Today's Partners

British Columbia Pharmacy Association

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

CRISM | Providence Health Care Research Institute | Providence Health Care | UBC | St. Paul's Foundation

Today's Speakers

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Thank you also to the rest of our team in the room with us

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Disclosure(s)

None related to the development of this presentation

I respectfully acknowledge that I am a humble guest on the unceded traditional territories of the Musqueam, Squamish, and Tsleil-Waututh Nations.

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Outline of our time

- **National Guideline**
- **Chart of Medications used for Opioid Use Disorder (OUD)**
  - Methadone
  - Suboxone (Buprenorphine/Naloxone)
  - Slow Release Oral Morphine
- **Guided Questions and Scenarios**
- **Questions from the Audience**

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Key Findings from the National report

Apparent opioid-related deaths in Canada (released November 2018)

- The opioid crisis has affected every part of the country, but some provinces and territories have been impacted more than others. According to data reported as of November 16, 2018: there were **9,078** apparent opioid-related deaths between January 2016 and June 2018
- in 2016, there were **3,014** apparent opioid-related deaths (corresponding to a death rate of **8.3 per 100,000** population) and
- In 2017, there were **3,998** apparent opioid-related deaths (corresponding to a death rate of **10.9 per 100,000** population)
- from January to June 2018, there were **2,066** apparent opioid-related deaths, corresponding to a death rate of **11.2 per 100,000** population

Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: Apparent opioid-related deaths in Canada (January 2016 to June 2018). Web Based Report. Ottawa: Public Health Agency of Canada; December 2018.

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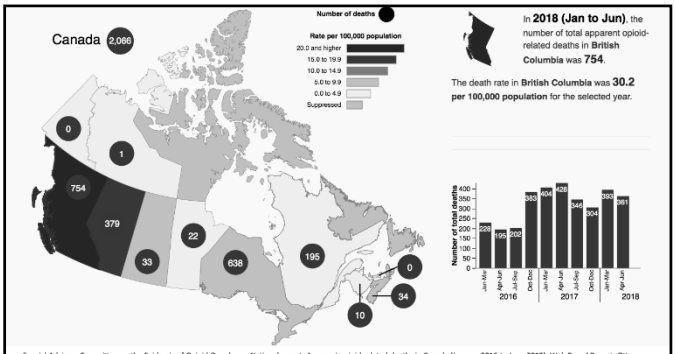


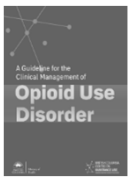
Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: Apparent opioid-related deaths in Canada (January 2016 to June 2018). Web Based Report. Ottawa: Public Health Agency of Canada; December 2018.

Canadian Research Initiative in Substance Misuse (CRISM)

- Funded by the Canadian Institutes of Health Research (CIHR)
- National research consortium focused on substance use disorder, comprising four large interdisciplinary regional teams (nodes)
  - British Columbia
  - the Prairie Provinces
  - Ontario
  - Quebec/Atlantic
- Each CRISM node is an expert network of research scientists, service providers, policy-makers, community leaders, and people with lived experience of substance use disorder.
- CRISM's mission is to translate the best scientific evidence into clinical practice and policy change.

Development of CRISM National Guidelines for the Clinical Management of Opioid Use Disorder

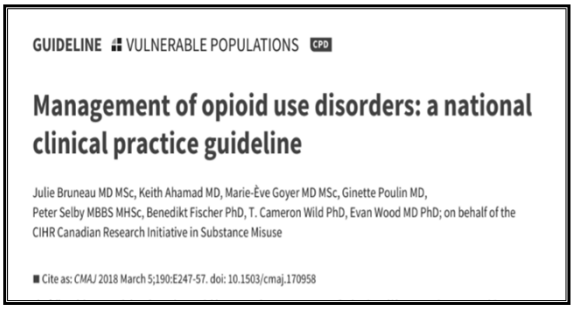
VCH Opioid Guidelines, 2015



BC Opioid Guidelines, 2017

National Opioid Guidelines, 2018

Other Provincial Opioid Guidelines

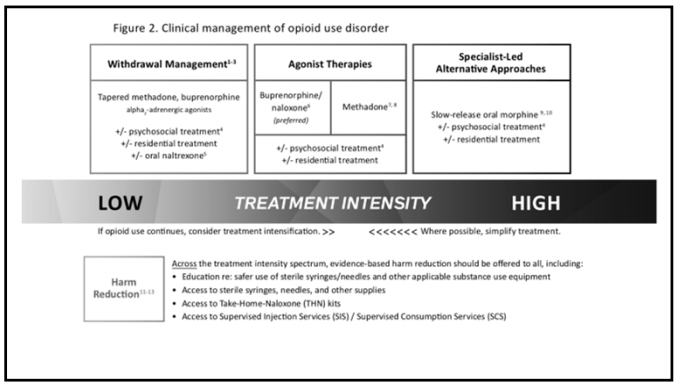


GUIDELINE VULNERABLE POPULATIONS CPD

Management of opioid use disorders: a national clinical practice guideline

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

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



Requests for treatment for OUD should be treated with urgency.

