Recommendations for the provision of opioid agonist therapy in publicly funded residential addiction treatment centres in Ontario

March 2022

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Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META:PHI)

Toronto

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Introduction

These recommendations were written by a group of concerned addiction clinicians in Ontario, who came together under the leadership of Mentoring, Education, and Clinical Tools for Addiction: Partners in Health Integration (META:PHI) and Addiction and Mental Health Ontario's (AMHO) Residential Treatment Community of Practice. They were written to dispel common myths and misconceptions surrounding OAT and to ensure that there is consistent guidance on OAT for programs across the province.

Residential treatment facilities provide 24/7 intensive time limited treatment in a structured, in-house environment for people who want to stop their use of harmful substances. An informed decision on an appropriate referral to treatment will be based on standardized provincial assessment tools (GAIN) and referral packages. Most clients accessing these services are already on OAT or have tried OAT as part of their outpatient journey, prior to be assessed and matched with residential treatment. AMHO has 31 publicly funded treatment providers in their membership; of these 31 providers, 67% admit patients on methadone and 89% admit patients on buprenorphine. The providers have indicated a strong desire for additional resources and training to enable them to provide OAT. This can only be achieved through a collaborative effort between AMHO, the programs it represents, and the Ministry of Health.

Background: Opioid agonist treatment

Opioid agonist medications are taken once daily and their effects last for at least 24 hours. Methadone and buprenorphine formulations are the two opioid agonist medications currently indicated for the treatment of opioid use disorder (OUD), with a long history of strong scientific evidence for efficacy, both on individual and population levels. Buprenorphine is a partial opioid agonist that, in the absence of other sedatives, rarely causes respiratory depression. For this reason, it is far safer than methadone, and is even safer than commonly prescribed opioids such as oxycodone, morphine and hydromorphone. However, methadone is more potent than buprenorphine, and is probably more effective for patients who inject fentanyl or heroin.

Both methadone and buprenorphine are opioids, but their effects on the nervous system are distinctly different from those of short-acting opioids such as fentanyl or hydromorphone which are commonly used for non-therapeutic purposes by people with OUD. When injected, snorted, crushed or smoked, drugs like fentanyl reach the brain within seconds, inducing pleasure or euphoria. In those who become addicted to opioids, the brain adapts to these reinforcing effects, such that individuals develop tolerance and must increase the dose to achieve the euphoria they are seeking. Although the initial stages of opioid misuse are driven by "drug-liking" or positive reinforcement, daily and progressive use of opioids over time is usually sustained in response to severe, debilitating withdrawal symptoms (negative reinforcement), compelling patients to seek and maintain a regular opioid supply just to avoid the withdrawal experience.

Methadone and buprenorphine, on the other hand, have a very slow onset of action, – on the order of minutes to hours – and a long duration of action – up to 2 days, in the case of buprenorphine. When properly prescribed,

methadone and buprenorphine will achieve a "steady state" concentration after a few days of treatment, which means the effect and benefit of the medications remains constant through the entire day. Therefore, patients on OAT medications do not experience euphoria or sedation, and they are able to function normally with minimal or no sedation or cognitive impairment. They also experience substantial, if not complete relief from withdrawal symptoms and cravings, reducing the risk of relapse.

OAT medications (methadone and buprenorphine-naloxone) are prepared and dispensed in ways that prevent diversion and misuse. Methadone is a powder which is dissolved in a volume of fruit-flavoured drink and swallowed in front of a staff member once daily. Buprenorphine-naloxone is a tablet which contains the long-acting opioid buprenorphine combined with naloxone and is intended to be dissolved under the tongue. The presence of naloxone in the formulation is intended to discourage the misuse of buprenorphine by way of injection, due to fear of precipitated withdrawal. When buprenorphine is properly dissolved under the tongue, the buprenorphine is absorbed into the blood stream and the naloxone is poorly absorbed and inactivated by the liver, so withdrawal is not induced. Newer formulations of buprenorphine include an injectable, depot dose which is administered once a month.

OAT medications do not impair patients' ability to engage in the therapeutic process. In fact, patients are far better able to engage in counselling than someone who is being 'detoxified' from opioids. People who are undergoing acute or subacute withdrawal experience intense anxiety, dysphoria, powerful cravings for opioids, and insomnia. This very physical experience is almost always a mental distraction from the necessary exercise of self-reflection in recovery.

