Alberta Addiction Education Sessions

2019-20 Livestream Dates

Alberta Health Services

Addiction and Mental Health

Join our monthly Addiction Education Sessions (formerly the ODT Livestream)!

These 3 hour sessions (9am-12pm), spanning the 2019/20 academic year, will give you an opportunity to learn from experts across the province about Addiction and Mental Health through didactic presentations, de-identified case discussions, and question and answer periods.

Alberta Health Services

UNIVERSITY OF CALGARY

College of Physicians & Surgeons of Alberta

CARNA

Alberta College of Pharmacy

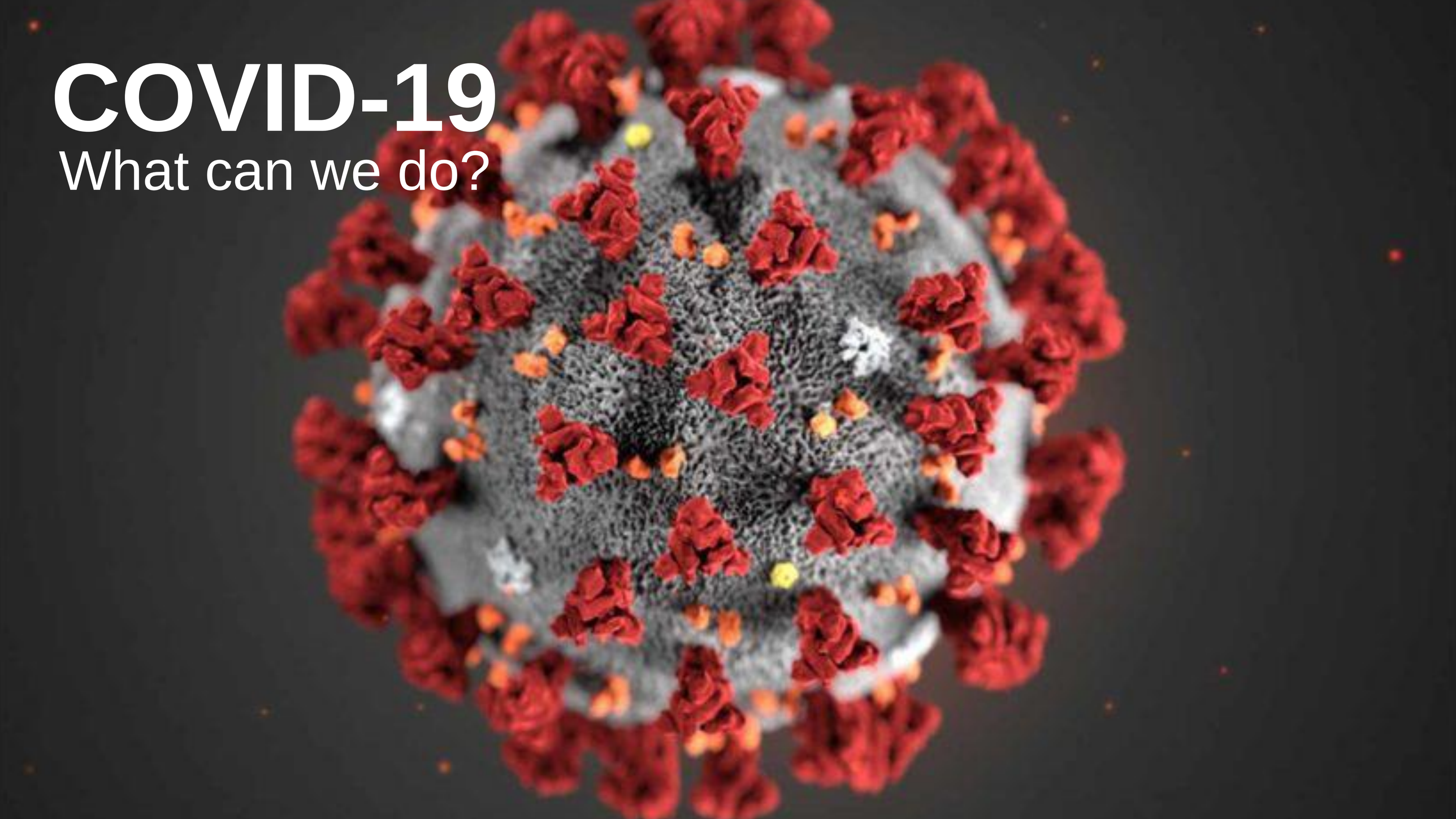
CRISM-ICRAS

Canadian Research Initiative in Substance Misuse

Initiative Canadienne de Recherche en Abus de Substance

COVID-19

What can we do?



Substance Use Disorder during COVID-19

Challenges During this Time

- Negative emotions may increase substance use in the general population.
- Mental health burdens may trigger relapse into substance use.
- Individuals who use substances may have concerns acquiring substances (whether legally or illegally) which may trigger withdrawal symptoms, and can trigger psychiatric

Opioid Use Disorder a potential risk factor for COVID-19 mortality?

American Journal of Therapeutics 11, 354–365 (2004)

Opioid Therapy and Immunosuppression

A Review

Ricardo Vallejo,[1]* Oscar de Leon-Casasola,[2] and Ramsun Benyamin[3]

Opioid-induced immunosuppression

Paola Sacerdote

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Current Opinion in Supportive and Palliative Care 2008, 2:14–18

Purpose of review
This review provides an overview of the immunological effects of commonly used analgesic opioid drugs with particular emphasis on human studies, with the final aim to highlight their potential clinical relevance.

Recent findings
The immunomodulatory effects of morphine have been characterized in animal and human studies. Morphine decreases the effectiveness of several functions of both natural and acquired immunity, interfering with important intracellular pathways involved in immune regulation. Mainly from animal studies, however, it has emerged that not all opioids induce the same immunosuppressive effects and evaluating each opioid's profile is important for appropriate analgesic selection. The potent opioid fentanyl also exerts a relevant immunosuppression, while the partial agonist buprenorphine appears to have a more favourable immune profile. The impact of the opioid-mediated immune effects could be particularly dangerous in selective vulnerable populations, such as the elderly or immunocompromised patients.

