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

NEWSLETTER

PROGRAM INNOVATION

Inpatient Addiction Consult Service

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Sunnybrook HSC, Toronto

At Sunnybrook HSC we became acutely and increasingly aware that an inpatient Addiction Consult Service (ACS) was necessary because many patients presenting to the hospital had undiagnosed substance use disorder. As a result, there were missed opportunities to start patients onto appropriate anti craving medications, specifically Opioid Agonist Therapy (OAT) for Substance Use Disorder (SUD) patients.

When the new ACS was initiated in 2020, one of the biggest challenges (in addition to informing departments of our existence) lay in changing the mindset of staff toward SUD patients. The departments we targeted for outreach were GIM, orthopedics, trauma, burn unit, and psychiatry. Over time the number of consults increased, and the attitude on the wards changed from “Why are you here?” to “You’re from addictions, thanks for coming!”.

As the service evolved, we found that many patients admitted for medical, surgical or psychiatric problems had an SUD. Prior to the establishment of the ACS, most if not all these patients were discharged without intervention or appropriate follow up.

Many patients had complex long standing SUD with polysubstance abuse and significant comorbid primary mental health disorders requiring psychiatry consultation. Our ACS services include: identifying the presence or absence of SUD, assisting with acute withdrawal management, suggesting anti-craving medication, working with Acute Pain Service, and, upon discharge, referring to RAAM clinics, OAT clinics, mental health professionals, and/or primary care providers.

In order to thrive, services have been expanded to include post-grad learners in Psychiatry (PGY 1,4) and electives for family medicine residents (PGY 1,2). In addition to RAAM clinic attendance, the residents do consultations on the wards. These consultations deal with more complex patients that those seen in RAAM clinic, and expand the scope of clinical rotations by providing the learners with a more comprehensive exposure to the comorbid issues that are inherent in SUD patients. The residents are supported by two MDs and an NP, as well as the RAAM clinic peer support worker and social worker in follow-up.

Access to multi-disciplinary support in post discharge management is a key element necessary when establishing an inpatient service. An ACS should be included in the Addiction Service strategy in all hospitals. It enables early identification and treatment to patients with SUD and thus improves outcomes.

FACES FROM THE FIELD

Chris Cull
Peer Support Specialist
Lakeridge Health, Oshawa

My path to becoming a Peer Support Specialist in the Emergency Department at Lakeridge Health Oshawa has been unique. The journey began with losing my father who took his own life after a battle with Huntington’s Disease. The pain and trauma from the experience led me down a path of an 8.5 year addiction to opioids, of which 5 years was spent on methadone. After having lost everything that meant anything to me, I hit my bottom. I decided I was going to do whatever it took to climb out of where I was.

I created my own system to figure out my path where I dreamt as big as possible: I decided to ride a bicycle across Canada and film a documentary on the opioid crisis. Not having ridden a bicycle in 8 years, nor having any experience in film, journalism, public speaking, or public relations - not to mention being on a high dose of methadone - I had my work cut out for me. But I succeeded. The ride took me from Victoria, B.C. to St. John’s, Newfoundland, going town to town, coast to coast documenting the impacts of the opioid crisis across Canada. The resulting film also documents my personal journey with opioid addiction, as well as pursuing all of my wildest dreams, like teeing golf balls off the mountains in B.C., and skydiving over Montreal.

This experience led to consulting work on mental health and addiction policy and strategy around the opioid crisis at all three levels of government. I became a motivational speaker, as well as a Peer Support Specialist at Lakeridge Health which is the very hospital I went to when I was at my worst. Knowing what it's like to navigate the complex health system, I simply try to be the person I wish I had been when I was a patient. Whether it’s through listening, motivational interviewing or referral to the best patient-suited community supports, I try to be a representative of the positive ideas and possibilities that can come from a visit to the Emergency Department. We all start somewhere, and I am honoured to be in a position to help others begin their journey to wellness.
http://www.Inspirebyexample.ca

Join the META:PHI listserv:
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CASE STUDY and PERSPECTIVE

Navigating Human Rights and Buprenorphine In Residential Treatment: A Case for Inclusivity in Addiction Services