- Why?
- When you see patients, what are the reasons coming in for help?
- How do you approach the conversation? What are some tips for pharmacists to use to aid in a conversation if our patients ask for help?

Withdrawal management (commonly known as detox) alone without long-term OAT or linkage to continuing care is not recommended.

- Why?
- Sometimes in pharmacy we also have patients inquiring about detox.
- How do you approach this conversation? What are some tips for pharmacists to use to aid in a conversation?

What is treatment retention?

- How can pharmacists help in treatment retention?
- Are relapses expected while on OAT (at start, long duration of therapy)?
  - How do you suggest pharmacists address potential relapse?
  - What about when a patient has relapsed and is feeling badly?

Case 1: JW, a 36 year old male with a history of OUD has dropped into your clinic for help (has been taking illicit opioids since a back injury sustained 10 years back from a fall in the construction industry).

- What are you assessing for when a client/patient first comes in for help?
- DSM-5 for OUD?
- When would you use the Clinical Opiate Withdrawal Scale (COWS), Subjective Opiate Withdrawal Scale (SOWS)?

Opioid Use Disorder Diagnostic Criteria (DSM-5)[13]

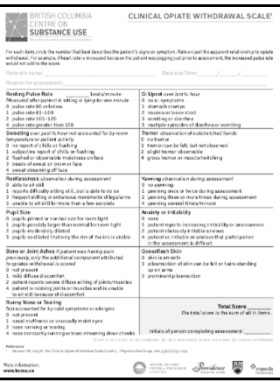
Impaired Control:
- ❑ Opioids are often taken in larger amounts or over a longer period than was intended.
- ❑ There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- ❑ A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- ❑ Craving or a strong desire to use opioids.

Social Impairment:
- ❑ Recurrent opioid use resulting in a failure to fulfil major role obligations at work, school, or home.
- ❑ Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- ❑ Important social, occupational, or recreational activities are given up or reduced because of opioid use.

High Risk Use:
- ❑ Recurrent opioid use in situations in which it is physically hazardous.
- ❑ Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.

Physiologic effects:
- ❑ Tolerance*, as defined by either of the following:
  - ❑ Need for markedly increased amounts of opioids to achieve intoxication or desired effect.
  - ❑ Markedly diminished effect with continued use of the same amount of opioid.
- ❑ Withdrawal*, as manifested by either of the following:
  - ❑ Characteristic opioid withdrawal syndrome.
  - ❑ Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

*Note: For patients who are prescribed opioids under appropriate medical supervision, the presence of tolerance and withdrawal alone does not indicate OUD; additional criteria are required for diagnosis.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CLINICAL OPIATE WITHDRAWAL SCALE[1]

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SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS)

The SOWS is a self-administered scale for grading opioid withdrawal symptoms. It contains 16 symptoms whose intensity the patient rates on a scale of 0 (not at all) to 4 (extremely), and takes less than 10 minutes to complete.

Patient instructions: please score each of the 16 items below according to how you feel right now. Circle one number only.

Item	Symptom	Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have pinpoint pupils	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Total Score: _____

Additional information: www.bccsu.ca

Case 1 (cont'd): JW, a 36 year old male with a history of OUD has dropped into your clinic for help (has been taking illicit opioids since a back injury sustained 10 years back from a fall in the construction industry).

- How do you assess what to start a patient on for OUD?
- How do you incorporate a shared decision making process?

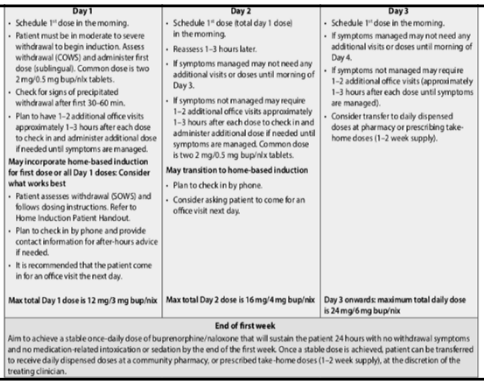
How does methadone compare to buprenorphine/naloxone?