Summary
The impact of opioid drug treatment on immunity may be a new safety concern for the physician. Although many advances have been made in understanding the effects of opioid drugs on immune responses, their relevance is not completely clear. The scientific community must be aware that it is about time to perform well designed clinical studies in order to assess the importance of opioid-induced immune suppression.

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Clinically what should we do?

Virtual Care

- Almost all Provinces, States, and Countries around the world have put together Virtual Compensation for Physicians
- This allows patients to see their docs and specialists, important for complex patients
- This reduces risk of spread to community and health care workers

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Don’t let patients run out!

- Talk about being careful with dose
- Talk about delivery for those needed shorted dispensing intervals
- Don’t have patients come to Clinic unless ABSOLUTELY NECESSARY

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Key Pieces

- Suspend all Urine Drug Screens
- Delivery when possible
- No Daily Witnessed dosing of Bup/Nal
- No in office invitation of Bup/Nal - Home Induction
- Up to 60 days Bup/Nal Dispensing
- Carries for Methadone and potentially SROM on physician assessment of risk
- Consider discussing rotating to Bup/Nal

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Prescriptions

Health Canada / Santé Canada

SUBSECTION 56(1) CLASS EXEMPTION FOR PATIENTS, PRACTITIONERS AND PHARMACISTS PRESCRIBING AND PROVIDING CONTROLLED SUBSTANCES IN CANADA DURING THE CORONAVIRUS PANDEMIC

- permit pharmacists to extend prescriptions;
- permit pharmacists to transfer prescriptions to other pharmacists;
- permit prescribers to issue verbal orders (i.e., over the phone) to extend or refill a prescription; and
- permit pharmacy employees to deliver prescriptions of controlled substances to patient's homes or other locations where they may be (i.e self isolating).

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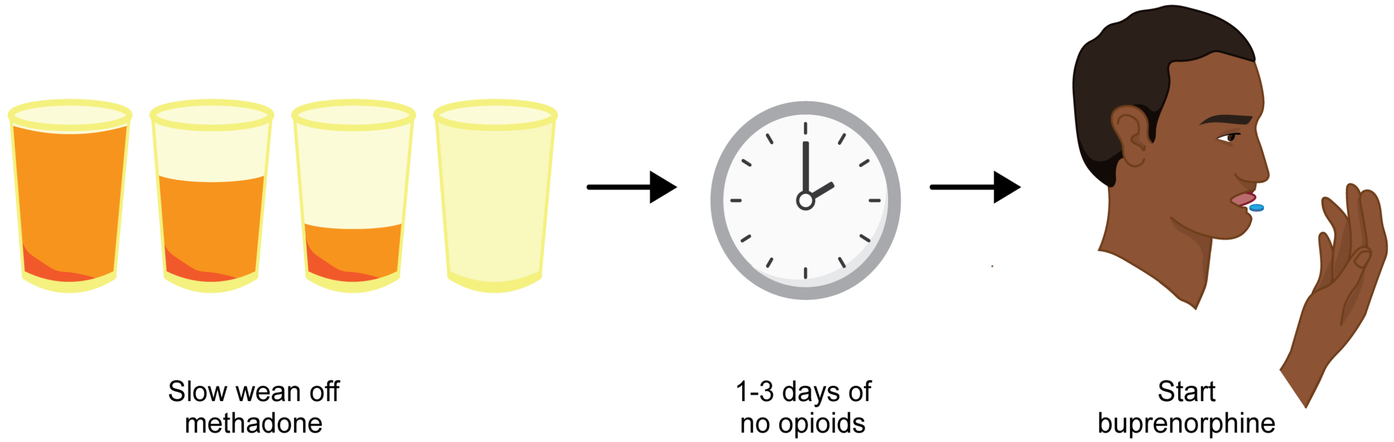
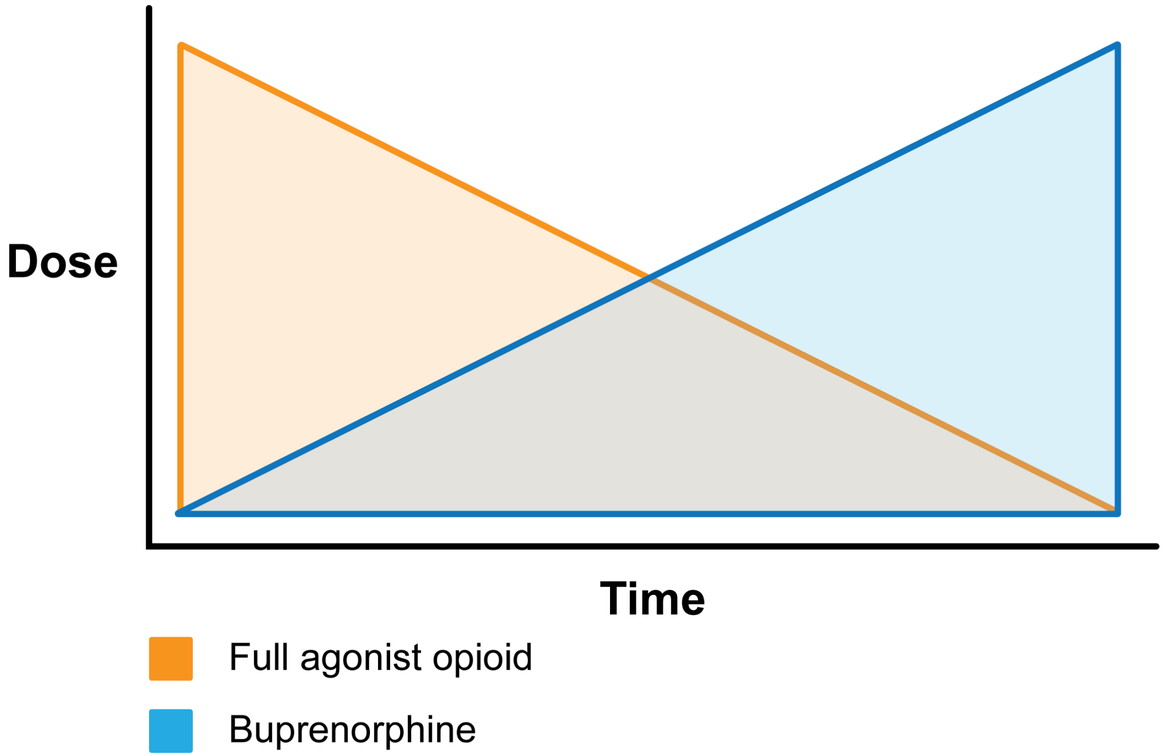
Rotating from Methadone to Buprenorphine/Naloxone SL