Corinna Chung MD MPH CCFP (AM)
Family Physician, Thunder Bay

Owen, a homeless man in his late 20's had been a daily user of fentanyl and cocaine for many years. He had been on methadone and Kadian, but was transitioned to injectable buprenorphine (Sublocade) after being hospitalized with a leg infection. He found Sublocade preferable to methadone, especially as the pharmacy in the remote community where his parents lived did not dispense methadone. On a maintenance dose of 300 mg Sublocade, Owen decreased his drug use but still used intermittently. In October 2023, Owen was charged with possession and trafficking, and incarcerated. This was his first offence, and the Crown attorney was willing to release him into a supervised treatment program since his parents, being so far away, were unable to take him. The only program in Thunder Bay is Teen Challenge, a faith-based abstinence organization. While entry criteria differs among the Canada-wide chapters, this one stipulated that he had to discontinue Sublocade. After some discussion with the local group and head office, they conceded that he would be accepted into their program provided there was a plan to wean him off expeditiously in the first month of his placement. Owen was desperate to be released from jail and asked me, as his prescriber, to write a letter of support to the Crown in support of Teen Challenge. My reservations were ultimately for his risk of relapse should he decide to leave the program. Thunder Bay has the highest rate per capita of overdose deaths in Ontario. Teen Challenge did not provide any medical reason for discontinuing Owen's medication. He had already had several overdoses necessitating the used of Narcan, and his supportive family was justifiably concerned about stopping Sublocade since he had experienced the most stability with his health and drug use since starting it. This is a common concern when considering treatment programs which vary in the level of medical supervision and acceptance of OAT medication. As there are ethical and medical concerns about directing a high-risk patient on a stable dose of medication to a treatment program that is mandating discontinuation of any opiate substitution therapy, I reached out to the META:PHI community of practice for input. This thoughtful piece by Mark Weiss is a response to my listserv post:

Mark Weiss MD MCFP (AM)
Medical Director, Bellwood Health Services, Toronto

The Ontario Human Rights Code, a vital legal framework, safeguards individuals with disabilities in accessing various social services and facilities. This protection, when viewed through the lens of addiction as a form of disability, becomes particularly significant in ensuring equitable healthcare access. Instances where medical treatments like Sublocade or other forms of buprenorphine are denied, possibly due to moral or philosophical disagreements with standard evidence-based care, raise crucial human rights concerns. It is not clear if the Ontario Human Rights Commission would agree that addiction falls under its protection as a disability, and to my knowledge, the matter has never been adjudicated. Nonetheless, such denial can impede an individual's right to essential services in medical and treatment facilities, contributing to stigmatization and potential harm.

As I understand it, the Human Rights Code requires accommodation for medically-necessary interventions, ranging from wheelchairs to aids like service dogs, except where such accommodation imposes undue hardship. For instance, a treatment center that does not reasonably have a way to administer buprenorphine or another medical treatment might justifiably decline a patient. In addressing the rejection issue of OAT generally, or specifically buprenorphine, it is advisable to engage in a dialogue with the concerned organization. It is essential to understand whether the rejection stemmed from a lack of resources, such as qualified personnel to administer buprenorphine. Approaching this situation with curiosity and a focus on finding solutions is key.

One proactive strategy could be to offer a presentation to the organization, aiming to reshape their perspective and suggest feasible ways to manage buprenorphine injections. Additionally, consulting with or seeking advice from established institutions like London's Teen Challenge (which supports buprenorphine and Sublocade) could provide valuable insights. Should these approaches not yield results, another avenue is to seek a second medical opinion on the implications of ceasing buprenorphine before admission. In cases where legal advocacy is available and appropriate, a supporting letter from one and preferably two expert healthcare professionals can be an effective course of action.

In the letter, it's important to highlight several key points:

1. The life-saving role of buprenorphine.
2. Extensive evidence supporting buprenorphine as a primary treatment for Opioid Use Disorder (OUD).
3. Expert opinions against any precondition requiring cessation/tapering of buprenorphine due to potential harm to the client.
4. Concerns about the cessation of buprenorphine undermining the client's safety and well-being, potentially risking their life.
5. The unpredictability and individuality of tapering off buprenorphine, underscoring the need for ongoing assessment and shared decision-making on a case-by-case basis.
6. The non-interference of buprenorphine use with other treatment modalities like psychotherapy. If anything, buprenorphine would enable one's ability to benefit from psychosocial interventions rather than hinder them.
7. The potential human rights implications of requiring a client to taper off a medically-indicated treatment.
8. A request to eliminate any precondition to stop or wean buprenorphine and make decisions about buprenorphine treatment on a case-by-case basis, in line with current standards of care for OUD.

It is crucial to recognize that changing institutional mindsets is a gradual process. Persistent advocacy for patient rights and evolving healthcare practices is essential to foster progressive change in the treatment of addiction and related health services.

RAAM Monthly Video Conferences
Provider Dec 5, 8:00 am
Counsellor Dec 8, 9:00 am

RAAM TOWN HALL
For RAAM Leads/Administrators: Dec 13, 12:00 pm
Contact laurie.smith@wchospital.ca