” (NAS)
- NAS increase from 1.5/1000 births in 1999 to 6/1000 births in 2013 (High prevalence US area, similar to 2013 rate in Canada)
  
  (Opioid Use & Opioid Use Disorder in Pregnancy ACOG, ASAM Aug. 2017)
- 27% increase from five years ago
  - Ontario > 1000 cases/year
  - 16-fold increase from 2002
  
  (ON Ministry of Health and Long-Term Care)
56% Accessed at least 1 service within 30 days of death

Carfentanil is on the rise

1st deaths occurred in 2016
2017 deaths increased by 430%
>50% of carfentanil deaths occur in CALGARY
Crystal Methamphetamine on the rise

- Spike in use in Alberta reported by multiple agencies and law enforcement
- Potent stimulant which can result in drug-induced psychosis
- An estimated 10% of crystal meth contains fentanyl
- Combining with opioids or benzos to manage ‘the crash’

Alberta sees spike in youth reporting meth use, seeking help

Number of Albertans under 18 reporting meth use to Alberta Health Services nearly doubles since 2012

2013* Substance use admissions attributed to:

- Tobacco: 57%
- Alcohol: 34.4%
- Opioids: 2.7%
- Other CNS depressants: 2.2%
- Stimulants: 1.5%

*note, significant increases in opioid and stimulant use since 2014

Canadian Centre on Substance Use and Addiction, 2018
The role of primary care in the opioid crisis:

Prescription opioids
Chronic non-cancer pain prescribing
Moving forward
• National Institute on Drug Abuse (NIDA) indicate that between 2001 and 2014, mortality due to heroin overdose increased six-fold.
• More than 10,000 US deaths related to heroin in 2014 alone, a 439% increase from 1999.
• Nearly half of young IV heroin users reported using prescription opioid agents prior to initiating heroin use, some of whom noted that heroin is cheaper and easier to obtain than prescription narcotics.
• Thus, rise in heroin-related mortality = 1 of many consequences of the excessive prescription of narcotic agents, which contributed to the current prescription opioid overdose epidemic. (NIDA as cited in Medscape. Jan. 2017)
Prescription opioids

Type of substance dependence at admission: for those in Ontario Methadone Programs in 2005-2006

- OTC codeine preparations or Rx opioids: 46%
- Heroin (or opium): 16%
- Street obtained Non-heroin/ opium: 38%

(Hart, 2007)

Source of Non-Medical Prescription Opioids

- The opioid was obtained from a parent or sibling within the home for:
  - 69.6% in 2013, and
  - 55% in 2017

Ontario Student Drug and Health Survey (OSDUHS) 2013 and 2017 data

Decrease in parents/sibling as source corresponds to increase in fentanyl use
Opioid Prescribing Has Turned A Corner In Alberta

Physicians are prescribing opioids in lower doses and to fewer patients, and it could be in response to evidence-based guidelines, better physician education, new prescribing rules and general awareness of opioid-related issues.

http://www.cpsa.ca/lets-talk-about-prescribing//

OPIOID CRISIS RESPONSE TASK FORCE

In December 2016, in response to the crisis, ACFP Board of Directors struck a Task Force of dedicated family physicians working directly with patients in various practice settings. Our Task Force and staff have been working closely with membership, stakeholders and partners and to gather information on barriers, variance in care pathways, system changes required, continuing professional development needed, and the need for new initiatives that would better equip our members and colleagues to care for their patients and change the trajectory of the opioid crisis.

The Opioid Crisis Response (OCR) Task Force is comprised of a variety of family physicians working in high risk communities, chronic pain management, palliative care, comprehensive family practice and emergency rooms. It is the vision of the Task Force to advocate and develop strategies for minor adjustments in provision of services to drastic systemic changes that will support better and more comprehensive care for their patients and, ultimately, reverse the trajectory of the opioid crisis.

ACFP OCR Task Force: Recommendations Document

This comprehensive reference book offers recommendations on eight system areas that can influence better care for patients with chronic pain, on opioid treatment, with opioid dependency, with opioid use disorder, or those with imminent risk of morbidity or mortality. It is the hope of the ACFP that this booklet will act as a catalyst for open discussion, positive change, and investment into solving some of the systemic issues that have contributed to the opioid crisis and other chronic disease management challenges.

https://acfp.ca/who-we-are/acfp-governance/board-committees/operational-committees/opioid-crisis-response-task-force/
Role of primary care in reducing risk of iatrogenic OUD

Initiating Opioids for CNCP

- If no hx of SUD or current mental illness trial of opioids may be considered for patients with chronic non-cancer pain, after non-opioid medication approaches have been fully trialed and titrated, and non-medication approaches have proven unsuccessful
- Opioids for chronic pain advised against if active SUD or current mental illness
- If current psychiatric illness (but no SUD) stabilize the psychiatric disorder before trial of opioids for chronic pain
- Taper off opioid trial if “important improvement in pain or function is not achieved”
- Recommended max dose <90mg MED; suggest <50mg MED

2017 Canadian opioid prescribing guideline

http://www.cpsa.ca/lets-talk-about-prescribing//
Role of primary care—
Patient already on opioids for CNCP?