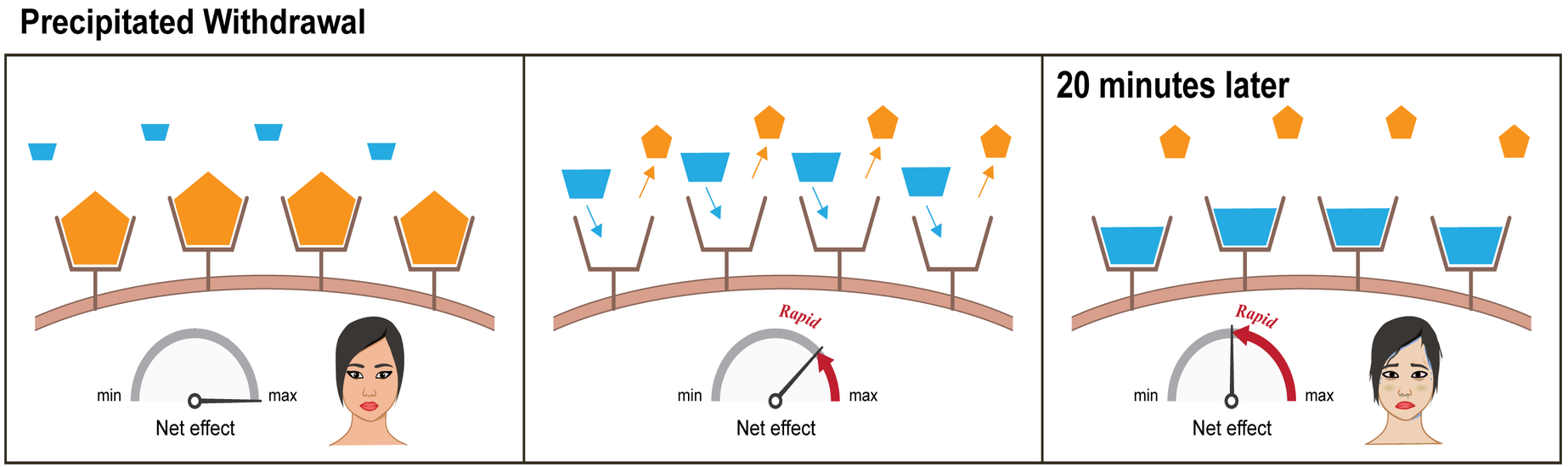
Typical Opioid Rotation to SL buprenorphine



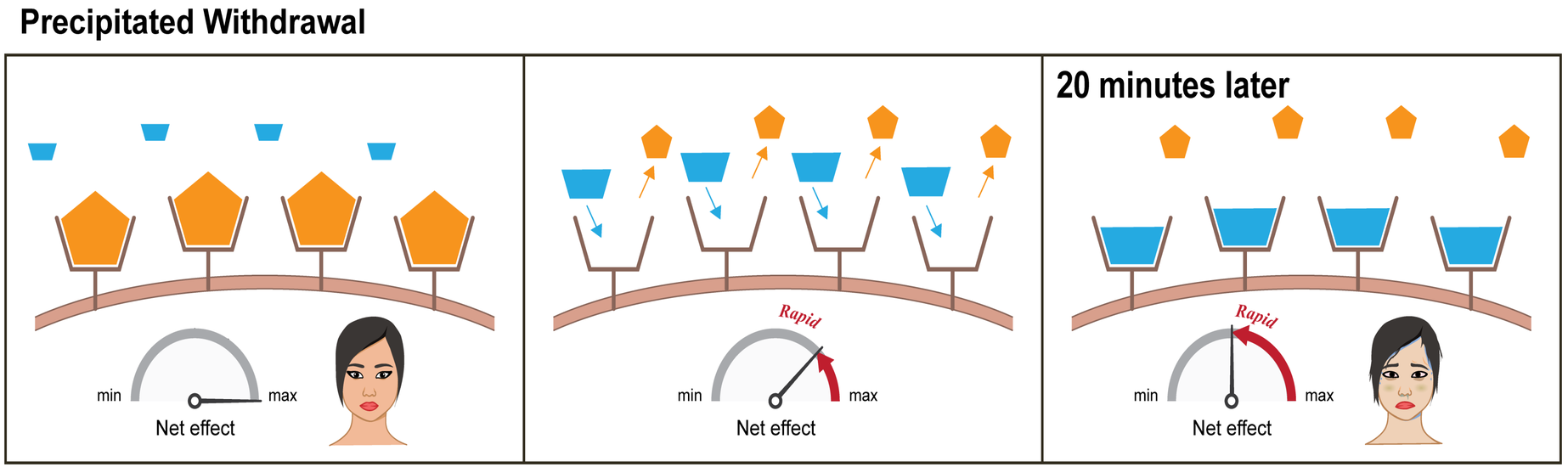
How does “Bridging” work?



