Assessing and treating opioid use disorder, and rationalizing opioid prescribing for chronic pain

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Faculty/Presenters Disclosure

- **Faculty: Erin Knight**

- **Relationships with commercial interests:**
  - **None**

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Learning objectives

- At the conclusion of this educational activity, participants will be able to:
  - Diagnose Opioid Use Disorder (OUD)
  - Approach long-term opioid treatment (LTOT) with patient-centered strategies to reduce harm
  - Describe evidence-based interventions for treatment of OUD, including buprenorphine/naloxone
  - Be aware of addiction medicine resources

Reflective exercise

- I prescribe opioids for treating chronic pain
- I discuss opioid use disorder as a potential adverse effect of long-term opioid therapy (LTOT)
- I screen for or consider opioid use disorder when I assess patients on LTOT
- I can think of someone in my practice who has an opioid use disorder, or who I worry has an opioid use disorder
- I think family physicians can prescribe opioid agonist therapy
- I think family physicians should prescribe opioid agonist therapy
- I currently prescribe, or I plan to prescribe buprenorphine/naloxone in my practice

Diagnosing OUD

Reframing Addiction

- Substance Use Disorder
- Not a moral issue, a chronic medical condition

"Treatment of heroin addiction with detoxification is no more effective than treatment of diabetic ketoacidosis with intravenous fluids and insulin. In both conditions, the underlying disorder requires a strategy for long-term care. In the chronic management model there will be periods of success, during which compliance is high and the disease is quiescent, and periods of relapse in which additional therapies are needed for management."

Natural history of opioid use disorder

- Mortality rates for untreated opioid use disorder
  - 1-3% per year
    - Approximately half of this is due to opioid overdose
    - 417 drug poisoning deaths in MB last year
- Morbidity
  - Infectious diseases
    - HIV
    - HCV
    - Infective endocarditis
    - Skin and soft tissue infections, osteomyelitis, septic joints…
  - Social and economic impacts
    - Crime, unemployment, underhousing…
    - Cost estimated at 0.4% GDP for developed countries

Behaviours that may reflect OUD

- Compulsive use:
  - Multiple early refill requests
  - Repeated lost or stolen Rx
  - "double-doctoring" or frequent ED visits
  - Strong resistance to medication changes, requests for specific formulations
- Social impacts
  - Job loss/school failure
  - Friends or family expressing concern
  - Social isolation
  - Family conflict
- Risky use
  - Clinically apparent sedation
  - Overdose events
  - Motor vehicle collision
  - Falls or traumatic injuries
  - Deteriorating mental health status
  - Alternate routes of use – chewing, snorting, injecting
- Physiologic effects
  - Continued requests for escalation of dose
  - Clinically apparent withdrawal, or overuse of medications to avoid withdrawal

Most people on LTOT do not have OUD

DSM-5 criteria for Substance Use Disorder (SUD)

- At least 2 within a 12 month period, of:
  - Compulsive use
    - Taken in larger amounts or over a longer period of time than intended
    - Persistent desire or unsuccessful efforts to cut down/control use
    - Great deal of time spent obtaining, using or recovering from substances
    - Craving, or strong desire to use
  - Social impact
    - Recurrent use resulting in failure to fulfill major obligations at work, school or home
    - Continued use despite persistent/recurrent social or interpersonal problems caused or exacerbated by substances
    - Important social, occupational or recreational activities are given up/reduced
  - Risky use
    - Recurrent use in physically hazardous situations
    - Continued use despite knowledge of persistent/recurrent physical or psychological problems caused or exacerbated by substances
  - Physiologic
    - Tolerance
    - Withdrawal

Mild: 2-3 Moderate: 4-5 Severe: >=6

BARRIERS TO SUD TREATMENT

- Stigma & lack of knowledge
  - Self: delays in seeking help
  - **Service/public: delays in referring to or initiating treatment**
  - Treatment agencies: limiting evidence-based therapies
- **Wait times**
  - Assessment/intake
  - Withdrawal management
  - Treatment
- Funding
  - Individual
    - Medication coverage
    - Treatment programs & counseling
    - Short and long-term income support
  - Systemic
    - Governmental funding for addiction interventions including prevention, harm reduction & treatment

LANGUAGE – SIMPLE WAYS TO REINFORCE OR COMBAT STIGMA

- Alcoholic, drunk
- Junkie, meth-head
- IV drug user
- Clean (dirty)
- Alcohol/drug abuse
- Opioid replacement/substitution
- Addicted baby/infant

LANGUAGE – SIMPLE WAYS TO REINFORCE OR COMBAT STIGMA

~~Alcoholic, drunk~~	Person with alcohol use disorder
=	
~~Junkie, meth-head~~	Person who uses drugs/person with substance use disorder
=	
~~IV drug user~~	Person who injects drugs
=	
~~Clean (dirty)~~	In recovery/remission
=	
~~Alcohol/drug abuse~~	Alcohol/drug use (high risk use)
=	
~~Opioid replacement/substitution~~	Opioid agonist treatment
=	
~~Addicted baby/infant~~	Baby with neonatal withdrawal

Practical tips regarding LTOT Rx

- Never start opioids without a plan and discussion about when/why/how to stop them
- Frame LTOT as a topic of ongoing discussion
  - In most cases, no need to rush changes
  - Spend time building rapport and buy-in
  - Address polypharmacy and rationalize prescriptions
- Listen to pain experiences and offer supports
- Focus on realistic and functional pain goals