Tapering Opioids

• **Tapering to lowest effective dose or discontinuation**, particularly at doses > 90mg MED should be considered with patient’s consent
• **Forced taper are not recommended**
• In situations where patient experiences serious challenges with taper for CNCP, consultation with multi-disciplinary team, including addiction medicine specialist, may be warranted.

2017 Canadian opioid prescribing guideline

For patients on high-dose opioid therapy: The threshold of 50 OME/day is a recommendation not a rule, and individual circumstances need to be considered. Ultimately the goal is to ensure patient safety and well-being.

- For opioid-dependent patients: Patients asking for larger doses, seeking early refills or who exhibit other behavior suggestive of misuse may have opioid use disorder. These patients need help. Discharging them from practice is not in the patient’s best interests. Speak to an opioid dependency expert for advice on:
  - Initiating and managing opioid agonist therapy
  - Prescribing drugs like buprenorphine/naloxone, methadone or naloxone

- There is some public concern that physicians are abruptly cutting people off their medication. The College has been very clear physicians should not abruptly stop prescribing opioids and must not abandon their patients currently receiving opioids. If this situation applies to you, first speak with your physician. If this does not resolve the situation, you may wish to file a written complaint with the College. [File a complaint](http://www.cpsa.ca/lets-talk-about-prescribing/)

Role of primary care—
Patient with chronic pain & OUD

• Large proportion of those with an OUD initially use opioids when prescribed for pain
• Difficult for patients & provider to determine whether solely chronic pain, solely OUD, or combination
• If taking opioids appropriately, solely via prescription, then the DSM 5 OUD Diagnostic Criteria of Tolerance & Withdrawal are not considered met (see Diagnosis below)
• OAT should be offered to all individuals with OUD, including those with co-morbid chronic pain
Elevated risks with detox, tapers, abstinence or short-term OAT

- High rates of non-completion of detox
  - Only 52-61% complete detox
    - Whether with alpha2-adrenergic agonists e.g. clonidine, methadone or buprenorphine taper
  - Majority will relapse
    - Relapse rates 53-67% at 1 month; 61-89% at 6 months
    - Risks of serious harms are HIGHER than for those receiving no detox or taper!!
  - Fatal & non-fatal overdose; lost tolerance
  - STIBBI: HIV and Hep C transmission

BCCSU 2017
CPSA & prescribing buprenorphine/naloxone

**Buprenorphine/naloxone (Suboxone®) Prescribing**

**Requirement**

CPSA Approval NOT required.

**NOTE**: As a TPP Alberta medication, physicians need to be registered with TPP Alberta in order to prescribe buprenorphine/naloxone.

**Recommendation**

Completion of a Buprenorphine treatment for opioid use disorders course is strongly recommended.

For temporary prescribing, for a patient, consultation with a physician experienced in the treatment of opioid use disorders is recommended for any dosage changes.

Image Source: CPSA, 2018

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CPSA & prescribing methadone

**Methadone Approval Process**

**Opioid Use Disorder (OUD)**

- General (Initiate)
- Patient Specific (Maintain single or multiple patients)

**Requirements**

- Opioid Agonist Treatment (OAT) Course
- Experience in an OAT setting or evidence of appropriate postgraduate training

**Analgesia**

- General (Initiate)
- Patient Specific (Maintain single or multiple patients)

**Requirements**

- Opioid Agonist Treatment (OAT) Course
- Letter of support from OAT clinic for each patient
- Experience in a pain or palliative care setting or evidence of appropriate postgraduate training
- Letter of support from a pain or palliative care specialist for each patient

Image Source: CPSA, 2018
Identifying OUD in primary care:

- Screening, diagnosis
- OUD and Chronic pain
Tools at our Disposal to Identify and manage substance use disorders:

• SBIRT: Screening, Brief Intervention, and Referral for Treatment

Why is SBIRT important?