Precipitated Withdrawal



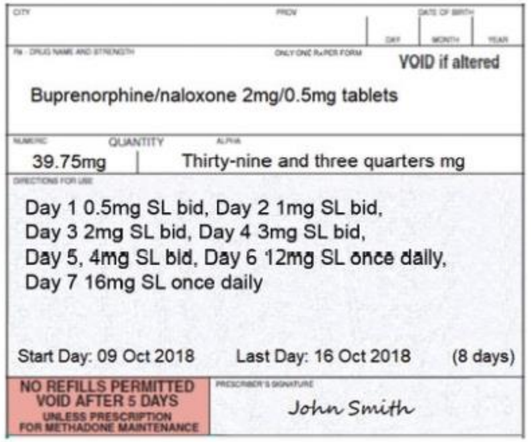
Precipitated Withdrawal



Bernese Method Micro-induction

- Overlap is key.
- Its a slow titration down of opioid of use, with slow titration up of buprenorphine.

FIGURE 1 Sample of full micro-induction regimen


CITY PROV DATE OF BIRTH DAY MONTH YEAR

Rx DRUG NAME AND STRENGTH ONLY ONE Rx PER FORM

VOID if altered

Buprenorphine/naloxone 2mg/0.5mg tablets

NUMERIC QUANTITY ALPHA

39.75mg | Thirty-nine and three quarters mg

DIRECTIONS FOR USE

Day 1 0.5mg SL bid, Day 2 1mg SL bid,
Day 3 2mg SL bid, Day 4 3mg SL bid,
Day 5, 4mg SL bid, Day 6 12mg SL once daily,
Day 7 16mg SL once daily

Start Day: 09 Oct 2018 Last Day: 16 Oct 2018 (8 days)

NO REFILLS PERMITTED
VOID AFTER 5 DAYS
UNLESS PRESCRIPTION FOR METHADONE MAINTENANCE

PRESCRIBER'S SIGNATURE

John Smith

https://www.bcpharmacy.ca/news/microdosing-buprenorphine-induction-bernese-method

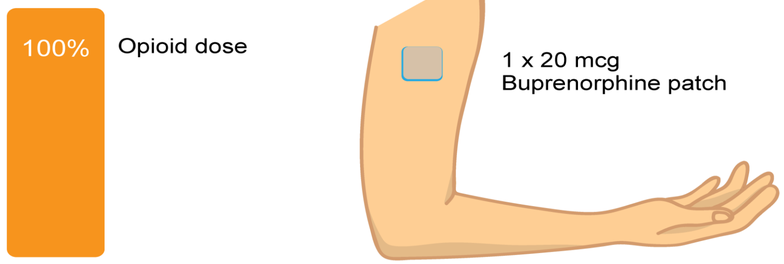
TABLE 2 Buprenorphine dosing schedule and use of heroin in Case 1

Day	Buprenorphine (SL) (mg)	Street heroin (sniffed) (g)
1	0.2	2.5
2	0.2	2
3	0.8+2 †	0.5
4	2+2.5 †	1.5
5	2.5+2.5 †	0.5
6	2.5+4 †	0
7	4+4 †	0
8	4+4 †	0
9	8+4 †	0