Prescribing strategies to limit harm

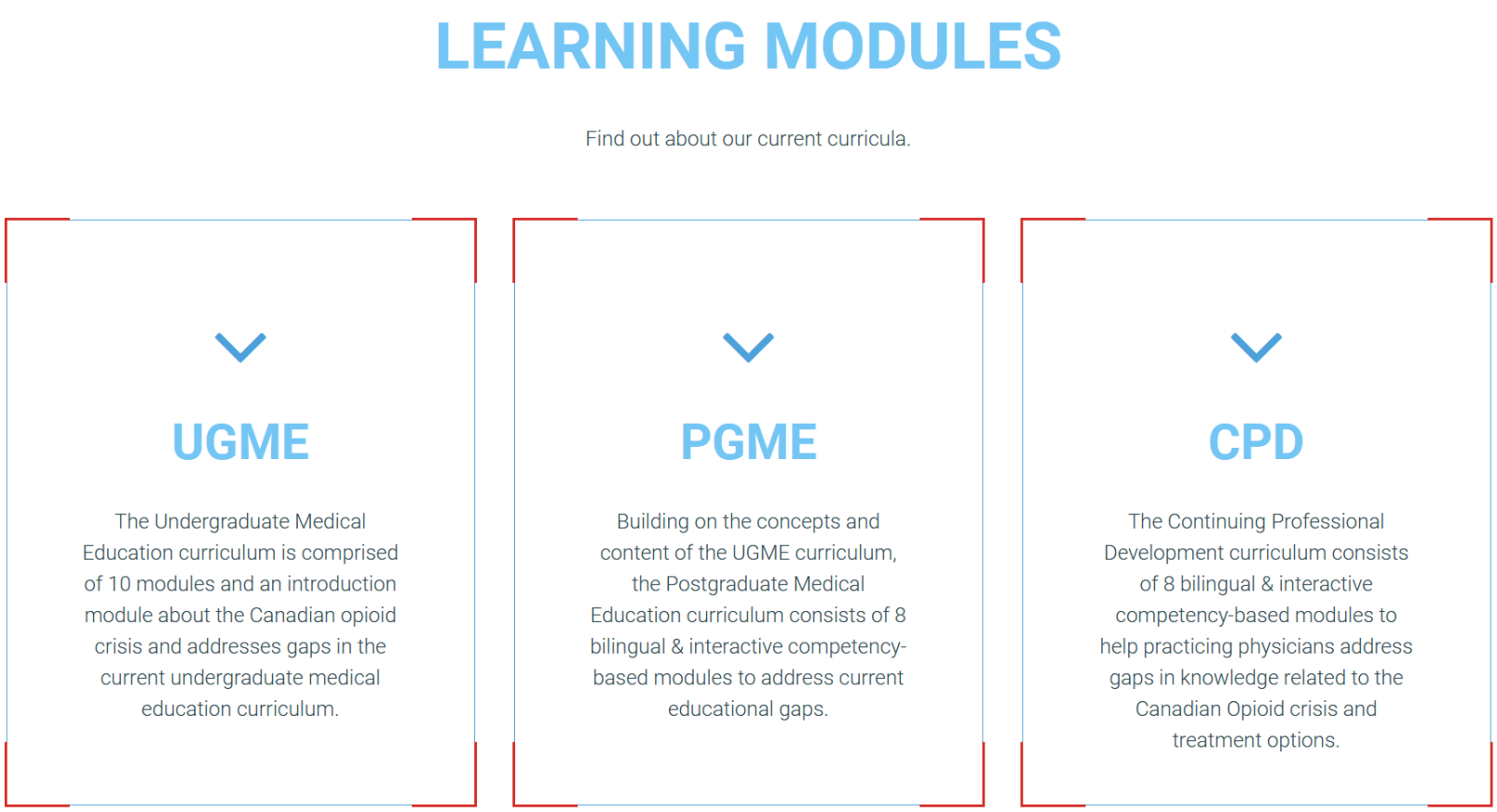
- Dispense smaller quantities more frequently
  - Utilize daily/witnessed dosing in pharmacy when needed
- Consider bubble-packing
- Limit to a single opioid formulation, rotate when necessary
- Rotate to long-acting formulation
  - When taken as prescribed, reduces reinforcing nature
- Establish treatment agreements
  - Therapeutic goals, focused on function
  - No early refills or replaced doses
    - If early refill for travel or other logistical issue, no extra tabs provided
  - Expectation for UDS and/or pill counts
  - Single prescriber
    - Check DPIN with every new Rx

Barriers to prescribing strategies

- Cost, if no medication coverage
  - Dispensing fees
  - Bubblepacking fees
  - Cost of long-acting formulations
- Transportation issues & time commitment for frequent pharmacy visits
- Challenge to establish useful therapeutic agreements when patient already on LTOT
- Time pressures
- Access to DPIN
- Timeliness of UDS results
- Cost for point-of-care UDS tests