• Treatment does work.
• Every interaction with a health care provider is an opportunity for intervention.
• Timely treatment and/or referral when necessary is important and overall it can help with:
  • Improves Morbidity and mortality.
  • Helps with Diminished Quality of Life
  • Reduces Harm to Self and Others
  • Saves costs to our health care system.
Screening widens our net

ABSTAINERS & MILD INTAKE (70%)

MODERATE (20%) at risk use

SEVERE (10%)

Primary Prevention

Brief Intervention

Specialized Treatment

Screening vs. Assessment

• Screening: Determines the possibility a condition exists.

• Assessment: confirms the existence of a condition and its severity.
Pre-Screening

• Screening can take time to do....
• Pre-screen for Alcohol:
  • How many times in the past year have you had “X” or more drinks in one sitting?
    • Where X = 5 for men, and 4 for women or anyone older than 65.
• Drug Pre-Screens: How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

If = or >1, then you must do a full screen.

Many validated screening tools:

• CAGE Questionnaire, AUDIT-C for Alcohol use disorder
• CAGE-AID Alcohol and other Drugs Screening
• DAST-10 Drug Abuse Screening Test
• CRAFFT 2.0 Alcohol and Drug Screening Questionnaire ages 12-18
CAGE-AID Questionnaire

CAGE-AID Questionnaire: When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

- Have you ever felt you should Cut down on your drinking or drug use?
- Have people Annoyed you by criticizing your drinking or drug use?
- Have you ever felt bad or Guilty about your drinking or drug use?
- Have you ever taken a drink or used drugs first thing in the morning (Eye Opener) to steady your nerves or get over a hangover?

1: need for further assessment.

1 or more questions are positive: Sensitivity = 79%, Specificity = 77%
2 or more are positive: Sensitivity = 70%, Specificity = 85%

CRAFFT Universal screening tool for adolescents

2+ questions requires more inquiry

- Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
- Do you ever use alcohol or drugs while you are by yourself, ALONE?
- Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
- Do you ever FORGET things you did while using alcohol or drugs?
- Have you gotten into TROUBLE while you were using alcohol or drugs?
Opioid Use Disorder: DSM-5

Problematic Opioid use with 2 or more of the following over 12 months:

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired control</td>
<td>• Opioids used in larger amounts or for longer than intended</td>
</tr>
<tr>
<td></td>
<td>• Unsuccessful efforts or desire to cut back or control opioid use</td>
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<tr>
<td></td>
<td>• Excessive amount of time spent obtaining, using, or recovering from opioids</td>
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<td></td>
<td>• Craving to use opioids</td>
</tr>
<tr>
<td>Social impairment</td>
<td>• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use</td>
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<tr>
<td></td>
<td>• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems</td>
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<tr>
<td></td>
<td>• Reduced or given up important social, occupational, or recreational activities because of opioid use</td>
</tr>
<tr>
<td>Risky use</td>
<td>• Opioid use in physically hazardous situations</td>
</tr>
<tr>
<td></td>
<td>• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use</td>
</tr>
<tr>
<td>Pharmacological properties</td>
<td>• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount</td>
</tr>
<tr>
<td></td>
<td>• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal</td>
</tr>
</tbody>
</table>

2 to 3 Criteria = mild
4-5 Criteria = moderate
>6 Criteria = severe

Note: Tolerance and Withdrawal don’t count if solely taken under appropriate medical supervision; But the rest do count even when Rx’d

Brief Intervention

First must assess the Readiness to Change:
- Pre-contemplation - Ignorance is bliss
- Contemplation - Sitting on the fence
- Preparation - Testing the waters
- Action - new behaviors are implemented but not yet stable
- Maintenance - behaviors and lifestyle changes established long term
- Relapse - resuming old behaviors
How to Assess Readiness To Change:

“How on a scale of 1-10 (1 being not ready and 10 being very ready) how ready are you to change any aspect your use patterns?”

“FLO”

1. Feedback
2. Listen and Understand
3. Options Explored
Feedback:

- Your job is to deliver the feedback
- Just bringing up the subject is helpful
- Let the patient decide where to go with it

You can say things like:

- I’d just like to give you some information...
- What you do is up to you

Listen and Understand:

- Listen to what the situation sounds like from the patient’s perspective
- Show that you understand where they are coming from
- Listen to assess readiness to change
Enhance Motivation:

“On a scale from 1-10, how ready are you to change any aspect of your drinking?”

If patient indicates:

> 2 : “Why did you choose that number and not a lower one? What are some reasons that you are thinking about changing.”

