META:PHI MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION | PARTNERS IN HEALTH INTEGRATION

NEWSLETTER

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PROGRAM INNOVATION

Revolutionizing Opioid Treatment: Auto Micro-Induction of Buprenorphine XL

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Amidst Canada's tightening grip of the opioid crisis, Dr. Ken Lee and Nursing Lead Adam McInnis of London's Rapid Access Addiction Medicine (RAAM) Clinic are championing a ground-breaking solution. Their innovative approach introduces the "auto micro-induction" for monthly injections of Buprenorphine XL (BUP XL), offering a beacon of hope in the battle against opioid addiction. Notably, the addictions team in Timmins led by Dr. Louisa Marion-Bellemare and Dr. Julie Samson have also seen success with this induction process.

Traditional methods of initiating BUP XL therapy often involve a sublingual dose regimen, which prove challenging for many patients to complete. Recognizing the limitations of 'take-home' inductions, the London RAAM team sought a more client-centred and efficient approach. The auto micro-induction protocol conducted in an outpatient setting offers a swift alternative, significantly reducing the time and effort required of traditional inductions. This protocol targets clients who are not in enough active withdrawal to proceed with a macro-dosing of buprenorphine in clinic, are familiar with buprenorphine (no previous adverse events), and are determined to start treatment promptly.

Proceeding directly to BUP XL (without oral buprenorphine), followed by routine monitoring is proving to be a successful process. This is especially so for many clients who approach the team during 'fleeting moments of change' - they are adamant they want treatment that day. After being advised of the potential risk of precipitated withdrawal, many elect for the potentially life-saving treatment then and there. In addition, it has been observed that some clients who had dropped off of treatment as they felt well after receiving 3-4 injections of BUP-XL, returned asking for BUP-XL provided they didn't have to return the next day.

With more than 35 cases completed provincially, the success of the auto micro-induction approach in patients with complex substance use histories is evident. Bypassing the lengthy sublingual dosing period, patients swiftly transition to BUP XL injections, enhancing treatment outcomes and patient engagement. Thus far, clients have reported no issues with precipitated withdrawal.

In conclusion, the auto micro-induction protocol represents a significant advancement in Opioid Use Disorder (OUD) treatment, offering hope to individuals living amidst the opioid crisis. By revolutionizing the induction process and emphasizing timely treatment, this innovative approach holds promise in transforming opioid treatment. As the London RAAM team continues to pioneer advancements in addiction medicine, the path to recovery grows brighter for individuals across Canada grappling with opioid addiction.

FACES FROM THE FIELD

Suzanne Latreille
Peer Educator, Ottawa Public Health
META:PHI Community Consultant
Person with Lived Experience

My story is a little about methadone and a lot about relationship-building. About 16 years ago, I started going to a community health resource centre for harm reduction gear. I was also on Opioid Agonist Therapy (OAT). It was here that I met a student social worker who became an employee at the centre. The methadone I was taking was crucial, but the relationship built with this social worker was where my recovery really began. Many people in society might feel judged for many reasons, but for drug-users, judgement and stigma are constant. "My little Melissa", as I called her, never judged me, or anyone. When a drop-in service opened at the health centre, Melissa wanted to have a peer worker with her. We didn't have paid peer workers then, but a person could volunteer and be an "inspiration". 'Sue', she said, 'come in on Friday morning.' And that's how it began.

Melissa encouraged me to attend the Ontario Addiction Treatment Centre (OATC) clinic close to the resource centre. She knew when a physician was going to be onsite and suggested I go then. I was already attending this clinic, but this was the first time there was going to be a doctor physically there. I used to have to take a bus an hour each way every day to the clinic just to see a Toronto doctor on Skype. This made such a difference to have a physician in person to have a real relationship with. And Melissa gave me such good, encouraging advice: I told her I was having trouble staying away from drugs, because I used to walk my dog in an area where I used to get drugs, making it difficult to avoid temptation. She said, 'No Sue, you just have to learn how to walk in a different direction.' Just really practical advice like that.