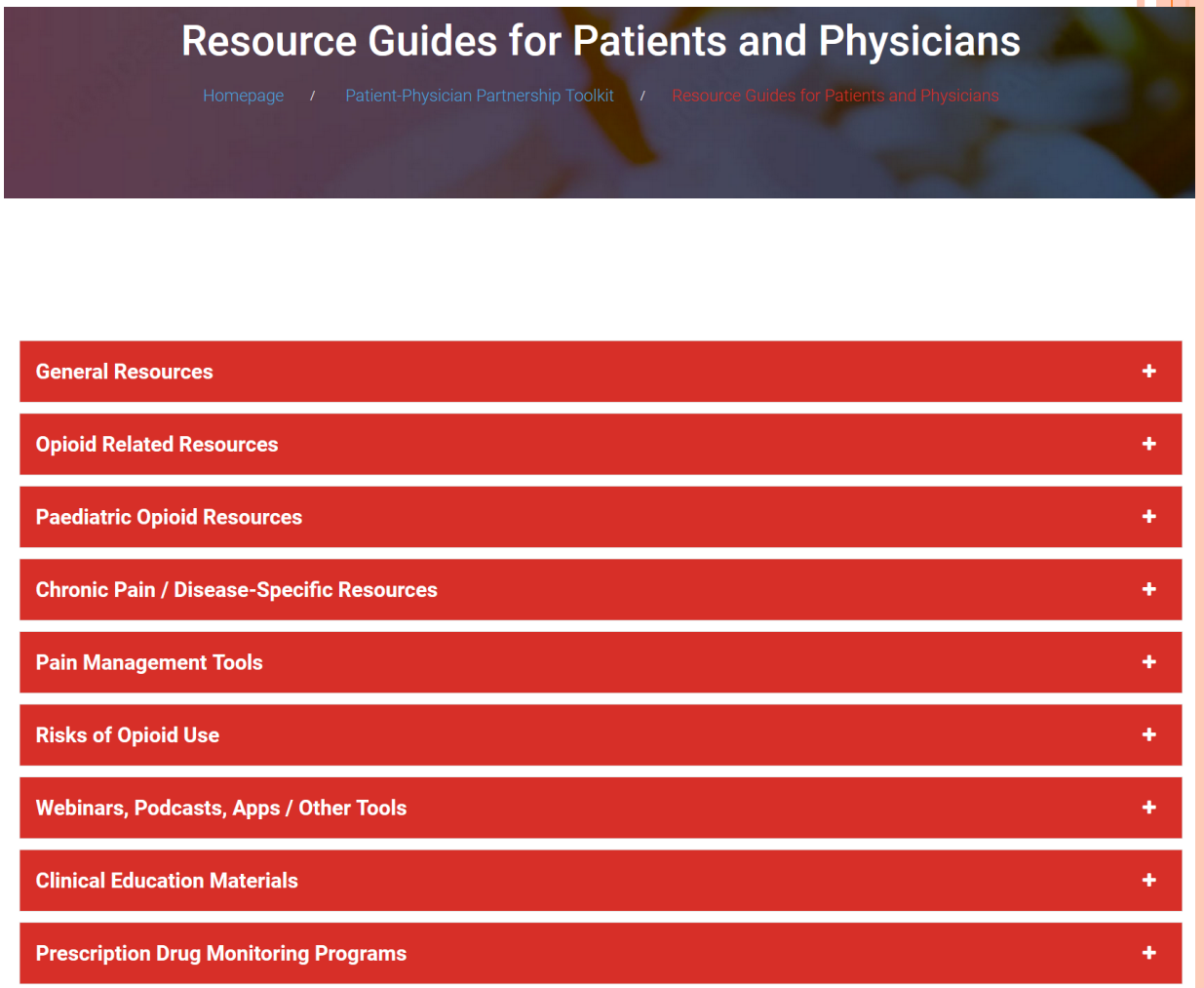
Useful Resources

- https://opioids.afmc.ca/#box3



Useful Resources

- https://opioids.afmc.ca/partnership-toolkit/resource-guides-for-patients-and-physicians/



Useful Resources

- https://opioids.afmc.ca/partnership-toolkit/

The information provided in this Toolkit is meant to act as a guide and provide helpful resources to patients and physicians.

The Toolkit should not be utilized to replace the treatment plan of your health care provider. if you are in crisis or require urgent medical attention.

Interventions for treating OUD

~~Detoxification~~

- Inpatient detox alone, associated with:
  - HIV transmission
  - High rates of relapse
  - Morbidity and mortality
- Requests for detox can be an important 1st contact with health care
- Safety considerations for detox
  - Outpatient slow tapers
    - +- antagonist treatment upon completion
    - +- residential treatment
  - Intensive psychosocial follow-up
  - Take-home naloxone training

~~Detoxification~~

Management of opioid use disorders: a national clinical practice guideline

Julie Bruneau MD MSc, Keith Ahamad MD, Marie-Ève Goyer MD MSc, Ginette Poulin MD, Peter Selby MBBS MHSc, Benedikt Fischer PhD, T. Cameron Wild PhD, Evan Wood MD PhD; CIHR Canadian Research Initiative in Substance Misuse

Cite as: *CMAJ* 2018 March 5;190:E247-57. doi: 10.1503/cmaj.170958

KEY POINTS

- Opioid use disorder is often a chronic, relapsing condition associated with increased morbidity and death; however, with appropriate treatment and follow-up, individuals can reach sustained long-term remission.
- This guideline strongly recommends opioid agonist treatment with buprenorphine–naloxone as the preferred first-line treatment when possible, because of buprenorphine's multiple advantages, which include a superior safety profile in terms of overdose risk.
- Withdrawal management alone is not recommended, because this approach has been associated with elevated risks (e.g., syringe sharing) and death from overdose in comparison to providing no treatment, and high rates of relapse when implemented without immediate transition to long-term evidence-based treatment.
- This guideline supports using a stepped and integrated care approach, in which treatment intensity is continually adjusted to accommodate individual patient needs and circumstances over time, and recognizes that many individuals may benefit from the ability to move between treatments.