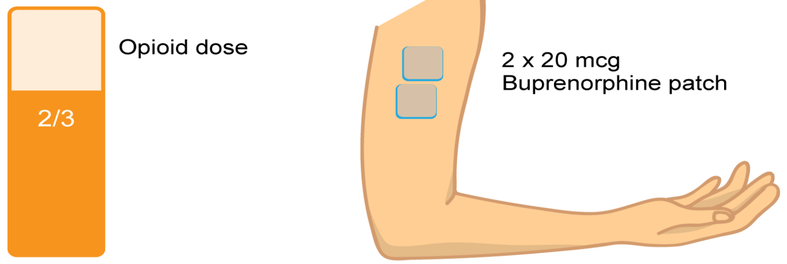
† denotes twice daily dosing

Calgary 7 day protocol

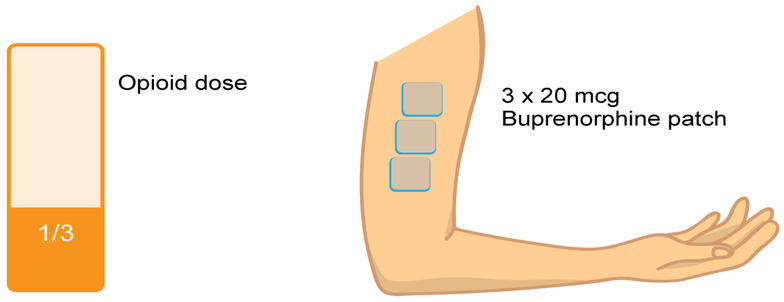
Day 1



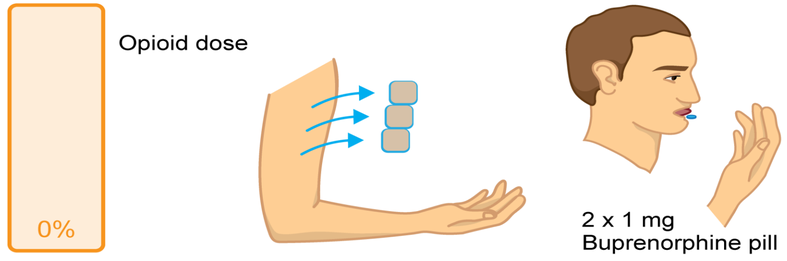
Day 3



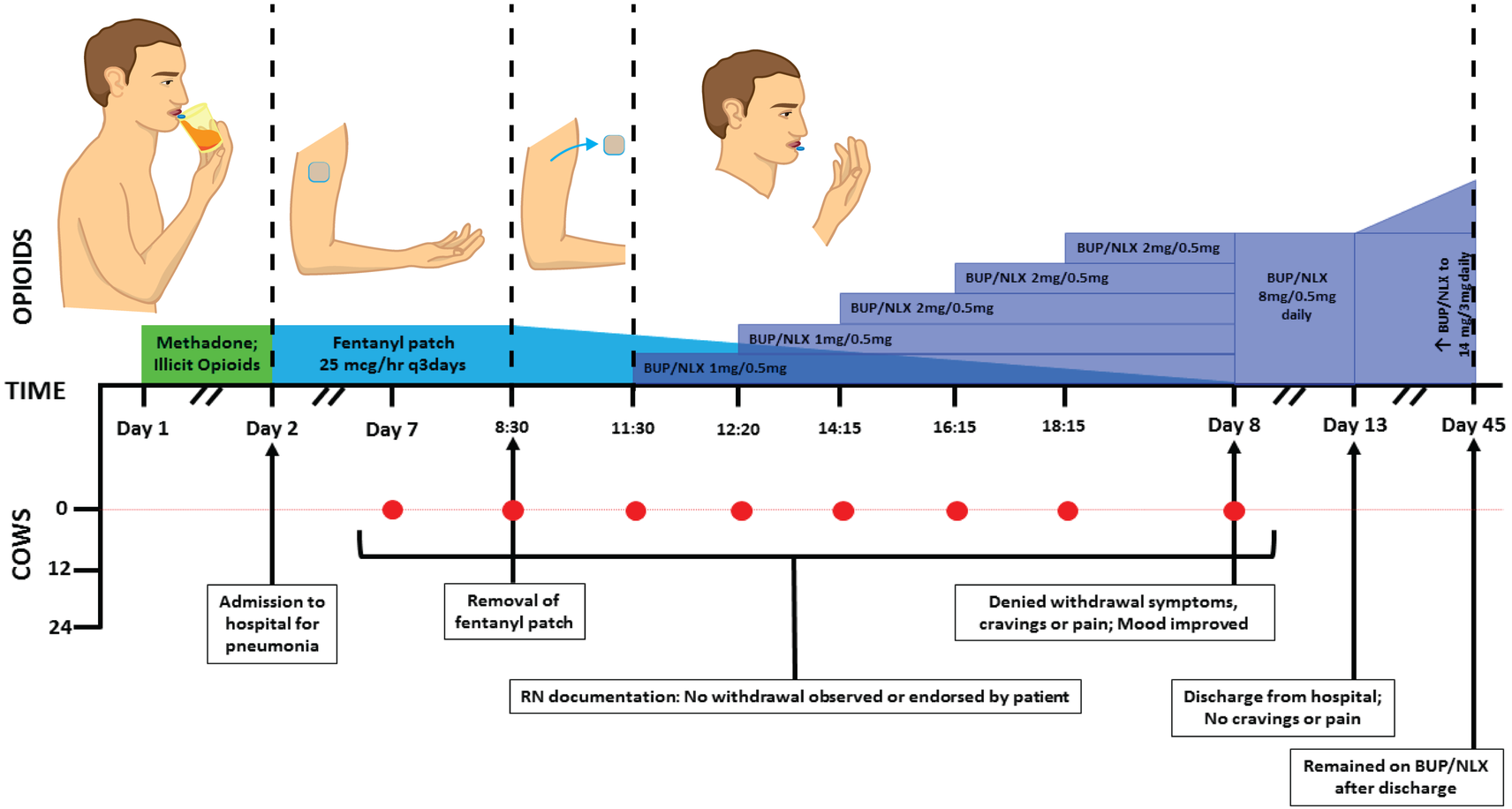
Day 5



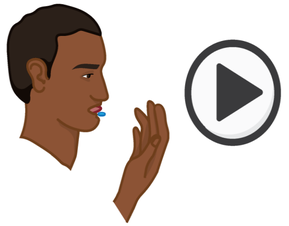
Day 7



Fentanyl Bridge Case



Calgary SROM strategy

Day 0	Day 1	Day 2-5	Day 6	Day 7
				
Last dose of methadone in the AM	24hrs after last methadone dose, transition to 1:4 ratio of STROM	Increase SROM ratio as needed to help with withdrawals and cravings	Last single dose of SROM in the morning	24hrs after last SROM dose, induce buprenorphine

Variable	Classic Induction	Micro-induction	Butrans® Patch Method	Fentanyl Patch	SROM
Setting of Treatment	Outpatient for methadone less than 70mg. Inpatient setting for methadone doses greater than 70mg	Outpatient settings	Outpatient	Inpatient	Outpatient
Dose of methadone most effective for: <50mg = low 50-100mg = moderate >100mg = high	Low	Low to Moderate	Low to High	Low to High	Low to High
Risk of Precipitated Withdrawal	High risk of precipitated withdrawal.	Low	Low	Moderate	Moderate
Time to Induction	Typically 24 to 72 hours but sometimes as long as a week.	A few days to a week.	A few days to weeks	Hours to days	1 week of SROM then 24 hour wait to start buprenorphine/naloxone SL
Cost	No increase in cost for this transfer method	Minimal cost increase	Expensive due to high cost of patches	Expensive due to cost of fentanyl patches.	Expensive due to high cost of SROM
Additional Concerns		Dividing tablets into small portions. Missed doses making it difficult for titration of buprenorphine and tapering of methadone	Risk of diversion with buprenorphine patches	Risk of diversion of fentanyl patches if patient is not observed carefully.	Risk of diversion if short acting morphine is used during last leg of SROM transfer.

REVIEW ARTICLE

CJA–JCA

OPEN

A Review of Novel Methods To Support The Transition From Methadone and Other Full Agonist Opioids To Buprenorphine/Naloxone Sublingual In Both Community and Acute Care Settings

Sumantra Monty Ghosh, *MD, MSc, FRCPC, ISAM*[1], Sukhpreet Klaire, *MD, CCFP*[2], Robert Tanguay, *MD, FRCPC, ISAM*[3], Mandy Manek, *MD, CCFP*[4], Pouya Azar, *MD, FRCPC, ISAM*[5]

Opioid Agonist Therapy

Home Induction

A CASE SERIES OF HOME INDUCTION

- 103 patients (68% heroin, 18% pills, 14% methadone < 40 mg)
- An initial 4-mg buprenorphine dose followed by one to two additional 4-mg doses, as needed every 1-4 h, for a day 1 maximum of 12 mg, was recommended to all patients.
- 1 week retention 73% “similar to a comparable primary care based study” of office induction
- No severe precipitated withdrawal was noted.
- 5 patients had mild-moderate “buprenorphine-prompted withdrawal symptoms” including symptoms of anxiety, nausea without vomiting, sweating, musculoskeletal aches, and sleepiness/sedation.