When a Peer Educator job at Ottawa Public Health came up, I never would have thought of applying for it had it not been for Melissa. How could I do it - I didn't know what it was like to live on the streets, I didn't know about the drug use outside downtown – that wasn't my lifestyle. I was volunteering and it was working for me. The thought of applying for that job was scary – how could I walk in there with all those nurses and see them looking at me? I didn't really understand what stigma was at that time – I just knew how I felt when people looked at me with judgment.

When I went for the first interview at OPH, I was so scared that everyone was going to judge me. Then I had a second interview, and then a third. Being interviewed 3 times, by three people (not just one), is REALLY intimidating. I would never have succeeded in getting the job on my own. I know for a fact that I wouldn't be where I am today without Melissa's encouragement and wholehearted support.

I was so devastated when Melissa left the field. She finally got her 'for-real' job as a professor at Algonquin College, which is what she always wanted. We keep in touch, and I go into the college twice a year to speak to her classes. My in-person OATC doctor who I also relied on also left the clinic, to my great disappointment. I needed those relationships so much. But Melissa told me that all I needed to do was remember everything that I learned and keep it with me. And that's how I got through.

While the methadone has made a huge difference in my life, my recovery journey would not have been possible without these two relationships. If I were to offer advice to anyone, it would be to say that when someone needs your help, you need to think about who they are as a person first. That's the only way to build trust.

In the Media

Debates across Canada re Open Drug Use Globe and Mail

PERSPECTIVES

Opioid Stewardship Program in Saskatchewan

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Canada is the second highest consumer of prescription opioids worldwide (trailing only the United States) with 12% of our population - 4.8 million people - utilizing opioids. Studies show that approximately 4% of those individuals receiving an opioid prescription for chronic pain will initiate injection drug use within the next five years, which is 8x higher than opioid-naïve population. [1] One of the ways in which we can reduce opioid-related harms, including opioid use disorder (OUD) and overdose, is through opioid stewardship. Opioid stewardship programs (OSPs) are aimed at optimizing pain management while minimizing opioid-related harms.[2] In addition to general practitioners and dentists, many specialists including surgeons, internal medicine and ER physicians have the authority to prescribe opioids. As such, an effective OSP must consist not only of individual practitioners with a drive to "do better", but also a widespread coordinated effort to promote true stewardship principles through clinician, patient, and public education; system-wide policies; and quality improvement and research.

As a pharmacist with the Saskatchewan Health Authority's OSP, I am part of only a few formalized programs in the country. Our OSP is unique in that we are a multi-disciplinary team that includes nurse practitioners, pharmacists, social workers, and physicians. Supported by research scientists, data analysts, and program specialists, the program is comprised of two clinical teams situated in Regina and Saskatoon:

- Our Regina team is dedicated to supporting the needs of inpatients. By utilizing opioid reports from the pharmacy data system, our clinical team triages patients with multiple opioid-related risk factors, high MEDs, and/or active OUD; we then review patients and provide recommendations and advice to the healthcare team as appropriate. (Note: Regina inpatient facilities do not offer mental health and addiction, social work, addiction medicine, chronic pain, or acute pain services; therefore, all patients that would typically require these services are managed by attending physician/MRP, and our OSP clinical team is frequently consulted to assist with treatment.)
- Our team in Saskatoon provides a comprehensive outpatient chronic pain service, including patient support groups, clinician mentorship, and Project ECHO series for chronic pain. Our referral process ensures specialized care for chronic pain patients.

The OSP's active participation in local, provincial, and national organizational initiatives includes developing and promoting evidence-based policies, pre-printed order sets, and collaborating with key stakeholders. This means we can effectively implement practice changes on a larger scale than if we represented a single healthcare discipline. Our clinical and support teams prioritize research and quality improvement efforts, consistently monitoring key quality metrics to identify areas for improvement and assess the impact of our OSP interventions.

Returning to the current landscape of fatal opioid toxicities in Canada, I believe that opioid stewardship can begin preventing OUD through promotion of appropriate prescribing of non-pharmacological and pharmacological therapies for pain management, while concurrently enhancing accessibility to treatment and harm mitigation strategies for individuals living with OUD. I do not believe it to be a mere coincidence that the nations with the highest consumption of prescription opioids (per capita) are similarly the nations with the highest mortality rates related to opioids.