OAT is an effective and critically important public health strategy for preventing opioid overdose. OAT prevents overdose in two ways: (a) most patients on OAT either stop or markedly reduce the frequency and amount of their opioid use, and (b) a patient who injects fentanyl or other opioids is much less likely to stop breathing if they are on OAT medications, due to the sustained respiratory opioid tolerance conferred by the regular, long-acting OAT dosing regimen. These protective effects of OAT are lost if the medication is discontinued. Patients will usually relapse to opioid use because they cannot tolerate the withdrawal symptoms and cravings that accompany opioid cessation.

Opioid withdrawal can be viewed as having two phases. The first phase, often referred to as "acute opioid withdrawal", can last 7- 14 days, in some cases longer, and may include muscle aches, runny nose, sweating, vomiting, abdominal pain, diarrhea and chills. When the acute withdrawal symptoms abate, significant, lower grade withdrawal symptoms, such as anxiety, dysphoria, insomnia, restlessness, difficulty concentrating, and ongoing cravings for opioids, can last for months. These lower grade, subacute withdrawal symptoms often cause clients to relapse to opioid use after the acute withdrawal phase. For this reason, short term treatment of opioid withdrawal with medications like buprenorphine or clonidine for only several days to a few weeks, is associated with a higher rate of relapse and increased mortality than longer-term opioid agonist treatment. The short-term use of OAT to treat acute opioid withdrawal, after which the OAT is rapidly tapered, is not recommended and is strongly discouraged. In contrast, relapse to use of most other types of drugs such as cannabis, stimulants or alcohol is much less likely to lead to a fatal exposure event if an individual suddenly accesses those substances. This makes total opioid medication abstinence as a "treatment" approach, much more dangerous for opioids than for any other substance.

It is the opinion of the authors that opioid agonist therapy is consistent with the concept of "abstinence", if one considers the goal of "abstinence" to be the elimination of all drug use which causes harm or is associated with significant risk of causing harm or relapse. With this approach in mind, OAT can be used in residential treatment

settings where the psychotherapeutic process promotes abstinence from all harmful drug use. By way of example, use of therapeutic medications such as mood stabilizers, anti-depressants and buprenorphine or methadone, which have clearly been shown to improve health outcomes, should be included under the umbrella definition of "abstinence" in the sense of helping people abstain from harmful behaviours or situations. Opioid agonist therapy can also be used in an outpatient "harm reduction" model, where the use of buprenorphine or methadone allows for continued use of illicit drugs in lesser amounts, and in as safe a way as possible, aiming for fewer injecting events per day, fewer injecting days per month, and a lower dose per injection.

Literature review on opioid agonist therapy and residential treatment programs. We conducted focused literature searches on the use of OAT in residential or inpatient psychosocial treatment programs for patients with opioid use disorder (OUD), using various combinations of search terms. We looked at treatment retention rates, overdose rates, comparisons of programs with- or without- OAT, number of programs that allow OAT, and attitudes of residential clients and staff towards OAT.

Effectiveness of OAT. OAT has been shown to reduce mortality from opioid overdose. In a systematic review and meta-analysis (1), the all-cause mortality rate for patients on methadone maintenance treatment (MMT) was 11.3 per 1000 patient years, compared to 36.1 for patients who were off MMT. The relative protective effect of OAT appears to have increased during the fentanyl era. A retrospective cohort study from BC (2) analyzed mortality on and off OAT among 55,347 individuals from 1996 to 2018. From 1996 to 2012 (before illicit fentanyl became available in BC), patients had a 2.1 times greater risk of dying while off OAT than on it. After 2016, when BC declared fentanyl a public health emergency, those off OAT had a 3.4 times greater risk of dying than those on OAT.

OAT is associated with other positive outcomes besides reduced mortality. In Canada, this has been most vividly demonstrated in studies of buprenorphine programs in remote First Nations communities in Northern Ontario. In a study of 526 patients on buprenorphine programs in six First Nations communities, the 12 month treatment retention rate was 78%, and the proportion of urine drug screens positive for illicit opioids ranged from 5% to 16% (3). In a telephone survey of 32 First Nations students who had been on buprenorphine while attending a high school in a Northern community, those who were still on buprenorphine at the time of the survey trended towards high graduation rates, higher employment rates, less alcohol use, greater involvement in substance use counselling, and a greater sense of well-being (4). In an evaluation of measures of wellness in a remote community which had recently started a buprenorphine program, one year after the program began, "police criminal charges had fallen by 61.1%, child protection cases had fallen by 58.3%, school attendance had increased by 33.3%, and seasonal influenza immunizations had dramatically gone up by 350.0%. Attendance at community events is now robust, and sales at the local general store have gone up by almost 20%" (5).