Home Buprenorphine/Naloxone Induction in Primary Care
Joshua D. Lee, MD MSc eta all J Gen Intern Med. 2009 Feb; 24(2): 226–232.
Information courtesy of Jim Walsh MD from the Swedish Medical Centre (next 4 slides)

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Home Induction

Chose your own strategy for 79 patients

- **13 had chosen in office based induction**
- **66 received home induction kit. This includes:**

1. **A instruction sheet**
2. **Ten 2/0.5mg BUP/NX pills**
3. **Four 8/2 BUP/NX pills,**
4. **Six pills each of ibuprofen, clonidine, and loperamide hydrochloride**

A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions. Cunningham CO, et al J Subst Abuse Treat. 2011 Jun;40(4):349-56.

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Contents of the tool kit for patient-centered home-based inductions

Instruction sheet

Section	What the section addresses
What's in the tool kit?	Guides when/how to use medications in the kit
When to start Suboxone	Guides the timing of treatment initiation
Things not to do	Warns against common mistakes or misunderstandings
How to take Suboxone	Facilitates correct dosing method
Plan	Guides treatment, provides support, and facilitates follow-up
What was taken	Facilitates keeping track of dosing

Medications

# Pills	Medication	Dose (mg)	Rationale
10	Buprenorphine/naloxone	2/0.5	Initiate buprenorphine treatment (day 1)
4	Buprenorphine/naloxone	8/2	Buprenorphine treatment (days 2–3)
6	Ibuprofen	200	↓ Withdrawal symptoms (pain)
6	Clonidine	0.1	↓ Withdrawal symptoms (anxiety)
6	Loperamide hydrochloride	2.0	↓ Withdrawal symptoms (diarrhea)

A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions. Cunningham CO, et al J Subst Abuse Treat. 2011 Jun;40(4):349-56.

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Home Induction

- **Adjusting only for baseline opioid use, participants with standard-of-care office-based inductions and patient-centered home-based inductions had similar reductions in opioid use (AOR=0.74, 95%CI=0.16–3.50).**
- **Adjusting for baseline opioid use, age, gender, and ethnicity, this finding remained (AOR=0.63, 95%CI=0.13–2.97).**

A comparison of buprenorphine induction strategies: patient-centered home-based inductions versus standard-of-care office-based inductions. Cunningham CO, et al J Subst Abuse Treat. 2011 Jun;40(4):349-56.

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Home Induction

RANDOMIZED CONTROL TRIAL

- 20 patients randomly assigned to unobserved vs office induction, stratifying by past buprenorphine use.
- Outcome results were similar in the two groups: 60% successfully inducted in each group,
- 30% experienced prolonged withdrawal, and 40% stabilized by week

Unobserved versus observed office buprenorphine/naloxone induction: a pilot randomized clinical trial. Gunderson EW et al Addict Behav. 2010 May;35(5):537-40

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Home Induction

- Patients received a prescription for BUP/NX, usually sixteen 2mg/0.5mg tablets filled at a local pharmacy
- They were instructed to initiate medication taking 1–2 tablets after abstaining 16 hours or more from opioids and when the SOWS reached ≥17.
- Both groups were instructed to take no more than 16mg on Day 1

Unobserved versus observed office buprenorphine/naloxone induction: a pilot randomized clinical trial. Gunderson EW et al Addict Behav. 2010 May;35(5):537-40

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Home Induction

LITERATURE REVIEW

- **10 clinical studies describing unobserved induction were identified: 1 randomized controlled trial, 3 prospective cohort studies, and 6 retrospective cohort studies.**
- **Evidence is weak to moderate in support of no differences in adverse event rates between unobserved and observed inductions. There is insufficient or weak evidence in terms of any or no differences in overall effectiveness.**

Unobserved "home" induction onto buprenorphine.
Lee JD, Vocci F, Fiellin DA. J Addict Med. 2014 Sep-Oct;8(5):299-308.

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Calgary Method

- Day 0: Stop all opioids and provide withdrawal medications including clonidine 0.1 MG TID for 1-3 days, gabapentin 300mg TID for 1-3 days, and if necessary clonazepam 0.5mg BID for 1-3 days.
- Day 1: Once appropriate withdrawal is reached, initiate 2mg SL q1hour Suboxone, as needed for persistent or reoccurring withdrawal symptoms up to 16mg. Hold if sedation.
- Day 2: Total of Day 1 (eg. 16mg) then 2mg SL q1hour for persistent or reoccurring withdrawal symptoms, up to 32mg total. Hold if sedation.
- Call Patient to review final dose, provide Rx for 1week, follow up in 1 week, then 28 days prescriptions if appropriate.

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Harm Reduction Advice

Education

- All the usual education
- Increased Risk of OD
- Buddy up, BUT stay 2m away
- Continue to use SCS/OPS

Harm Reduction in the Time of COVID-19

- Understand that smoking increases risk of COVID-19 mortality, even if it is Cannabis as well as stimulants.
- Educate your clients who are still using substances to be careful handing parcels of substances which have been carried in people's mouths.
- Ensure clients stock up on needles, syringes, and other injecting kits.
- Encourage clients to co-plan with local harm reduction services on how to obtain supplies.