Harm Reduction -Needle/paraphernalia distribution

- Needle/Syringe programs associated with:
  - Reduction in injecting risk behavior
  - Reduction in HIV infection and other blood-borne infections

- In Thompson, supplies available at:
  - Thompson harm reduction: 300 Mystery Lake Rd
  - Thompson public health: 867 Thompson Dr. S
  - RAAM: 90 Princeton Dr.

https://streetconnections.ca/locations

Harm Reduction -Supervised consumption

- Insite
  - Canada's first supervised injection site
  - Located in Vancouver's Downtown East Side
- Evidence of benefit
  - Decreased syringe sharing, positive changes in injection practice
  - Increased referral to detox and community services
  - No increase in drug dealing, drug-related crime, new IDU or relapse to IDU
  - Conservative estimates show prevention of:
    - 35 cases of HIV per year
    - 3 deaths per year
  - Overall cost-savings over 6 million$ per year after program costs

Harm Reduction
-Naloxone distribution/ Take Home Naloxone

- WHO guidelines on Community Management of Opioid Overdose, 2014
  - "people likely to witness an opioid overdose should have access to naloxone and be instructed in its administration"
- Conclusion from a narrative systematic review
  - THN programs reduce overdose mortality rates in community, AND
  - Have a low rate of associated adverse events
- In Thompson…THN kits and training available at:
  - Same 3 places as supplies, plus:
    - Thompson clinic: 50 Selkirk Ave.

https://streetconnections.ca/locations

Opioid Agonist Therapy

- Buprenorphine/naloxone (Suboxone)
  - Doses > 2mg retain people in treatment
  - Doses >=16 mg decrease illicit opiate use
- Methadone
  - Increased retention in treatment
  - Decreased use of heroin
- Both effective in reducing overdose

CRISM National Guideline

for the Clinical Management of

OPIOID USE DISORDER

CIHR IRSC
Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

CRISM-ICRAS
Canadian Research Initiative in Substance Misuse / Initiative Canadienne de Recherche en Abus de Substance

Diagnosed OUD (DSM-5 criteria)

Is OAT indicated?

Yes → **Opioid Agonist Therapy (OAT)**
+/- psychosocial treatment
+/- residential treatment

Is Buprenorphine/naloxone indicated?

Yes → **Buprenorphine/naloxone** (*First-line option*)

No → *Is Methadone indicated?*

Yes → **Methadone** (*Second-line option*)

No → *Is SROM indicated?*

Yes → **SROM** (*specialist-led approach*)

According to patient circumstances, move between approaches as needed

No → *To avoid* X

Slow taper with an OAT medication
Over months to years, as appropriate, preferably with support
+/- psychosocial treatment
+/- residential treatment

Withdrawal management alone (i.e., detoxification without immediate transition to long-term addiction treatment)

+ HARM REDUCTION APPROACHES

Regardless of the selected treatment scheme, evidence-based harm reduction should be offered to all, including:

- Education re: safer use of sterile syringes/needles and other applicable substance use equipment
- Access to sterile syringes, needles, and other supplies
- Access to Take-Home-Naloxone (THN) kits
- Access to Supervised Consumption Services (SCS)

Interventions for OUD – Deep dive on buprenorphine

Pharmacology and Pharmacokinetics

- Buprenorphine
  - Partial mu-opioid agonist
    - Extremely high affinity
  - Kappa-opioid antagonist
    - May have antipsychotic and antidepressant effects
  - Good mucosal absorption, but poor oral availability
    - Must be taken sublingual, not swallowed!
  - T ½ = 24-32h, dose-related
  - Peak concentration at 1 hour post-dose
  - Maximal effects at 1-4 hours post-dose
  - Considerable inter-subject variability in plasma levels
    - Doses must be titrated clinically!

Pharmacology and Pharmacokinetics

- Naloxone (Narcan)
  - Opioid antagonist
  - Limited sublingual absorption
  - Nearly complete 1st pass metabolism
    - More bioactive in cirrhosis, can cause withdrawal!!
  - T ½ = 1 hour
  - Onset of action within 2 minutes
- Does not affect the efficacy of sublingual buprenorphine
- Included only to decrease injection or intranasal use

MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

About the Manual

CPSM convened a working group of experts in the treatment of opioid use disorder (OUD) in 2019. This working group was tasked with assisting the Prescribing Practices Program to develop a new *Recommended Practice Manual* for the use of buprenorphine-containing medications in the context of Opioid Agonist Therapy (OAT) in Manitoba.

By 2021 the same working group was tasked with updating the CPSM 2014 publication *Manitoba Methadone and Buprenorphine Maintenance Recommended Practice*. This publication contained minimal guidance on buprenorphine-containing OAT medications and the methadone guidance was outdated. The resulting combination of these two important projects created this new publication, the *Manitoba Opioid Agonist Therapy Recommended Practice Manual*, completed in 2023.

CPSM receives frequent requests for guidance on the issues addressed in this manual. The chapters are posted individually under the main sections, as below, for providers to find their topic of interest more easily. Where appropriate, buprenorphine-specific and methadone-specific guidance has been provided separately. However, many OAT care topics are addressed collectively for overarching guidance, with medication-specific recommendations provided throughout chapters as applicable.

This manual is intended to be a dynamic online publication that is hosted on this webpage to permit more regular revision. It will be updated periodically as evidence and best practices in this field evolve over time. The manual is also intended to contribute to quality assurance in OAT practice, promote collaboration among professionals and with patients, and inspire continued growth of the OAT community.