Studies in other countries have also demonstrated multiple positive effects from OAT. In a systematic review of methadone maintenance treatment (MMT) in China (6), patients on MMT had marked reductions in arrest rates and drug- related crime, increases in employment rates, and improvements in family relationships. OAT impacts health outcomes in numerous ways. For example, in a retrospective cohort study of patients admitted to hospital for complications of injection opioid use (7), being on opioid agonist therapy with methadone or buprenorphine while in hospital was associated with lower rates of leaving against medical advice (30.0% vs 59.6% for those not on OAT), and 90-day all-cause readmission rates were lower for patients who were discharged on OAT versus those not on OAT (27.3% versus 42.7%).

Effectiveness of residential treatment with and without OAT

Residential treatment without OAT. Observational studies have found that patients with opioid use disorder have high relapse rates and low treatment retention rates after attending residential programs that do not offer OAT. For example, in a study of 109 patients who participated in a six- week residential treatment program without OAT (8), only 32% had completed their program. In follow up interviews two years later, 91% had relapsed; 59% reported relapsing within the first week after discharge.

Inpatient detoxification followed by outpatient counselling also has low retention and high relapse rates. In a study of 112 male veterans in the US with OUD (9), 78% successfully completed inpatient detoxification and 76% accepted the VA aftercare plan; yet only 22% were still in aftercare at 90 days. By one year 4.5% of the cohort had died.

OAT compared to residential treatment without OAT. OAT is significantly more effective than outpatient or residential psychosocial treatment alone in retaining patients in treatment, reducing opioid use and preventing overdose. In one controlled trial (10), 179 patients with OUD were randomized to receive either methadone maintenance, or a slow methadone taper with intensive outpatient counselling. The methadone group had lower heroin use and longer time in treatment (median 438 days vs 174 days). In a retrospective cohort study involving 48,250 patients with OUD attending outpatient treatment services, the risk of overdose death was markedly lower (AHR =0.18) in patients attending OAT programs than in those attending non-medication programs (11). Another retrospective cohort study involving 40,885 individuals with OUD compared six different mutually exclusive treatment pathways: OAT without formal behavioural intervention, residential treatment, intensive outpatient treatment, non-intensive outpatient treatment, naltrexone, and no formal treatment (12).

At three month and 12 month follow up, OAT was associated with a markedly reduced risk of overdose and opioid-related ED visits and hospitalizations at three-month and twelve-month follow-up. The other pathways showed no reductions in risk of overdose or ED visits and hospitalizations. Other outcomes such as quality of life or recovery capital were not measured.

OAT combined with psychosocial treatment. The impact of adding psychosocial treatment to OAT on patient outcomes remains uncertain (13). A recent systematic review of 48 RCTs comparing OAT with and without psychosocial treatment (14) found that in most of the trials reviewed, patients in the OAT plus psychosocial group had longer treatment retention times than patients in the OAT-only group. A Cochrane review of twenty-eight trials (15) found that OAT combined with psychosocial treatment was associated with higher rates of opioid abstinence than OAT alone, although treatment retention and other outcomes did not differ significantly. Another systematic review (16) found evidence of benefit from psychosocial interventions, particularly on secondary outcomes such as improved treatment attendance, improved adherence to psychiatric medications, and decreased alcohol use. These positive outcomes were not seen in all the studies reviewed.

Our perspective is that psychosocial treatment is an essential component of OAT, and vice versa. Psychosocial treatment is needed to assist patients to make changes to their psychiatric and social status, while patients need OAT in order to remain engaged in and benefit from psychosocial treatment. Without OAT, most will drop out of psychosocial treatment, because they cannot tolerate the distraction and discomfort of opioid withdrawal symptoms and cravings.

OAT tapering. Most patients with OUD will relapse after being tapered off OAT (17). Tapering off OAT is associated with a marked increase in risk of overdose death, particularly in the first few weeks after cessation. In a systematic review and meta-analysis of six cohort studies on methadone and mortality (1), the mortality rate while on methadone treatment was 5.8 per 1000 patient years, increasing to 32.1/1000 patient years in the first four weeks off methadone treatment, and stabilizing at 13.5/1000 patient years after the first four weeks.

The ideal candidate for tapering would be someone who has "recovery capital"(17) : no recent use of opioids or other drugs, strong social support, productive daily activities, and healthy coping strategies. A review of 23 clinical studies (18) found that tapering is more likely to be successful if done very slowly on an outpatient basis, and when the dose is increased if the patient relapses or experiences intense cravings or withdrawal symptoms. A retrospective cohort study found that very slow tapers – less than 5% of the total dose per week – are associated with higher success rates than faster tapers (19).