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Education

- Do not share supplies, such as cigarettes, joints, pipes, injecting equipment, containers for alcohol, utensils, and other supplies. If you have to share, wipe pipes with alcohol wipes or use new mouthpieces.
- Reduce close contact (e.g. shaking hands, hugging, kissing) and ensure condom use
- Wash your hands or use wipes before preparing, handling or using your drugs.
- Wash down surfaces where you are preparing.
- Prepare your drugs yourself.

Education

- Cough or sneeze into your elbow or use tissues. Throw tissues away immediately and wash your hands thoroughly.
- Clean surfaces with soap and water, alcohol wipes, bleach or hydrogen peroxide before preparing drugs if possible
- Carry naloxone and have an overdose plan. Please use breathing masks available in the THN kits if responding to an overdose.

Overdose Management

- Naloxone 2-3 injections right away.
- If CPR is needed, place mask on client then do chest compressions.
- No airway interventions (ie. Bag-valve-mask) unless you have PPE and an N95 mask.

Overdose Management

- Recommendations for Suspected Opioid Poisoning Response
- Call 911. If COVID-19 is suspected, tell the 911 operator. o See Symptoms of COVID-19.
- Anyone not responding to the suspected opioid poisoning event should leave the room or immediate area.
- If available, don Personal Protective Equipment (PPE), including gown, face mask, eye protection and gloves. o See Putting on (Donning) Personal Protective Equipment (PPE) and Taking off (Doffing) Personal Protective Equipment (PPE).
- If PPE is not available, put on the gloves included in the naloxone kit.
- Administer naloxone.
- If you choose to provide rescue breaths, use the one-way rescue breathing mask included in the naloxone kit which has a one-way valve to decrease the possibility of transmission for the responder. Ensure that the airway is open by performing a “jaw-thrust” maneuver (if previously trained and familiar with this technique), or tilting the head back and lifting the chin up (“head-tilt-chin-lift technique”), regardless of whether rescue breaths are provided.

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Overdose Management

- Continue to monitor the individual; assess response after 2 minutes. If no response, administer another dose of naloxone and continue to provide rescue breaths as able. Repeat these steps until first responders arrive or the individual begins breathing on their own.
- If the individual is breathing, place them in the recovery position.
- Once the scene has been cleared, thoroughly clean the area in which assistance was provided.
- See Environmental Cleaning in Public Facilities and Prevention.
- After the response, thoroughly wash hands with soap and water or with an alcohol based hand sanitizer and dispose of all items used in the response safely.
- Use new or appropriately cleaned PPE with each poisoning event.

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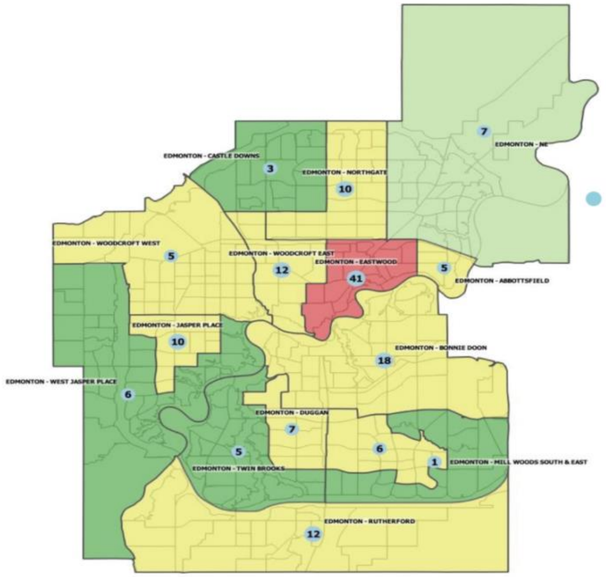
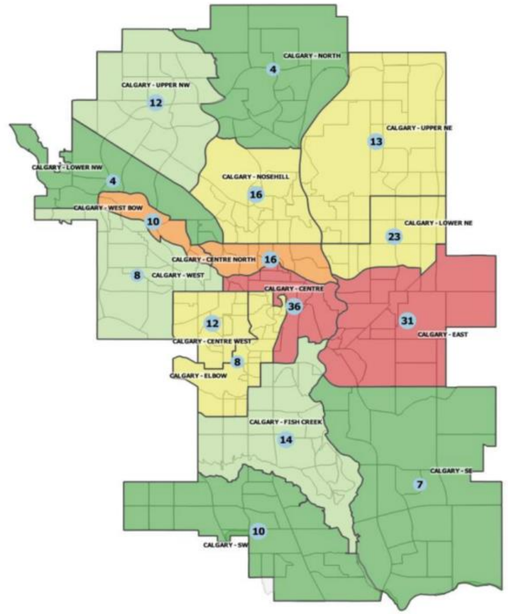
Virtual Supervised Consumption

Edmonton

Calgary





Legend

Rate of opioid/fentanyl drug overdose deaths per 100,000 compared to city average

- Significantly lower
- Lower
- Average
- Higher
- Significantly higher
- No deaths

- Physical Supervised Consumption Sites are a primary tool to reduce mortality and overdoses in our communities, but they are only effective for **500 meters** surrounding them
- The majority of overdoses occur outside of the red regions, with **83%** of them occurring in suburban and rural communities