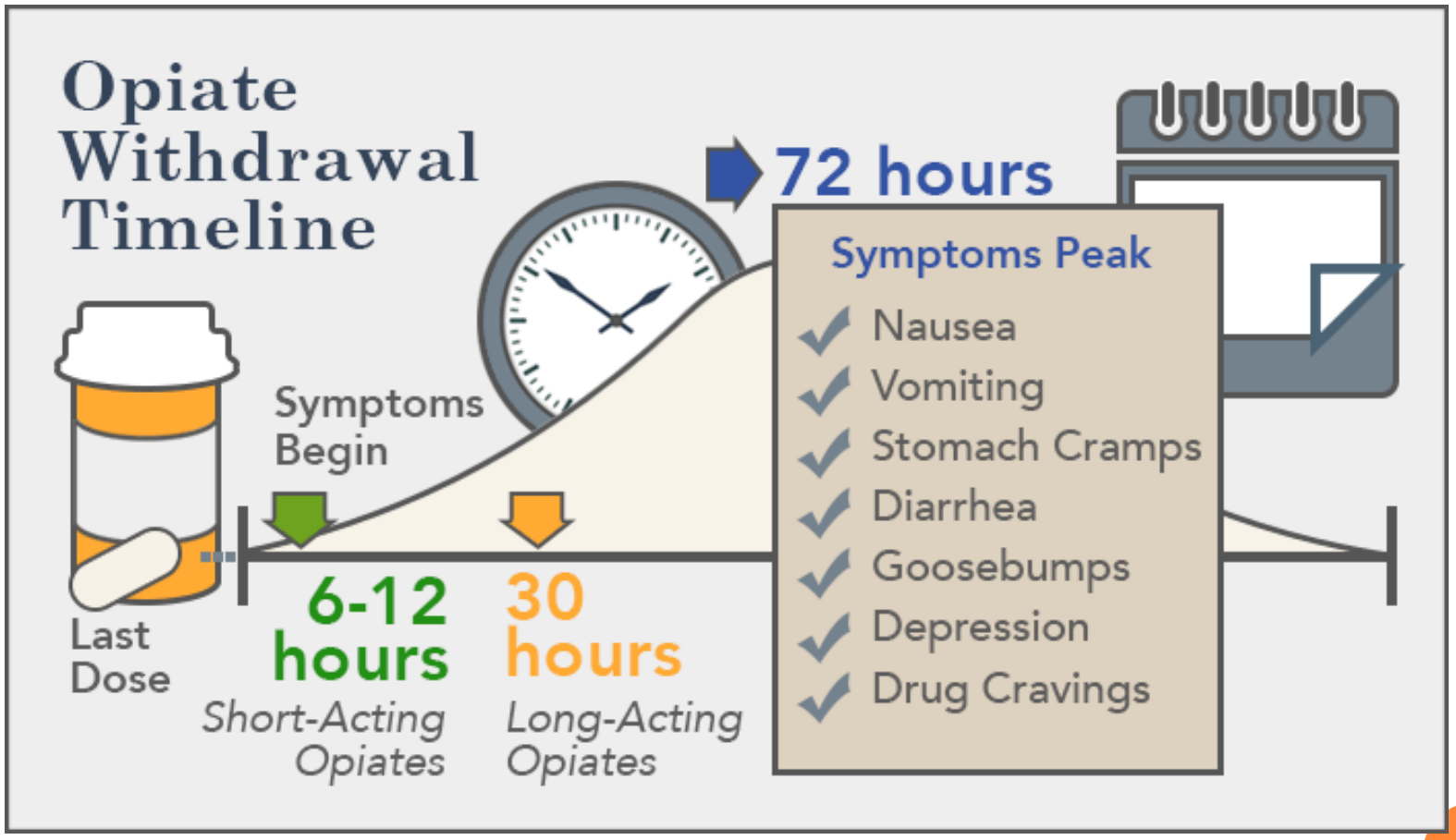
Clinicians are encouraged to adopt and incorporate these recommendations into their OAT practice without delay. Should CPSM registrants have any questions about the interpretation of this guidance, please contact the working group Chair, Dr. Marina Reinecke at 204-774-4344.

http://cpsm.mb.ca/prescribing-practices-program/manitoba-buprenorphine-naloxone-recommended-practice-manual

Considerations for Induction

- Discussion about opioid withdrawal
- Frank discussion re: precipitated withdrawal
  - Very rare in straightforward starts (except with fentanyl)
  - Usual treatment = give more buprenorphine
- Timing of induction
  - Take advantage of existing withdrawal!
  - Consider important upcoming activities/responsibilities
  - Consider planned admission for induction if complex

Opioid Withdrawal Syndrome



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Patient's Name:_____ Date and Time ___/___/___:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute
Measured after patient is sitting or lying for one minute
0 pulse rate 80 or below
1 pulse rate 81-100
2 pulse rate 101-120
4 pulse rate greater than 120

GI Upset: *over last 1/2 hour*
0 no GI symptoms
1 stomach cramps
2 nausea or loose stool
3 vomiting or diarrhea
5 multiple episodes of diarrhea or vomiting

Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.*
0 no report of chills or flushing
1 subjective report of chills or flushing
2 flushed or observable moistness on face
3 beads of sweat on brow or face
4 sweat streaming off face

Tremor *observation of outstretched hands*
0 no tremor
1 tremor can be felt, but not observed
2 slight tremor observable
4 gross tremor or muscle twitching

Restlessness *Observation during assessment*
0 able to sit still
1 reports difficulty sitting still, but is able to do so
3 frequent shifting or extraneous movements of legs/arms
5 unable to sit still for more than a few seconds

Yawning *Observation during assessment*
0 no yawning
1 yawning once or twice during assessment
2 yawning three or more times during assessment
4 yawning several times/minute

Pupil size
0 pupils pinned or normal size for room light
1 pupils possibly larger than normal for room light
2 pupils moderately dilated
5 pupils so dilated that only the rim of the iris is visible

Anxiety or Irritability
0 none
1 patient reports increasing irritability or anxiousness
2 patient obviously irritable or anxious
4 patient so irritable or anxious that participation in the assessment is difficult

Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored*
0 not present
1 mild diffuse discomfort
2 patient reports severe diffuse aching of joints/muscles
4 patient is rubbing joints or muscles and is unable to sit still because of discomfort