≤ 1: “Have you ever done anything that you wish you hadn’t while drinking: What would make this a problem for you.” Discuss pros and cons

If they’re not ready for change

• Don’t
  • Use shame or blame
  • Preach
  • Label
  • Stereotype
  • Confront

• But..
  • Offer information, support and further contact
  • Present feedback and express concerns, if permitted
  • Negotiate: “What would it take you to consider a change?”
Approach to treatment

Trauma informed care

• Standard when working with individuals with SUDs
• Patient-centered and empowering vs. trauma specific
• Key principles:
  • 1) Trauma awareness: High correlation between trauma and development of SUDs. High prevalence and significant impact on development and trajectory.
  • 2) Emphasis on safety & trustworthiness: Physical and emotional safety for clients paramount. Welcoming intake; exploration and adaptation of physical environment; clear information about programs; importance of informed consent; crisis plans, predictable expectations; consistent scheduling.
  • 3) Choice, collaboration, & connection: self-efficacy, self-determination, dignity, personal control are paramount. Equalization of power imbalances, expression without judgment, choice, collaboration.
  • 4) Strengths-based and skill-building: clients assisted to identify their strengths, and augment their resiliency and coping. Emphasis on teaching & modeling skills, recognizing triggers.

Patient-centered language & reducing stigma

- Describe the person then the behaviour: Person with alcohol use disorder vs. alcoholic
- Language reflecting SUDs as medical disorder vs. moral failing
- Use language that emphasizes autonomy: “opted not to” vs. “non-compliant”
- Avoid slang, stigmatizing language: Negative/positive urine drug test vs. ‘dirty’ or ‘clean’ urine drug test. Opioid agonist therapy or medication for the treatment of opioid use disorder vs. Opioid replacement therapy

Toward the heart. Respectful language and stigma regarding people who use substances. 2017.
http://towardtheheart.com/assets/uploads/1502392191GWLqGqDbSw5GlajwRucq4IPo5yhSoMkp3T7rL5ml.pdf

Detoxification is not treatment

- Medical detoxification is only the first stage of SUD treatment
- Manages the acute physical symptoms of withdrawal
- Rarely sufficient to help people with SUDS achieve long-term abstinence
- Like going on a crash diet for 6 weeks without addressing the cause of overeating or going to hospital for very high blood sugar without changing diet, exercise or medications

Treatment—Bio-Psycho-Social-Spiritual

- Stopping use is only the first step
- To be effective, treatment must address the associated medical, psychological, social, vocational, legal, and spiritual problems
- Staying in treatment for an adequate period of time is important.
- Concurrent mental disorders should be treated at the same time
Self referral
- AA/SMART Recovery/Crystal Meth Anon/Cocaine Anon/NA/Refuge
- Adult Addiction Services:
  - Intake M-F 12:45pm
  - Access mental health (FMC-Addiction Centre, etc.)
- Via Detox
  - Renfrew Recovery & Detox; Medical Detox
  - Alpha House
  - Foothills Detox; Non-medical, Fort Macleod
  - Others
- Via Hospital Addiction Consultation Services

How/why OAT works:

Goals:
- Eliminates withdrawal
- Diminishes cravings
- Eliminates the drive for repeated use and relapse
- Opioid receptor blockade, blocks euphoria
- Facilitates rehabilitation, skill building and recovery
- Keeps people alive!!
Buprenorphine/Naloxone vs Methadone

National Guidelines for Treatment of Opioid Use Disorder—CRISM, 2018 March & BC Centre on Substance Use—2017:

- **Buprenorphine/naloxone** preferred over methadone for reduced overdose potential, in absence of C/I (Maremmani 2010; Marteau 2015; Nielsen 2016)
  - UK study of 19m prescriptions over 6 year period revealed that buprenorphine was 6X safer than methadone re: overdose risk (Marteau 2015)
  - Lower potential for respiratory depression (Nielsen 2016)
- **Methadone** has higher potential for drug interactions and dysrhythmia re: QT prolong (BCCSU 2017)

Buprenorphine/Naloxone

- Synthetic opioid for the treatment of opioid addiction
- Partial opioid agonist with a high affinity and slow dissociation for mu receptor
  - Ceiling effect – greater safety (low risk of respiratory depression)
  - Precipitated withdrawal because of high affinity for receptor
- Degree of physical dependence is less and therefore withdrawal syndrome should be less severe
- Less abuse potential but possible
- Numerous clinical trials show that it is equally effective as moderate doses of methadone
- Less Qt prolongation

Citation: CSAM MMT Introductory Workshop September 2013
Buprenorphine/Naloxone (Suboxone)—Partial Agonist

**Partial Agonist**

- **Methadone** (Full agonist)
- **Buprenorphine** (Partial agonist)

**Antagonist**

- **Naltrexone** (Full antagonist)

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**Buprenorphine/Naloxone (Suboxone®)—Safer**

- **Low Risk of Overdose**
  - **Ceiling Effect:**
    - Due to low intrinsic activity at the mu receptor, as the dose is increased, the agonist effect does not increase.
    - Higher doses occupy greater number of receptors but do not produce increasing opioid effects.
    - Maximum effect is reached, regardless if the dose continues to increase (24mg-32mg).
    - Overdose is less likely to cause fatal respiratory depression unless consumed with ++ ETOH and Benzos.