Provision of OAT in residential programs

As far as we are aware, a full survey of services provided at residential programs in Ontario has not been conducted; the inability to easily and accurately track which treatment centres offer opioid agonist therapy is a significant concern. Available evidence suggests that many Ontario residential programs do not provide OAT. In a retrospective cohort study of 1910 patients with opioid use disorder who attended an Ontario residential treatment program, only 52.8% of the cohort attended a program which permitted OAT (20). This study relied on publicly available data from 2016, and we understand that since this study was conducted, a number of programs have begun to offer OAT. Ontario residential programs are not alone in failing to consistently provide OAT. An American cross-sectional study found that of 2,863 residential programs offering treatment of OUD, only 953 (33%) offered buprenorphine, and only 60 (2%) offered methadone (21).

Furthermore, programs which allow patients to *continue* taking OAT do not necessarily offer OAT *initiation* for patients who would benefit from OAT and are willing to try it. In a simulated patient study (22), a researcher posing as a 27 year old heroin user contacted 368 residential treatment programs in the US, and asked for treatment with buprenorphine/naloxone. Of the 368 programs contacted, only 107 (29%) offered maintenance treatment with buprenorphine, while 114 (31%) used buprenorphine for detox only, and 143 (39%) did not use buprenorphine at all or were unclear about their policy. The study also found that 78 programs (21%) of the 368 programs contacted actively discouraged the simulated patient from trying buprenorphine. Accreditation, state licensure and non-profit v. for-profit status were not relevant to whether OAT was offered in residential programs.

Recommendations

1. **Residential programs should allow and encourage patients on OAT to continue on OAT during their residential stay. Clients should be able to access their OAT prescriber for virtual appointments when required. If the residential treatment facility does not have a designated OAT provider, the outpatient OAT provider should work with the residential staff to continue OAT during a patient's residential stay. In most cases, the buprenorphine or methadone should be dispensed daily under observation, either at the residential program or at a nearby pharmacy. (Depot forms of buprenorphine should be acceptable and available for program participants).**

The best scientific evidence clearly supports the use of OAT as first line treatment for OUD. Patients who are not on OAT have higher relapse rates, higher death rates, lower treatment retention rates, and higher rates of crime and unemployment. The authors of this guideline recognize that programs which don't provide OAT usually do so because of lack of resources and training; nonetheless, every effort must be made to redress the lack of resources, because published guidelines and standards have consistently stated OAT is an essential medical service. For example, the Health Quality Ontario Opioid Use Disorder Standard (23) states, "If a person receiving agonist therapy enters an inpatient facility (e.g., a hospital or residential addiction treatment program) or a correctional facility, their opioid agonist therapy should be continued without disruption" (p.24). Several news stories [1,2,3] have described clients who have overdosed after being forced to taper as a condition of admission to a treatment program.

Feedback from AMHO's Residential Treatment Community of Practice (CoP) indicates that the majority of programs already admit clients on OAT. Where programs are not facilitating OAT, it is due in part to lack of staffing and resources, but it may also reflect long-standing negative beliefs about OAT. We recognize that most of the research on attitudes towards OAT among residential staff was conducted in the US, and the extent to which this research applies to Canadian residential settings requires additional research and clarification. Nevertheless, feedback META:PHI has received from addiction medicine providers referring patients to some residential treatment centres, suggest that it may be helpful for Canadian programs to be aware of, and if relevant to their setting, address the negative attitudes that have been identified in the American studies. Attitudes that might dissuade patients from accepting OAT were identified in a qualitative study (24) conducted with administrative and clinical leads at 25 outpatient and residential programs in Pennsylvania. In semi-structured interviews, the respondents endorsed several negative attitudes and non-evidenced based beliefs about OAT. These beliefs are addressed below:

a) *"OAT is not true recovery, but merely "substituting one drug for another"*. OAT and illicit opioids have opposite effects. In OAT, long-acting opioid medications are dispensed in a highly regulated manner, so the patient takes the same, safe dose every day. As well, long-acting opioids such as methadone and buprenorphine prevent escalating opioid tolerance, overdose, intoxication and withdrawal caused by unregulated self-injection of potent, short acting opioids.

b) *"Opioid agonist medications are easily sold and diverted, contributing to drug culture among clients and undermining their recovery."* Methadone and buprenorphine are rarely sold or diverted in residential programs, because they are dispensed under the supervision of a staff member, or at a local pharmacy, which makes diversion very difficult.

c) *"Patients on OAT cannot fully participate in group counselling and other program activities because the medication 'distracts them' or causes them to 'nod off'*. Patients on a stable dose of an OAT medication will be more focused, and better able to participate in group activities than a patient distracted by the physical effects of opioid withdrawal.

d) *"Patients on OAT can be 'triggering to patients who are trying to be drug-free'."* Residential programs that provide OAT do not report that these medications are triggering to other patients. And if this were to occur, it may mean that patients with OUD who are not being treated with opioid agonist medications have unacknowledged opioid cravings or withdrawal that need to be addressed while in treatment.