Gooseflesh skin
0 skin is smooth
3 piloerrection of skin can be felt or hairs standing up on arms
5 prominent piloerrection

Runny nose or tearing *Not accounted for by cold symptoms or allergies*
0 not present
1 nasal stuffiness or unusually moist eyes
2 nose running or tearing
4 nose constantly running or tears streaming down cheeks

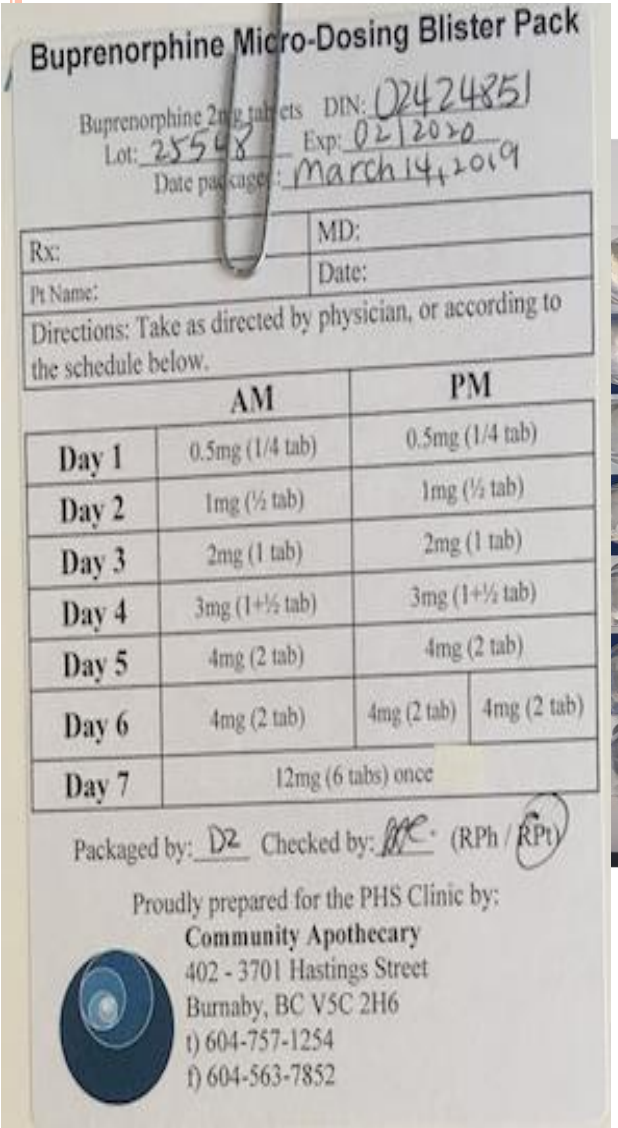
Total Score _____
The total score is the sum of all 11 items
Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

Initiating buprenorphine/naloxone -classic start

- Patient must be in moderate withdrawal (if recent opioid use)
  - Minimum 6-8 hours since last short acting opioid, 24+ hours since last long-acting (unless used in a short acting method!)
  - Assess using COWS: score >= 12 prior to starting
- Day 1 initial dose: 2-8 mg depending on withdrawal severity and opioid tolerance
  - 2-4 mg top-up doses q1h PRN
  - typical outpatient max dose day 1 = 16mg
    - consider higher doses if previously on high dose buprenorphine, high opioid tolerance
- Day 2-3 initial dose: total of previous day ± additional 2-4 mg
  - A second dose can be given after 1 hour if needed
- Dose can be adjusted daily
  - A stable dose can be reached within 1-4 days

Initiating buprenorphine/naloxone -an alternate approach: microdosing



Buprenorphine Micro-Dosing Blister Pack

Buprenorphine 2mg tablets DIN: 02424851
Lot: 25548 Exp: 02/2020
Date packaged: March 14, 2019

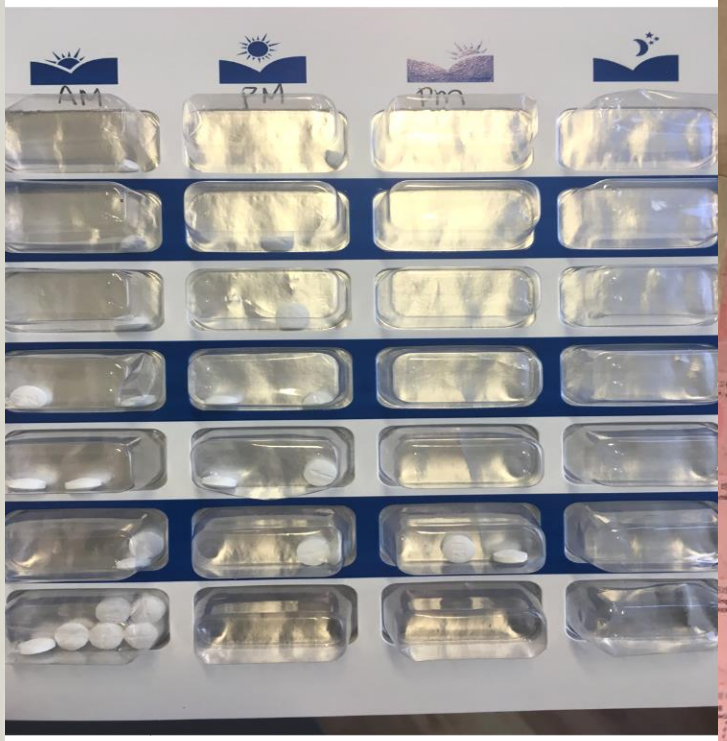
Rx:	MD:
Pt Name:	Date:

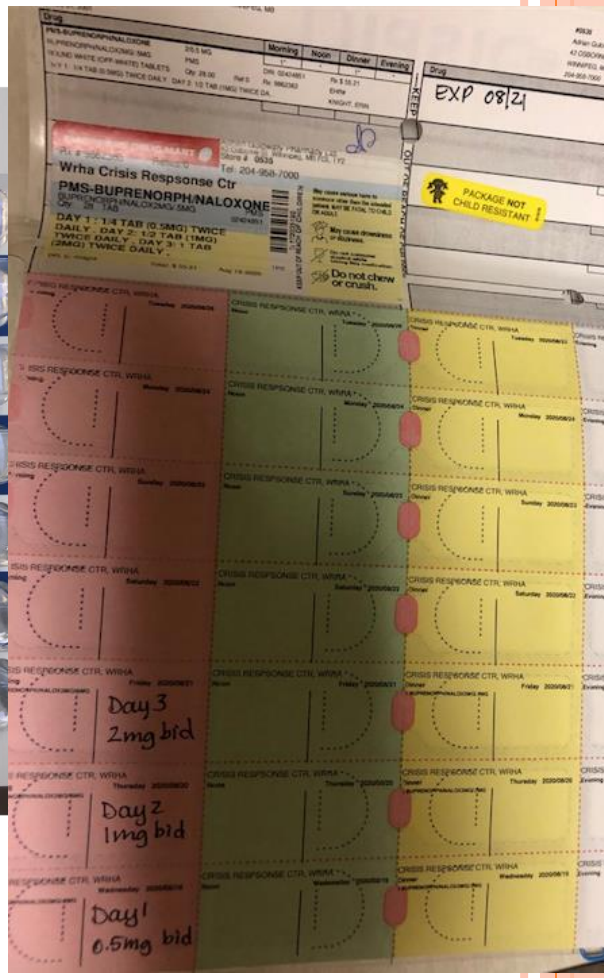
Directions: Take as directed by physician, or according to the schedule below.

	AM	PM	
Day 1	0.5mg (1/4 tab)	0.5mg (1/4 tab)	
Day 2	1mg (½ tab)	1mg (½ tab)	
Day 3	2mg (1 tab)	2mg (1 tab)	
Day 4	3mg (1+½ tab)	3mg (1+½ tab)	
Day 5	4mg (2 tab)	4mg (2 tab)	
Day 6	4mg (2 tab)	4mg (2 tab)	4mg (2 tab)
Day 7	12mg (6 tabs) once		

Packaged by: DZ Checked by: MC (RPh / RPt)

Proudly prepared for the PHS Clinic by:
Community Apothecary
402 - 3701 Hastings Street
Burnaby, BC V5C 2H6
t) 604-757-1254
f) 604-563-7852





Initiating buprenorphine/naloxone -patient education

- **Tablet is SL and can take up to 10 minutes to dissolve**
  - Do not swallow or drink water
  - Avoid smoking or drinking coffee 1 hour before
  - After dissolved, swallow or spit out tablet/saliva
- Naloxone component is only active when it is snorted or injected
- Caution about alcohol, benzodiazepine, other sedative use
- Medication is intended for long-term use
  - Physical dependence will still exist
  - Risks are similar to other opioids, but less

Dose Adjustments

- As dose increases, duration without withdrawal increases & cravings decrease
- Balance prevention of withdrawal, cravings and illicit use vs. avoidance of side-effects
  - Avoid dose increases for seeking sedative effect, treated co-occurring disorders (ex. anxiety, PTSD, chronic pain)
- Usual dose: 8-24mg
- Doses > 24 mg are sometimes needed, up to 32mg
- After induction period, dose adjustments are minimal

Barriers to integrating OAT into primary care

- Time pressures & complexity of care
- Access to DPIN
- Timeliness of UDS results
- Cost for point-of-care UDS tests
- Lack of billing codes to reflect care
- Lack of resources for case management and non-pharmacologic treatment
- ~~Cross-coverage or on-call system for urgent issues~~
- ~~Requirement for extra training to prescribe~~

Office-based Addiction Care

- Primary care is the **ideal setting** for treating substance use disorders including OUD
  - Greater capacity than specialized care for long-term management
  - Other health concerns can also be addressed
  - Length of treatment more important than intensity of treatment
  - Patients prefer primary care setting
  - Good relationship with care provider important determinant of effective counselling
  - Less stigmatizing environment than a specialized addiction clinic

OAT Training in Manitoba

Buprenorphine/naloxone Only

1) Write a letter to the Registrar requesting approval to prescribe buprenorphine/naloxone for OUD

Bonus!
MB Addiction Resources

Substance Use Pathway: Referral to Treatment (sbiRT)

Connect to Primary Care anywhere in Pathway.

Connect to *RAAM* anywhere in Pathway.

START HERE

Seeking help for problematic substance use?

YES

In withdrawal?

YES

Seeking Residential Withdrawal Management?

YES

NO

NO

What service?

NO

Harm Reduction
- Take home Naloxone
- Injection & smoking supplies
- Low risk drinking handout
- Lower risk cannabis handout
- Counselling
  - •Don't use alone
  - •Don't mix drugs
  - •Preferred routes: Oral > snorting > smoking > injecting
  - •Injecting
    - Clean skin
    - Clean supplies
    - Bevel up
    - Arms > legs
    - Avoid neck and groin veins
- CATIE harm reduction handouts
- Street Connections
- Motivational interviewing

Peer Support
- AA/NA/CA/CMA
- SMART
- SOS
- Jibstop
- Recovery Dharma
- Thirteen Moons

Outpatient
- RE:ACT/Finding Freedom
  - Trauma & SUD
- St. Raphael's Wellness
- AFM
- Native Addictions
- Laurel Centre
- Men's Resource Centre

Inpatient TYPES

-Contingency Management
-CBTm

Medication
- OAT
  - Phoenix
  - OATS
  - MOST
  - LifeSmart
  - Primary Care
  - MWMS (Klinic)
- Naltrexone, etc.