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*Adapted from reference 3*
Buprenorphine effectiveness

Retention in Treatment
- Doses greater than 2 mg/day > placebo
- Compared to methadone,
  - Low doses (≤ 6 mg/day) = low doses of methadone (≤ 40 mg/day)
  - Medium doses (7–16 mg/day) and = medium doses methadone (40–85 mg/day)
  - High doses (≥ 16 mg/day) = high doses methadone (≥ 85 mg/day).

Reducing illicit opioid use
- Buprenorphine (>16 mg) = methadone
- Recent meta-analysis comparing buprenorphine and methadone for prescription opioid dependence reached similar conclusions

Source: Edward Salsitz 2012; Review Course in Addiction Medicine, ASAM
Initiating Bupe/Naloxone—Contraindications

- Allergy to bupe/nalox or component
- Severe liver dysfunction: consider risks vs. benefits carefully if liver enzymes >3-5 x ULM
- Severe respiratory distress
- Delirium tremens
- Acute alcohol intoxication

**BUPE/NALOX NO LONGER CONTRAINDICATED IN PREGNANCY AS PER HEALTH CANADA**

Induction—Buprenorphine/Naloxone

- Discuss risks & benefits, including physical dependence, risk of sedation, overdose esp. if combined with CNS depressants, ETOH, benzos
  - Treatment agreement & consent form
- Don’t operate machines/drive during induction
- Will need to stop all opioids 12-48 prior to 1st dose of bupe/nalox (longer if switching from methadone; consider seeking addiction medicine specialist support)
- Explain that they must be in moderate-severe withdrawal before 1st dose, using Clinical Opioid Withdrawal Scale “COWS” scoring tool
- Ensure patient understands: taking 1st dose too early will result in severe precipitated withdrawal
Clinical Opioid Withdrawal Scale (COWS):

- **Total Score:**
  - Mild: 5-12
  - Moderate: 13-24
  - Moderately Severe: 25-36
  - Severe: Over 36

*MD Calc can be used for this: https://www.mdcalc.com/cows-score-opiate-withdrawal

Induction—Buprenorphine/Naloxone

- **In office:** early in week
  - Very difficult to get into adequate withdrawal at the right time, and go to a medical appointment when in moderate to severe withdrawal
- **Home induction:**
  - Home induction comparable outcomes to office-based induction provided stable housing and no sedatives being taken
PREScribing suboxone in the outpatient setting

A Quick-Reference Guide to In-Office Induction

By Patricia Caddy, MD, and Kesh Smith, MD

Adapted from A Guideline for the Clinical Management of Opioid Use Disorder published by the British Columbia Centre on Substance Abuse and the BC Ministry of Health, June 2017

Assessment

Suboxone
- Combination of buprenorphine and naloxone at ratio of 4:1
- Available in 2.0 mg/0.5 mg and 8 mg/2 mg sublingual (SL) tablets
- Tablets may be split if necessary
- May take up to 10 min to dissolve completely (no talking, smoking, or swallowing at this time)
- Absorption better with moistened mouth
- Naloxone prevents IMV diversion of drug and is not active when taken SL, so does not protect patient from overdose
- Max dose approved in Canada 24 mg/6 mg daily

Rule out contraindications
- Allergy to Suboxone
- Severe liver dysfunction
- Severe respiratory distress
- Acute EtOH intoxication

Order/review lab test results
- CBC
- Electrolytes
- Renal panel
- Liver panel
- Hep A/B/C serologies
- STI panel (including HIV)
- Urine drug test

Confirm opioid use disorder using DSM-5

Obtain substance use history
- All drugs used, including ethanol (EtOH), nicotine, benzodiazepines
- Age and amount of first use, current use
- Any periods of abstinence
- Treatment history
- Goals

Confirm
- COWS* score > 12
- No contraindications
- No long-acting opioids used for >30 hours

Give Suboxone SL 4 mg/1 mg

Withdrawal symptoms gone?