[1] https://www.medpagetoday.com/special-reports/exclusives/88870
[2] https://www.tvo.org/article/why-residential-treatment-often-fails-ontarians-with-addictions
[3] https://www.wbur.org/commonhealth/2020/08/25/addiction-treatment-buprenorphine-research

e) *"Patients who have been refused admission at our program are free to attend another program that does provide OAT."* This is not entirely true when one considers that a patient's choice is limited by cost, distance, and long waiting lists. Further, patients may be required to attend treatment as a condition of parole or due to family pressure. If the treatment centres available to a patient require them to come off OAT to gain admission, then the patient may adopt the false belief that tapering before treatment is an acceptable approach, when the scientific evidence clearly contradicts this.

f) As noted above, we recognize that, in all likelihood, only a minority of residential staff hold these attitudes. Given the high mortality rate of untreated opiate use disorders, even a small minority of programs or staff can cause a significant negative impact, leading some patients and their families to reject OAT initiation, or seek to taper off OAT before or during their treatment program resulting in higher rates of relapse, overdose, mortality and early discharge. Additional training on OAT would facilitate a better understanding of its vital role in treating opiate use disorder, and the way in which OAT supports and enhances the integration of the psychosocial interventions provided by residential centres.

2. Clients with an active opioid use disorder who are not on OAT at the time of admission should see an OAT prescriber as soon as possible after admission, to discuss the benefits and risks of OAT. The prescriber should initiate methadone or buprenorphine treatment during the residential stay if OAT is indicated and if the patient is willing.

The authors of this standard recognize the challenges treatment facilities face in finding OAT prescribers able to provide support to patients attending residential treatment and the expectation is that both residential treatment services and outpatient treatment providers effectively collaborate to support patients with OUD. While recognizing that it may not always be possible to have an OAT provider see a client during the treatment program, most communities have OAT providers and RAAM clinics who are accepting new patients. Residential treatment centres can establish relationships with local OAT providers to support clients with opiate use disorder who are not on OAT.

Ideally, clients should be stabilized on OAT prior to attending residential treatment, but those who are not on OAT should be offered buprenorphine or methadone, if indicated, during their residential stay. If the client declines buprenorphine or methadone, they should meet with the NP or MD again if they report cravings or withdrawal symptoms, or if they have a slip or lapse. They should all be given information on outpatient OAT clinics on discharge regardless of their stated goals.

It is not sufficient to defer initiation of OAT to a community OAT clinic after the patient has been discharged. Discharged patients often have cravings and subacute withdrawal symptoms which could cause them to relapse. If they relapse to their usual opioid dose, they are at high risk for overdose due to loss of respiratory tolerance. Therefore, it is far safer to introduce OAT while the patient is still in residential treatment.

If a client who is not on OAT has relapsed on opioids during residential treatment and is being discharged from the facility, and if a prescriber is not immediately available, the client should be counselled on the following options for initiating OAT:

a) Immediate attendance at a local ED or WMS, if they are known to initiate buprenorphine or methadone on site.

b) Same or next day follow up at a RAAM clinic or community OAT provider. Clients should be provided with a list of available RAAM clinics and information on community OAT providers.

c) A virtual follow up appointment with an OAT prescriber at the earliest possible appointment time.

3. **Patients who are on Opioid Agonist Therapy with Slow Release Oral Morphine (alone or in combination with methadone) should be permitted to take these medications under observation during their residential stay.**

Controlled trials suggest that SROM is of comparable effectiveness to methadone in retaining patients in treatment and reducing opioid use (25). SROM can also be combined with methadone to relieve withdrawal symptoms and retain patients in treatment (26).

Unlike methadone and buprenorphine, SROM has not yet been shown to reduce overdose, deaths and hospitalization For this reason, SROM should be reserved as a third line agent, for patients who have not achieved their treatment goals or have had serious adverse side effects from methadone and buprenorphine.

We understand that there has been some reluctance among residential programs and OAT providers to prescribe SROM, given its lack of evidence compared to methadone and buprenorphine, and its potential for diversion and injection. These are legitimate concerns, but nevertheless we encourage residential programs to accept patients on SROM. Refusing entry will deny patients the benefits of residential treatment, and this could have serious consequences.