Consultation
- Complex Addiction & Recovery Medical Assessment (CARMA)
- CODI
- RACE
- eConsult
- HSC Addiction Consults

Home detox
+/- MWMS
+/- Medications
- ex: daily dispense diazepam, quetiapine

Acute Medical Needs?
- Withdrawal seizure
- Mod to severe ETOH withdrawal
- History DTs

NO

YES

Main Street Project (Wpg), Eaglewood Detox (Thompson), Withdrawal Support Services (Brandon), MWMS STAR
- MSP Medical clearance

Addiction Unit at HSC
- Via HSC ED

Aurora
- Private funding

Private
- Aurora
- Kelburne
- Tamarack*

Bruce Oake

First Nations
- Pritchard House #
- Sagkeeng ~?
- Peguis #
- Nelson House ?
- Rosaire House #

Religious
- ~~Salvation Army/ Anchorage ?~~
- UGM
  - Men's
  - Charis (women's)
- Teen Challenge

AFM #
- Thompson
- Brandon
- St. Rose
- Winnipeg Men's
- Winnipeg Women's

Long-Term
- Behavioural Health Foundation ~
- Charis (UGM Women's) ~
- Teen Challenge

2nd Stage Housing

(Most require residential treatment program before entry)
- 210 Recovery
- Destiny House
- Addictions Recovery inc.
- Esther House
- Native Women's Transition
- North End Women's Centre
- AFM River Point Apartments

MB Addiction Helpline
http://mbaddictionshelp.ca/
1-855-662-6602

*non-profit; limited funded beds per year

~ allows children

covered by Manitoba Health (unsure marked by ?)

Feb 28, 2020

Addiction Resources in Manitoba -consultation

- E-consult
  - https://www.lhinworks.on.ca/
  - Web-based consultation system, response within 7 days
- Rapid Access to Consultative Expertise (RACE)
  - Telephone based consultative service – 204-940-2573
    - Currently staffed by CODI psychiatrists
  - Monday to Friday 9am-4pm, *excluding* STAT holidays
  - Same day response within 2 hours
- Hospital-based Addiction Consult Service
  - Telephone advice available through HSC paging – 204-787-2071
  - 7 days per week 8am-8pm, *including* STAT holidays
- Complex Addiction & Recovery Medical Assessment (CARMA)
  - Outpatient consultative service for complex addiction consults
    - Useful for diagnostic clarification and therapeutic recommendations
  - Fax consult to 204-787-3996 with patient and physician contact info

Addiction Resources in Manitoba -withdrawal management

- Non-medical withdrawal management:
  - Prairie Mountain Health withdrawal management service – Brandon
  - Eaglewood withdrawal management – Thompson
  - Main Street Project – Winnipeg
- Community-based withdrawal management:
  - Mobile Withdrawal Management Service (MWMS), Klinic – Winnipeg
- Medical withdrawal management
  - Addictions Unit, RR2 Health Sciences Centre Winnipeg
  - Brandon Regional Health Centre
  - Emergency departments, hospital wards…

Addiction Resources in Manitoba -peer support

- 12-step
  - Alcoholics Anonymous (AA)
  - Cocaine (CA)
  - Narcotics (NA)
  - Crystal Meth (CMA)
  - Gamblers (GA)
  - Etc.
  - Al-anon for family/friends/supports
- Non 12-step
  - SMART Recovery
  - Recovery Dharma
  - Secular Organizations for Sobriety (SOS)
  - JibStop

RAPID ACCESS TO ADDICTION MEDICINE (RAAM)

- Low-barrier, walk-in access to addiction care:
  - Addiction physician/NP
  - Nurse/clinician
  - Addiction counselor
    - System navigation, referral to treatment
- No appointments, no referrals, all substances
- 6 clinics across the province, 2 in Winnipeg
- Outpatient service, NOT APPROPRIATE if:
  - Urgent medical or mental health needs
- 24/7 "RAAM on-call" service available to care providers supporting RAAM clients – 204-787-2071
- http://mbaddictionhelp.ca/services/rapid-access-to-addictions-medicine-raam/

Office-based Addiction Care -resources for care providers

- http://www.metaphi.ca
- https://www.porticonetwork.ca/tools/toolkits/pcat
- http://www.bccsu.ca/
- https://www.cfpc.ca/en/education-professional-development/practice-tools-guidelines/practical-approach-to-substance-use-disorders

Take-home Messages

- Consider and screen for OUD as part of LTOT
  - Explore diagnostic criteria
  - Employ harm reduction measures
- Frame substance use disorders as chronic disease management
- Share evidence-based information on OUD
  - Withdrawal management/detox NOT recommended
  - Strong evidence for harm reduction
  - 1st line treatment is long term OAT
- Screen for and move toward treating substance use disorders, including OUD in primary care

Reflective exercise - repeat

- I already do, or I will discuss opioid use disorder as a potential adverse effect of LTOT
- I already do, or I will screen for or consider opioid use disorder when I assess patients on LTOT
- I can think of someone in my practice who has an opioid use disorder, or who I worry has an opioid use disorder
- I think family physicians can prescribe opioid agonist therapy
- I think family physicians should prescribe opioid agonist therapy
- I already do, or I will prescribe buprenorphine/naloxone in my practice

Questions?

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