No
- Additional doses needed
- Go to Day 2

Yes
- 2 hours

Precipitated withdrawal
- Can occur due to replacement of full opioid receptor agonist (e.g., heroin, fentanyl, morphine) with partial agonist that binds with a higher affinity (e.g., Suboxone, methadone)
- Symptoms
  - Similar to opiate withdrawal (i.e., increased heart rate, sweating, agitation, diarrhea, tremor, unease, restless, tearing, runny nose, vomiting, goose flesh)
  - Can range from mild to severe
  - Can be very distressing and discouraging for patients
  - Largely reversible with higher doses of Suboxone or other opioid
- Avoid by ensuring adequate withdrawal before induction (COWS > 12), starting Suboxone at a lower dose (0.5 mg/0.5 mg), and reassessing more frequently

Treatment
- Explain what has happened
- Provide empathetic/compassionate/apologetic support
- Manage symptoms with clonidine, loperamide. Avoid benzodiazepines
- Encourage/motivate patient to try again soon

*COWS = clinical opiate withdrawal scale
INDUCTION: DAY 2 ONWARDS

- If adequate symptom relief not achieved over Day 1 and 2, additional days (usually no more than 2) may be required
- Day 2 max dose 16 mg/4 mg

Withdrawal symptoms recurred since last dose?

No
- Give Day 1 total dose again to complete induction. This will be the ongoing daily dose
- Consider titration up to optimal dose (≥ 12 mg/3 mg) for improved retention in treatment
- May increase dose every 1–3 days, or less frequently

Yes
- Give Day 1 total plus another dose Suboxone SL 4 mg/1 mg

~ 2 hours

Withdrawal symptoms gone?

No
- Additional doses needed
- Give Suboxone SL 4 mg/1 mg

Yes
- Induction complete
- Give Day 2 total as ongoing dose, or titrate up to ≥ 12 mg/3 mg for improved retention in treatment

MAINTENANCE

Goal = once-daily dosing, no withdrawal between doses. Ideally, dose ≥ 12 mg/3 mg

Monitor
- Check PharmaNet regularly to ensure prescriptions are filled, no doctor shopping, etc.

CONSIDERATIONS

Urine drug testing (UDT):
- Urine drug testing expected for patients on Suboxone to objectively document licit/illicit drug use
- UDT not to be used punitively but to facilitate open communication
- Perform point-of-care UDT at least monthly
- Consider ordering confirmatory testing for unexpected results (false positives do occur)

Take-home doses (“carries”)

- Suboxone ingestion commonly witnessed at the pharmacy but take-home doses may be prescribed
- Take-home “carries” appropriate for patients who demonstrate biopsychosocial stability, have not missed doses, are abstinent from illicit drugs, have a secure place to store their medication
Urine drug testing

• Standard of care in OAT treatment
• Use to assess:
  • Taking prescribed Bupe/Nalox?
  • Validate self-reports of additional opioids or other substances
    • Troubleshoot if UDS different than self-report
  • Safety: detect use of benzos, ETOH
  • OAT outcome: abstinence from other opioids?
    • Limitation: doesn’t capture harm reduction (e.g. ongoing use of fentanyl Q2nd day 10x/day)
• Frequency: monthly until at stable dose
• At least 4x/yr random testing to confirm presence of buprenorphine, if take-home dosing
• More frequent if safety concerns (e.g. relapse, diversion)

Take-home dosing—Buprenorphine/Naloxone

• Benefits
  • Motivation to participate in OAT
  • Improved retention (Stay on OAT longer)
  • Increased autonomy & flexibility
  • Positive reinforcement for abstinence
  • Decreased burden of treatment
  • Decreased dispensing costs related to daily witness ingestion

• Risks
  • Higher OD risk when taking other CNS depressants (benzos, other sedatives)
  • But still far safer than methadone
    • 25% of BC fatal opioid ODs involved methadone, whereas very rare for bupe/nalox to be involved

BCCSU 2017
Take-home dosing—Buprenorphine/Naloxone

• Considerations for not providing take-home doses:
  • Frequent interaction at pharmacy may improve safety, adherence, and engagement (especially early in treatment)
  • Homelessness or other reasons meds can’t be safely stored
  • Evidence of past diversion
  • Ongoing substance use, especially benzos, ETOH, sedatives
  • Unstable mental health, cognitive impairment, severe behavioural issues

MUST BALANCE LIMITED RISKS OF TAKE-HOME DOSING VS. VERY HIGH RISK OF FATAL OVERDOSE FROM HIGH POTENCY OPIOIDS IF PATIENT LEAVES TX