The risks of diversion and injection can be minimized by having patients take all SROM doses under observation. Ideally, SROM capsules should be opened by the pharmacist and the beads sprinkled on apple sauce or into a dry cup. For patients on both SROM and methadone, the SROM capsules should be swallowed prior to methadone dosing so that the methadone can wash the beads down.

In some circumstances, an OAT prescriber and residential program may collaboratively decide that SROM capsules can be delivered to the residential treatment centre, where staff would witness the daily ingestion of whole SROM capsules. Such circumstances would be exceptions and might, for example, apply to a client who is unable to walk to the pharmacy due to injury, illness or disability, *and* where the OAT prescriber and residential treatment centres deems this safe and appropriate.

4. **Residential programs should strongly discourage patients from tapering off OAT and the discussion held with the patient should be clearly documented. Where a client's request to come off OAT can reasonably be expected to interfere with the client's participation in the program, then a treatment centre can decline to taper the patient during the residential treatment period and ask the client to pursue their request to come off OAT after discharge.**

As discussed above (section on OAT tapering), it is simply not safe to taper patients in a residential setting. Rapid tapers will compromise the patient's ability to participate in psychosocial interventions, because the patient is in withdrawal and unable to concentrate. Rapid tapers almost always fail, putting the patient at risk for relapse, early discharge and death.

If the patient is on a low dose of buprenorphine and insists on discontinuing, it should be with the understanding that the taper should be held or reversed if the patient experiences strong cravings or withdrawal symptoms.

Sometimes residential clients express a strong desire to taper off high doses of methadone or buprenorphine, due to family pressure or to unrealistic expectations of the effectiveness of psychosocial treatment without OAT. The residential prescriber should discourage this request and have the patient discuss this at length with an OAT-affirming counsellor. The patient should be encouraged to bring this request to their outpatient OAT prescriber, reinforcing the importance of not leaving residential treatment in a completely opioid-abstinent state.

The prescriber can help such patients understand the need for recovery capital, sustained on an outpatient basis; the CAMH Recovery Capital Checklist (27) can help patients understand this concept.

The residential centre's OAT prescriber may agree to lower the dose of OAT if clinically indicated and if doing so would not destabilize the client. It is acceptable within this recommendation to taper down a methadone dose if the patient is experiencing side effects such as sedation, or if the prescriber is doing a micro-induction onto buprenorphine.

5. **Residential treatment centres should ensure that staff have an appropriate understanding about the use of OAT as a first line treatment for opioid use disorder. During the comprehensive assessment with clients, residential staff must give an evidence-based view of OAT, including its benefits, risks, and effectiveness relative to non-OAT treatment, while also respecting client choice, readiness and history of OAT treatment. Staff should refer patients to their OAT prescriber to clarify decision-making regarding initiation, continuation or tapering of OAT. Program staff should avoid any language that stigmatizes the use of OAT and should not try to dissuade a client from trying OAT, nor should they encourage a client already on OAT to discontinue it. The language and culture of acceptance of medication-assisted treatment is an essential component of de-stigmatization in recovery-oriented settings.**

Opioid agonist treatment is the first line treatment for opioid use disorder, and its benefits have been confirmed by rigorous research. Clients who decline OAT are unequivocally at greater risk of overdose, death and other harms. Thus, residential staff have a legal, moral and professional responsibility to provide accurate and complete information about OAT to their clients. Staff should utilize statements about OAT that are consistent with the evidence about OAT. Examples of statements that should be avoided include: 'OAT is just substituting one drug for another' or 'OAT is not true recovery'. Such statements are inaccurate and misleading, and will discourage clients from trying OAT (see Recommendation 1).

6. **Residential programs do and should continue to arrange for transition to an outpatient OAT program for patients who have been started on OAT during their residential stay. After-care options should include both pharmacotherapy and psychosocial follow-up. Patients who were admitted to the program with an active opioid use disorder and who are not on OAT should be given information on community OAT services regardless of their course in the program.**

Prior to discharge, the program should arrange follow-up at a RAAM clinic or other out-patient OAT service. The residential program's prescriber should ensure that the patient's prescription will last until the scheduled outpatient appointment. Patients with an active opioid use disorder who are not on OAT should be advised of the importance of starting OAT should they relapse after discharge, and they should be given information on community OAT services. Discharge planning should also include arranging outpatient treatment, connecting with peer support groups, and safe housing. They should also be instructed on overdose prevention strategies, and given a take-home naloxone kit (see below).