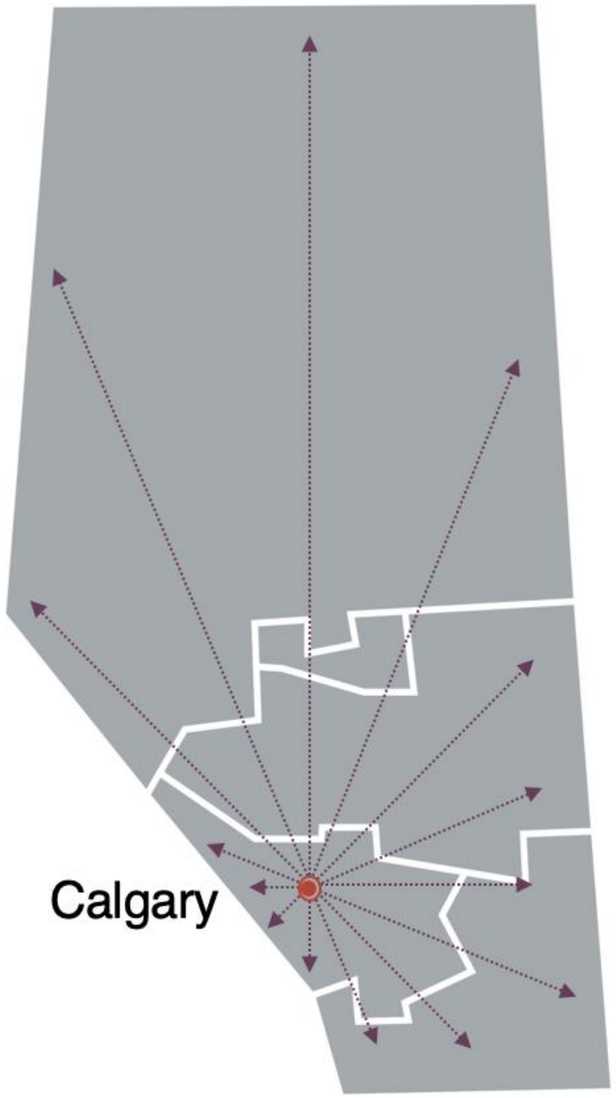
The Good News

Opioid overdoses can be reversed – Naloxone

Supervised consumption services reduce mortality

Proposed Intervention:

Virtual Supervised Consumption Service over the telephone



Virtual Supervised Consumption Service

Barriers Removed:

- Stigma
- Geographic distance
- Community opposition to physical Supervised Consumption Services
- Limited hours of supervised consumption services
- Withdrawal concerns, preventing access to supervised consumption services

Recovery

Online

12 Step Online Meetings

This is a directory of online Alcoholics Anonymous meetings in various formats, including email, chat room, audio/video, discussion forums, and telephone.

***Alcoholics Anonymous* -** http://aa-intergroup.org/directory.php

***Cocaine Anonymous* -** https://www.ca-online.org/

***Narcotics Anonymous* -** https://www.na.org/meetingsearch/text-results.php?country=Web&state&city&zip&street&within=5&day=0&lang&orderby=distance

Online

AA Sober Living

Online recovery help for those in all stages of recovery, family, friends and loved ones including message boards, chats, blogs, and daily and weekly readings.

www.aasoberliving.com

SMART Recovery

This website includes message boards, chat rooms, online meetings, and an online library of recovery resources.

https://www.smartrecovery.org/smart-recovery-toolbox/smart-recovery-online/

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Online

In the Rooms

A free online recovery tool that offers 130 weekly online meetings for those recovering from addiction and related issues. They embrace multiple pathways to recovery, including all 12 Step, Non-12 Step, Wellness and Mental Health modalities.

https://www.intherooms.com/home/

The Daily Pledge

This is Hazelden Betty Ford Foundation's free online Community Social Site. It provides a home page to make a Daily Pledge to sobriety with healthy daily activities to help people see others “recover out loud.” The site also includes a Discussions forum, Chat, Online Meetings, Fun and Photo sections, private messaging with other members, and other interactive involvements. You need to sign-up to participate.

https://thedailypledge.org/

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Managed Substances during COVID-19 Pandemic

Managed Substances

Opioid/Stimulant/Benzodiazepine/Alcohol Eligibility criteria:
o Not already connected to a health care professional or requiring further assistance
o Confirmed COVID-19 positive on self-isolation, or
o Suspect case awaiting diagnosis for COVID-19, or
o At risk of COVID-19 infection, or
o Has upper respiratory symptoms and is self-isolating as per public health guidelines

AND one or more of the following:
o History of active substance use disorder (opioids, stimulants, or alcohol)
o Deemed at high risk of withdrawal and/or overdose or with significant cravings that would put them at increased risk, via a detailed clinical assessment
o Have not been able to achieve a therapeutic dose with currently available OAT treatment, or treatments have not been beneficial
o Experiencing homelessness or living in a shelter, SRO or supported housing unit
o Deemed unable to stay in self-isolation without an adequate supply of substances and who are assessed as a risk for breaching self-isolation

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Managed Substances

OPIOIDS

The following would be for temporary use of home managed opioids for patients refusing OAT:

a. Oral hydromorphone 8 mg tablets (1-3 tabs q1h as needed, up to 14 tablets; daily dispensed)
b. M-Eslon 80 - 240 mg BID; daily dispensed

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Managed Substances

STIMULANTS

The following would be for temporary use of home managed stimulants for patients refusing home detox. Patients with psychosis should be excluded and treated with benzodiazepines in a home detox protocol.

i. Dextroamphetamine 10-20 mg BID SR; daily dispense (max dose of 60 mg BID per day)
ii. Methylphenidate IR 10-20 mg BID; daily dispensed (max dose of 100 mg/24 hours)
iii. Methylphenidate SR 20-40 mg once daily; daily dispensed (max dose 100 mg/24 hours)

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Managed Substances

BENZODIAZAPINES

The following would be for temporary use of home managed benzodiazepines for patients refusing home detox.

i. Enquire which benzodiazepine the patient is using per day and aim to prescribe according to current use.

- For example, if a patient describes buying diazepam 10 mg, three times a day, then consider starting diazepam 5 mg TID; daily dispensed. Doses can be titrated as needed.

Please be aware of increased overdose risk.

RAAM RAPID ACCESS ADDICTION MEDICINE

Alberta Health Services

Stay Home, Stay Safe, Be Safe

Rapid Access Addiction Medicine (RAAM)

- Located through Adult Addiction Services Calgary
- Physician, Psychologist, Addiction Counsellor lead addiction treatment.
- Home Detox, Ongoing pharmacotherapy, Counselling, Group Therapy and referral to residential treatment.
- (403) 367-5000 or email: monty.ghosh@ahs.ca

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