[1] Wilton J, Abdia Y, Chong M, Karim ME, Wong S, MacInnes A, Balshaw R, Zhao B, Gomes T, Yu A, Alvarez M, Dart RC, Krajden M, Buxton JA, Janjua NZ, Purssell R. Prescription opioid treatment for non-cancer pain and initiation of injection drug use: large retrospective cohort study. BMJ. 2021 Nov 18;375:e066965. doi: 10.1136/bmj-2021-066965
[2] Li Wang, Patrick J. Hong, Wenjun Jiang, Yasir Rehman, Brian Y. Hong, Rachel J. Couban, Chunming Wang, Corey J. Hayes, David N. Juurlink and Jason W. Busse. Predictors of fatal and nonfatal overdose after prescription of opioids for chronic pain: a systematic review and meta-analysis of observational studies. CMAJ October 23, 2023 195 (41) E1399-E1411; doi: https://doi.org/10.1503/cmaj.230459

Thoughts from a Semi-Retired Addiction Doctor

Treatment and Harm Reduction: A false – and Harmful – Dichotomy

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Medical Director, META:PHI

Harm reduction interventions reduce harm, even in people who continue to use substances. By that definition, opioid agonist treatment is harm reduction. Patients can, and do, continue to use opioids and other illicit substances while on OAT. OAT lowers the risk of overdose by building tolerance to the opioid-induced respiratory suppression, and by relieving withdrawal symptoms and cravings – thereby reducing opioid use. This is almost certainly how safer supply medications work as well – as opioids, they reduce withdrawal symptoms and cravings, and build tolerance.

People are not in fixed, binary states of motivation, as in "I want to continue using" versus "I want to abstain". Their thoughts, motivations and intentions are much more complex and variable than that. The person who is using daily may want OAT when they have no money for drugs or when they want to go home to see their family. The person who is abstinent while on OAT may have a slip or relapse when they meet an old friend or when they encounter a difficult situation.

That is why harm reduction and treatment services should be viewed as part of a single, integrated continuum. People who attend a Consumption and Treatment Service should have access to OAT, on site and same day whenever possible. OAT programs should routinely dispense take-home naloxone kits and inform patients of CTS and other harm reduction services. Safer supply programs should prescribe optimal doses of methadone, buprenorphine and slow release oral morphine, along with hydromorphone.

Unfortunately, there's still a split between treatment services and harm reduction services. An Australian study [1] found that only a minority of patients on OAT were given a take-home naloxone kit. I know of safer supply programs telling patients who want methadone to attend a separate methadone clinic, although safer supply programs appear more willing to prescribe methadone than they used to be.
OAT providers need to continue to pilot and evaluate innovative OAT protocols. For example, one provider in BC starts methadone at 80 mg in patients who are heavy fentanyl users. This is a radical departure from current protocols, but maybe it's safe in patients with an astronomically high opioid tolerance, and maybe the high dose will be more effective at retaining patients in treatment.
There remain major points of contention between the treatment and harm reduction fields. One controversy concerns take-home doses of hydromorphone and other opioids. This controversy can be addressed if treatment and harm reduction camps can move past talking points and ideology, and work together. This would mean objectively reviewing the evidence, sharing our clinical experiences, and coming up with common approaches. After all, we are working with the same group of patients, and our interventions complement each other.

Conway A, Valerio H, Peacock A, Degenhardt L, et al. Non-fatal opioid overdose, naloxone access, and naloxone training among people who recently used opioids or received opioid agonist treatment in Australia: The ETHOS Engage study. Int J Drug Policy. 2021 Oct;96:103421. doi: 10.1016/j.drugpo.2021.103421. Epub 2021 Aug 25. PMID: 34452808

EVENTS

2024 Webinar Series - Session #2
Considerations in the Care of People Who Use Stimulants
Tanya Hauck, Stephanie Rochon
Wed March 20, 7-8:30 pm Register HERE

RAAM Monthly Videoconference Dialogue Series
Follow-up to Feb. 20 webinar 'Treating Tobacco Use Disorder '
Wednesday March 6, 12:00-12:45 pm

Addiction NP Videoconference Discussion
Wed March 27, 12-1 pm
To join any of these events contact laurie.smith@wchospital.ca