7. **Residential programs should implement measures to reduce the risk of opioid overdose, including take-home naloxone, counselling on overdose prevention, and information on addiction treatment providers and harm reduction services.**

Ontario is experiencing an unprecedented public health crisis due to opioid overdose deaths. Residential programs have a responsibility to advise all at-risk patients on overdose prevention.

a) Clients with OUD should be given a take home naloxone kit and instructed in its use. If this is not possible clients should be advised to attend a pharmacy or harm reduction service where they can pick up a free naloxone kit.

b) Clients should be counselled on safe drug use strategies in the event of relapse. For example, never use alone; take a "test dose" first; don't combine opioids with benzodiazepines or alcohol.

c) Clients who have discontinued their opioids while in the residential program should be advised that they have lost their tolerance, and they could overdose if they use their previous opioid dose.

d) For clients who have discontinued prescribed opioids (non-OAT or OAT), the program should (with the client's permission) inform the prescribing physician that the opioid has been discontinued, so that if the physician chooses to prescribe it again, they will prescribe it at a much lower dose.

e) All patients who use any illicitly-sourced street drugs should be warned about the risks of fentanyl. Clients who use cocaine, crystal meth or illicitly manufactured opioid tablets should be warned that fentanyl is often added to these drugs without the user's knowledge, and could lead to unintended overdose and death. These clients should also be given a naloxone kit and instructions on its use.

f) Clients should be given contact information on local harm reduction services, including supervised consumption services and drug testing services.

8. **Residential programs should have processes and policies in place that ensure that OAT medications are witnessed /observed and recorded in settings where this service is available. The process by which each residential treatment centre will accomplish witnessed / observed dosing of OAT will vary and is subject to the resources available to each treatment centre. There is no requirement that residential treatment centres store OAT or witness OAT dosing onsite and in many cases it may be best for clients to attend a nearby pharmacy on a daily basis. In order to accommodate patients requiring OAT, residential centres should partner with regulated health care professionals with expertise in the use of OAT, ie pharmacists, nurses, nurse practitioners or physicians.**

Most addiction treatment centres are not regulated health care facilities and may be considered congregate living facilities with counsellors/therapists providing 24/7 supervision and without onsite pharmacists or 24/7 nursing. The process by which residential treatment centres should support OAT will vary depending on the physical layout of the treatment centre and the availability of onsite counsellors, nurses, or pharmacists. The majority of residential treatment centres do not have the necessary funding and staffing to oversee management, tracking, and dispensing of medications to patients as would be the case in a nursing home or hospital. In these circumstances, patients at residential treatment centres are generally responsible for self-monitoring and self-administering their own medication regimens.

However, in some cases, staff may require that patients be observed when taking some or all of their medications. Medications that may require observation include OAT, opioid analgesics, benzodiazepines, and other medications with abuse liability. "Observation" by non-medical staff is distinct from "dispensing" or “administering” of medications to a patient by a nurse or pharmacist, which requires a higher level of clinical knowledge respecting the medication being dispensed. The purpose of having staff "observe" patients self-administer some classes of medications is to optimize patient compliance and decrease the risk of diversion to the extent possible. With this in mind, the following principles should be considered in drafting or revising a policy or process supporting access to OAT medications.

a) OAT dosing should always be done under observation by staff.

b) Treatment centres may have clients attend a local pharmacy on a daily basis to obtain their OAT. For many treatment centres this will be the optimal solution for the safe administration of OAT.

c) If for varied reasons it is not possible to have clients attend a local pharmacy daily, for example, because daily transportation to and from a pharmacy is not practical or feasible, then it is acceptable to have the pharmacy deliver the OAT to the treatment centre. Most treatment centres should consider receiving and storing OAT doses for the least number of days necessary. For many centres, daily delivery by the pharmacy is preferred whenever possible. In some cases, it may be necessary for the pharmacy to deliver OAT for the weekend or over holidays when daily delivery is not possible. Treatment centres with greater OAT experience and appropriate resources may elect to store and provide OAT for longer periods of time.

d) All OAT should be securely stored by the treatment centre until the daily dose is given to a patient. OAT and other controlled substances should be stored in a locked container or safe.

e) When a nurse or pharmacist is not available to observe a patient take their daily OAT dose, then counsellors or therapists may provide this service for clients on buprenorphine.

f) Methadone has a higher risk of toxicity than buprenorphine, so treatment centres should carefully consider the risks of having non-regulated health care professionals observe their clients taking their daily dose of methadone. The authors of these guidelines recommend that this only be done if there are no alternative options and after a considered review with the regulated health care professionals

working with the treatment centres, as well as with the methadone prescriber. The authors encourage treatment centres to consult those facilities that have already implemented OAT into their programs.