Take-home dosing—Buprenorphine/Naloxone

• Timing
  • At discretion of prescriber
  • Once clinically stable; and able to safely store at home (locked container or cabinet)
    • Could be as early as 1-3 days
  • Data does NOT show improved outcomes for bupe/nalox daily witnessed ingestion
  • Some evidence that rapid transition to take-home doses improved adherence and retention
Buprenorphine Initiation: Home Induction

Buprenorphine Maintenance:

- Average effective maintenance dose is 16mg SL q daily
- Maximum dose is 24mg/day
  - Off label up to 28mg, sometimes 32mg
Missed Doses

<table>
<thead>
<tr>
<th>Buprenorphine Dose</th>
<th>Number of Consecutive Days Missed</th>
<th>New Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 8 mg</td>
<td>&gt; 7 days</td>
<td>4 mg</td>
</tr>
<tr>
<td>&gt; 8 mg</td>
<td>6–7 days</td>
<td>8 mg</td>
</tr>
<tr>
<td>6–8 mg</td>
<td>6 or more days</td>
<td>4 mg</td>
</tr>
<tr>
<td>2–4 mg</td>
<td>6 or more days</td>
<td>2–4 mg</td>
</tr>
</tbody>
</table>

Handford et al. Burprenorphien/Naloxone for Opioid Dependence: Clinical Practice Guideline. CAMH.

Harm reduction
What does this mean for clinical practice?
What is harm reduction?

- Seatbelts
- Sunscreen
- Hard hat at construction site
- Designated driver
- Condoms at summer camp where sex prohibited
- Cane when walker declined?

*Measures that lessen the potential harms from the risks being taken*
What is harm reduction for psychoactive substances?

• A philosophy of care and a set of evidence-based policies, programs & practices intended to mitigate harm from a range of legal and illicit psychoactive substances.
  • Four principles:
    • Pragmatism
    • Humanism: focuses on people; substance use is neither condemned nor supported; moralistic judgment is suspended
    • Focus on harms: health, social and economic
    • Hierarchy of goals: immediate health and social needs of person who uses substances > service providers’ goal of abstinence (Riley 2012)

Harm Reduction for Psychoactive Substances

“Come as you are” — G. Alan Marlatt

• Helps people take control over their lives and protect themselves and others
• Meets people where they are at and provides respectful and compassionate services
• Views substance use as a health and social issue, NOT criminal
Harm reduction

Roots...
Harm Reduction for Psychoactive Substances

• Criminalization & abstinence-based treatment were inadequate to stop spread of HIV
• Informal, peer-led risk-reduction efforts developed (syringe distribution, teaching on use of bleach), prior to institutional adoption (e.g. health care settings)
  • Peer involvement is still evident (Erickson 1999, James 2007, Hunt 2010)
  • Increasing contact with health service a key component (Cook 2010)
“Strong Evidence”…
Harm Reduction for Psychoactive Substances

- “Strong evidence” that syringe exchange programs reduce injection-related risk behaviours and HIV transmission (Strang 2012).
- After “three decades of extensive research, there is no convincing evidence that syringe exchange programs are accompanied by serious negative consequences” including increased use, IV use, crime, or publicly discarded syringes (Vlahov 2010).

Resources
**Opioid Dependency Outpatient Consultation Service—AHS**

- RAAPID phone consult for OAT initiation/management support
  - Physicians and NPs:
    - South of Red Deer can call RAAPID South at: 1-800-661-1700 or 403-944-4488
    - North of Red Deer can call RAAPID North at: 1-800-282-9911 or 780-735-0811

- eReferrals consult for OAT initiation/management support/Specialist LINK
  - See next page
  - Physicians and NPs:
    - www.albertanetcare.ca/ereferral.htm

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**SpecialistLINK eReferral**

*Two great ways to access timely, non-urgent advice in the Calgary Zone*

1. Go to www.specialistlink.ca or call 403-910-2551 / 1-844-962-LINK to request tele-advice. Get a response within one hour.