Methadone	Buprenorphine-Naloxone
Higher risk for overdose, particularly during treatment initiation	Decreased risk of overdose and parenteral abuse
Full mu agonist	Partial mu agonist
Generally requires daily witnessed ingestion in pharmacy	Allows for safer take home schedules
More severe side effect profile including CNS/Respiratory depression	Milder side effect profile
Long time to achieve therapeutic dose (weeks-months)	Rapid titration to achieve therapeutic dose (hours-days)
Higher potential for drug-drug interactions (i.e. ABx, ARVs)	Lower potential for drug interactions, monitor for meds metabolized by CYP 3A4
Increased cardiac arrhythmias as a result of **QTc prolongation**	Decreased risk of **QTc prolongation**
No risk of **precipitated withdrawal** potential	Risk of **precipitated withdrawal** with induction

Screening
Diagnosis of Opioid Use Disorder – DSM-5 criteria
Harm Reduction – provide/recommend naloxone kit
Preparing for buprenorphine/naloxone (bupl/nix) induction
• Explain how buprenorphine/naloxone works. • Discuss risk and benefits. • Complete Assessment and Investigations. • Complete treatment plan after shared decision-making. • Review withdrawal assessment scales (*Associated Document: COWS Clinical Opiate Withdrawal Scale* or *Associated Document: SOWS Subjective Opiate Withdrawal Scale* – discussed further below). • Consider whether offering unobserved take-home doses for part of induction (i.e., "home induction") would be beneficial. • Provide education and contact information if considering home induction for Day 1 or for first dose on Day 1.

Buprenorphine/naloxone Induction

- What does an induction of buprenorphine/naloxone look like?
- Describe office based induction?
- Describe home based induction?
- How can precipitated withdrawal be limited? What should be done from a pharmacist end and a prescriber/nurse end if this occurs?
- Discuss other potential induction models? (Emergency Room home starts; use of pharmacists?)



Day 1	Day 2	Day 3
• Schedule 1st dose in the morning. • Patient must be in moderate to severe withdrawal to begin induction. Assess withdrawal (COWS) and administer first dose (sublingual). Common dose is two 2 mg/0.5 mg bup/nlx tablets. • Check for signs of precipitated withdrawal after first 30–60 min. • Plan to have 1–2 additional office visits approximately 1–3 hours after each dose to check in and administer additional dose if needed until symptoms are managed. **May incorporate home-based induction for first dose or all Day 1 doses: Consider what works best** • Patient assesses withdrawal (SOWS) and follows dosing instructions. Refer to Home Induction Patient Handout. • Plan to check in by phone and provide contact information for after-hours advice if needed. • It is recommended that the patient come in for an office visit the next day. **Max total Day 1 dose is 12 mg/3 mg bup/nlx**	• Schedule 1st dose (total day 1 dose) in the morning. • Reassess 1–3 hours later. • If symptoms managed may not need any additional visits or doses until morning of Day 3. • If symptoms not managed may require 1–2 additional office visits approximately 1–3 hours after each dose to check in and administer additional dose if needed until symptoms are managed. Common dose is two 2 mg/0.5 mg bup/nlx tablets. **May transition to home-based induction** • Plan to check in by phone. • Consider asking patient to come for an office visit next day. **Max total Day 2 dose is 16 mg/4 mg bup/nlx**	• Schedule 1st dose in the morning. • If symptoms managed may not need any additional visits or doses until morning of Day 4. • If symptoms not managed may require 1–2 additional office visits (approximately 1–3 hours after each dose until symptoms are managed). • Consider transfer to daily dispensed doses at pharmacy or prescribing take-home doses (1–2 week supply). **Day 3 onwards: maximum total daily dose is 24 mg/6 mg bup/nlx**
End of first week Aim to achieve a stable once-daily dose of buprenorphine/naloxone that will sustain the patient 24 hours with no withdrawal symptoms and no medication-related intoxication or sedation by the end of the first week. Once a stable dose is achieved, patient can be transferred to receive daily dispensed doses at a community pharmacy, or prescribed take-home doses (1–2 week supply), at the discretion of the treating clinician.		

Opioid Use Disorder (OUD) can bring back uncomfortable memories or the want for privacy due to stigma

- What are some tips for pharmacists and pharmacy staff to use in addressing bad experiences patients may have had in the past with the healthcare system?
- How have you supported individuals that may not want family to know about their situation? (ie: South and East Asian Culture, LGBTQ?). What are some tips for pharmacists and pharmacy staff to use?

Case 1 (cont'd): JW, a 36 year old male with a history of OUD has dropped into your clinic for help (has been taking illicit opioids since a back injury sustained 10 years back from a fall in the construction industry).

- Tell us more about Urine Drug Screens?
- How often are they completed?
- What is being assessed?
- How can pharmacists help in this process?

Changing from methadone to buprenorphine/naloxone

- What if the patient was already on methadone and wants to change to buprenorphine/naloxone?
- How successful is the classic method of transitioning methadone to buprenorphine/naloxone due to the very long transition period and tapering down method?
- What can be an alternative approach?
- How do you suggest pharmacists can help and communicate with the prescribers/nurses?