g) Each OAT dose sent from the pharmacy to a treatment centre should include the patient's name, date of birth and date of the dose to be taken. Potential name alerts should be identified and flagged whenever more than one patient has a similar first or surname.

h) The authors recommend that if a pharmacist or nurse is not available to observe the patient when they take the OAT medication, then two staff members should administer the dose. Both staff members should confirm that the correct medication is given to the correct patient, and both should observe the patient taking the medication. Each treatment centre should develop its own documentation form that requires two staff to sign off on observation of OAT dosing. It is acceptable to have one staff person observe a client self-administering their OAT dose, when two staff are not available to do so. Please see attached at end of document an example of the form used by Renascent which also requires that the patient initial upon receipt of the dose.

9. **Residential programs should offer OAT to pregnant patients with OUD as soon as possible, in consultation with providers experienced in prenatal care and addiction medicine.** Ideally, ongoing OAT treatment would be provided by a comprehensive treatment center which offers counselling and social services as well as addiction and prenatal care. **It is critical that OAT be continued without interruption during the patient's pregnancy and after delivery.**

Opioid agonist treatment during pregnancy is associated with marked improvements in both maternal and neonatal outcomes (28, 29). It should be offered immediately to pregnant patients with opioid use disorder, as untreated opioid withdrawal carries a risk of miscarriage or premature delivery. When possible, treatment of pregnant patients should be done in consultation with a provider experienced in both prenatal and obstetrical care and in addiction medicine. Cessation of OAT is associated with relapse to opioid use and child apprehension and other adverse outcomes.

10. **After conducting a comprehensive assessment, residential programs should offer to connect youth with OUD to an OAT prescriber.**

Controlled trials have found that buprenorphine is more effective than psychosocial treatment alone in reducing opioid use among adolescents (30). Requiring youth to complete a trial of psychosocial treatment *before* offering OAT puts them at risk for overdose and other harms. OAT should be offered urgently for youth who are using opioids in a high-risk manner, such as youth who use fentanyl, who report a previous opioid overdose, who inject opioids, and/or who combine opioids with alcohol or high doses of benzodiazepines. Youth who decline OAT should be advised of the importance of starting OAT should they relapse after discharge, and they should be given information on community OAT services. Naloxone kits and harm reduction counselling and training should be essential components of youth residential treatment programs.

11. **Patients on Injectable Opioid Agonist Therapy (iOAT) or Safe Opioid Supply (SOS), should be converted to Slow Release Oral Morphine (SROM) or Methadone before admission to a residential treatment program.**

Injectable OAT refers to the supervised use of injectable hydromorphone or diacetylmorphine in a health care setting. SOS refers to the provision of high doses of oral immediate release hydromorphone tablets, often as take-home doses without supervision. It is beyond the scope of these recommendations to discuss the effectiveness and safety of these two harm reduction interventions.

The conversion to SROM should be done by the iOAT or SOS prescriber prior to admission. The BCCSU guidance document on iOAT therapy (24) outlines a protocol for converting from iOAT to SROM. The need to convert iOAT and SOS to SROM is based on the following rationale: Residential treatment centres are therapeutic communities where psychosocial interventions are focused on the goal of abstinence from high-risk substance use and behaviours. It is a generally accepted principle that clients should be matched with psychosocial interventions appropriate to their current stage of recovery and stage of change. Patients receiving SOS and iOAT tend to have different treatment goals and needs than those receiving OAT. For patients engaging in the therapy frameworks of residential treatment programs, patients receiving iOAT or SOS as harm reduction are unlikely to benefit while remaining on short-acting opioids and this degree of clinical instability may be detrimental to other participants (31). Furthermore, at this point there is insufficient evidence on the safety and effectiveness of SOS to support its use in residential programs.

In addition, residential treatment centres lack the staffing and training needed to safely provide iOAT or SOS. Residential staff are not registered healthcare professionals and supervising an intravenous opioid injection, as is required in iOAT, is outside their scope of practice. As for SOS, unsupervised ingestion or injection of hydromorphone tablets could result in overdose. Furthermore, diversion of hydromorphone tablets threatens the stability and recovery potential for other clients, and unsupervised injection can result in other medical harms than overdose, including serious bacterial infections.

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Suboxone Dosing Form

Patient Name:_____ DOB _____ File# _____

Two staff must check name on the suboxone prescription bottle prior to issuing dose to the patient. Two staff will witness and Initial

Suboxone dose given to client on:

Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time:	Staff Initials	Client Initial
Date: _____	Time: _____	Staff Initials _____	Client Initial

Patient Signature:_____ Patient Initial_____