2. Submit an Alberta Netcare eReferral Advice Request for a response within five calendar days. Visit albertanetcare.ca/ereferral.htm

- ADDICTION MEDICINE – OPIATE AGONIST THERAPY (provincial service)
- CHRONIC PAIN
- CONGESTIVE HEART FAILURE
- COMMUNITY PEDIATRICS
- ENDOCRINOLOGY
- GASTROENTEROLOGY
- GENERAL INTERNAL MEDICINE
- HEPATOLOGY
- NEPHROLOGY
- NEUROLOGY
- OBSTETRICS & GYNECOLOGY (including pelvic floor, colposcopy)
- OPHTHALMOLOGY (adult and pediatric; provincial service)
MEDICAL MENTORING FOR CHRONIC PAIN AND ADDICTION

The opioid crisis in Alberta has highlighted both the complexities and the importance of primary care. Family doctors are facing increased pressure to actively respond to the opioid crisis, which may be uncomfortable or daunting for family physicians. Just as the family practice is a trusted environment for patients to share their health concerns and seek help, the Collaborative Mentorship Networks (CMN) provides an environment and infrastructure for family physicians to share concerns and seek support in treating patients with chronic pain and addiction, including opioid dependency and prescribing Opioid Agonist Therapies (OATs).

Initiated by the Primary Health Care Opioid Response Initiative, the Collaborative Mentorship Networks (CMN) for Chronic Pain and Addiction connects family physicians with colleagues who have experience and expertise in treating patients with pain and addiction.

Please note this is not a referral service.

OBJECTIVES OF THE CMN FOR CHRONIC PAIN AND ADDICTION

- Support family physicians and other healthcare professionals in providing complex clinical care
- Enhance the quality of complex clinical care
- Provide practical and relevant complex clinical care continuing professional development (CPD) based on learning needs
- Increase the number of family physicians and other healthcare professionals who are able to treat complex clinical care patients
- Provide the means for improving integration among primary and specialty care.
Safeworks

- 403-850-3755 (Mobile Van, Calgary)
- Harm reduction supplies, wound care, vaccines
- HIV/hepatitis/STI testing
- Naloxone kits
- Several locations and mobile outreach
If referral for OAT is necessary—
Opioid Dependency Program—AHS

- Self-refer via telephone call to ODP
- Video conferencing from health clinics with video conferencing technology

Accessing OAT if referral is necessary

- Updated list of providers on CPSA website
  - Opioid Dependency Program
    - Phone: 403-297-5118, AHS program,
  - Metro City Clinic
    - Phone: 587-430-0905, Fee for service
  - ACT Clinics
    - Phone: 403-232-6990, 403-475-4006, Fee for service
  - Health Upwardly Mobile
    - 403-536-2480, Fee for service
  - Bridgeland medical Clinic
    - 403-457-9055, Fee for service
OAT Initiatives

• CUPS
  • Patients must be low-income and require primary care at CUPS
  • Buprenorphine/naloxone and methadone initiations and maintenance

• The Alex

• Alpha House
  • Will offer buprenorphine/naloxone inductions, will be transferred for maintenance

• Renfrew Detox offering OAT
  • Buprenorphine/naloxone inductions, will be transferred for maintenance

Detox Services

Renfrew
• 1511 Remington Rd NE
• 403-297-3337
• 40 bed, medical detox
• Non-smoking
• New: OAT inductions
• Arrive at 730am for triage

Alpha House
• 203 15 Ave SE
• 403-234-7388
• Shelter (intox)
• 30 bed Social detox -*Increasing medical monitoring
• Increased capacity for OAT
• Transitional program and housing
• Walk in any time
Adult Addiction Services
(AKA AADAC)

• ***MOVED May 22\textsuperscript{nd}: 3\textsuperscript{rd} floor, 707 10 Ave SW, Calgary
• Locations around AB—see website
• 403-297-3071 Calgary
• Walk in intake DAILY @ 12:30pm Calgary
  • Individual counselling and assessment
  • Group treatment
  • Referral assistance for residential treatment

Youth Addiction Services

Calgary: See website for other locations in AB
• 1005 17 Street NW
• 403-297-4664
• Walk in intake Mon/Wed/Fri 830-10am
• Outpatient counselling
• Referrals to detox, day treatment, and residential
The SORCe (Calgary)

• Safe Communities Opportunity and Resource Centre
• “Collaborative Support for People in Need”
• Multi-agency collaborative for homeless and those at risk
• Walk in, Monday-Friday 9am-4:30pm
• North side of the City Hall C-Train platform at: 316 7 Ave SE
• www.scorce.ca

Other Resources

• www.drugsafe.ca
• Health Link (24/7): 811
• Access Mental Health: 403-943-1500
• Addiction Help Line (24/7): 1-866-332-2322
• The Addiction Centre-Foothills Medical Centre: 403-944-2025
References p. 1/4
MacDougall, L., Mohammed, A., Emerson, B. (2017). The Epidemiology of Illegal Drug Overdoses in BC.

References p. 2/4
References p.3/4


References p.4/4


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