Illicit Drugs

- How can we tell what illicit drugs may have been taken by the patient? (often a lot of street drugs may be contaminated).
- How often do you see patients still taking illicit drugs on top of the prescribed OAT and what are some common reasons? Do patients still continue to be successful on OAT? How could pharmacists support these patients?

	Cocaine	Alcohol	Heroin	Cannabis (marijuana)
Intoxication				
Action	Stimulant	Sedative	Sedative, euphoriant, analgesic	Euphoriant, at high doses may induce hallucinations
Characteristics of intoxication	↑BP, ↑HR, ↑temp,↑energy,↑paranoia,↓fatigue, ↓appetite, move bowels/urinate	• Sedation, ↓respiration• Depresses CNS system, can result in coma, death	Drowsiness, "nodding," euphoria (happy giddiness)	↓BP, ↑HR, ↓intraocular pressure (pressure in the eyes), conjunctival injection (reddening of the eyes)
Withdrawal				
Onset	Depends upon type of cocaine used: for crack will begin within hours of last use	24–48 hours after blood alcohol level drops	Within 24 hours of last use	Some debate about this, may be a few days
Duration	3–4 days	5–7 days	4–7 days	May last up to several weeks
Characteristics	Sleeplessness *or* excessive restless sleep, appetite increase, depression, paranoia, decreased energy	↑BP, ↑HR,↑temp, nausea/vomiting/diarrhea, seizures, delirium, death	Nausea, vomiting, diarrhea, goose bumps, runny nose, teary eyes, yawning	Irritability, appetite disturbance, sleep disturbance, nausea, concentration problems, nystagmus, diarrhea
Medical/psychiatric issues	Stroke, cardiovascular collapse, myocardial and other organ infarction, paranoia, violence, severe depression, suicide	Virtually every organ system is affected (e.g., cardiomyopathy, liver disease, esophageal and rectal varices); fetal alcohol syndrome and other problems with fetus	During withdrawal individual may become dehydrated	

Detoxification and Substance Abuse Treatment. Appendix B: Common Drug Intoxication Signs and Withdrawal Symptoms. Treatment Improvement Protocol (TIP) Series, No. 45. Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2006.

Communication – something is not usual for the patient

- What would you like pharmacists to do if the patient is not presenting as his usual self?
- What if it is happening late on Friday, on a weekend, or a long weekend? What are some tips you can give pharmacists to help in communication?

Communication – travel

- Patients travel often back to rural communities from urban communities and vice versa or from province to province
- What do prescribers do to help transition in care in these cases?

Communication – Building interdisciplinary team in the community setting

- Could you share advice and what has worked well with community pharmacists building the circle of care with prescribers/nurses/team members in and out of clinics?
- Could you share your thoughts on how else you see community pharmacists and their staff working with prescribers/nurses/team members in and out of clinics to help patients?

Case 2: RH, a 47 year old First Nations male with a history of OUD, stabilized on methadone 150mg daily for the past 6 years has broken his arm and jaw when he slipped and fell down a long flight of stairs while carrying stacked boxes to his truck.

- How can his pain be controlled?
- What are some thoughts in care that First Nations peoples have shared with you in terms of what they would like healthcare providers to know?

Help Eliminate Stigma

- Learn how to be a safe person to talk with
- Use extra care and respect – come from a place of compassion and empathy
- Recognize that people who use drugs are real people
- Recognize that addiction is a health issue, not a moral issue
- Use respectful language
- Help share the campaign to eliminate stigma

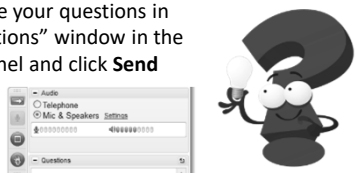
Respectful Language and Stigma

- People-first language – *"Person with a cocaine-use disorder" instead of "cocaine user" or "addict."*
- Use language that reflects the medical nature of substance use disorders – *"Addictive disease" and "substance use disorder" instead of "abuser" or "junkie."*
- Use language that promotes recovery – *"Opted not to" and "not in agreement with the treatment plan" instead of "unmotivated" or "non-compliant."*
- Avoid slang and idioms – *"Positive" or "negative" when referring to drug tests, instead of "dirty" or "clean*

Language matters: reduce stigma, combat overdose, BCCDC, http://www.bccdc.ca/about/news-stories/news-releases/2017/language-matters

Questions

Please type your questions in the "Questions" window in the control panel and click **Send**



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Email: bccsu_education@bccsu.ubc.ca

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http://www.pharmacists.ca/pharmacy-practice-webinar-archive/

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