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*This presentation reflects the views of Dr. Elwell; it does not reflect official views of YMC.

Definition of addiction (ASAM, 2011)

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.
- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

Impact of the substance use

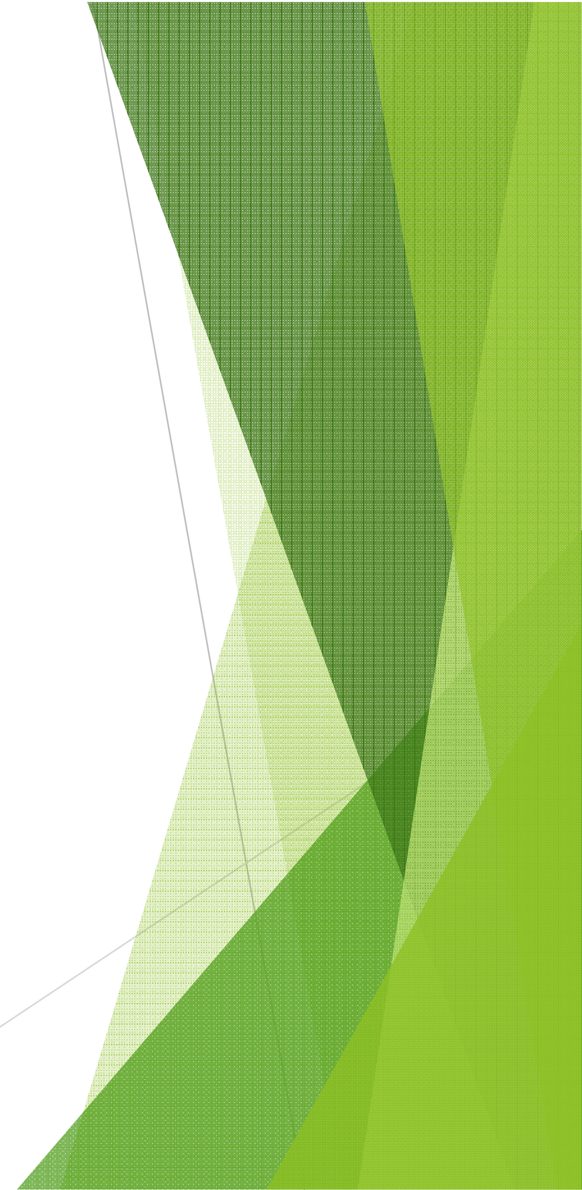
- How do we measure it?
- Which substance(s) being used?
- How do we measure outcomes?
- Severity of the Substance Use Disorder (SUD)
- Factors impacting it:
  - Age,   Gender
  - Ethnicity
  - Co-morbid (co-occurring) disorders eg PTSD

outcomes

- Substance use pre, post treatment
  - Urine Drug Screen, self report, collateral info
- Use; quantity, frequency, using days per 100 days, duration of total abstinence, low-volume or low-problem use
- School, work attendance or performance, job safety issues
- Rates of compliance with ongoing monitoring, disease management
- Utilization of health care, social services, corrections, child welfare, homeless shelter resources
- Impacts on others- STI's, MVC's with impaired driver

It is not just one episode or one course of treatment

- Just like arthritis, diabetes, high blood pressure, it is a chronic, relapse remitting kind of disorder



Current state of affairs

- Methadone
  - One clinic, two doctors, one nurse
  - All opiate SUD people in one room on one day
  - Insufficient monitoring at pharmacy
  - Risk of diversion
  - UDS takes weeks, no immediate feedback
  - Cost of treatment
  - No onsite access to counselling
    - Issues of access, addressing other primary care needs, marginalization, patient has impaired cognition (eg FASD, cognitive impairment with SUD) treatment of other co-morbid conditions, etc.

Current state of affairs

- ADS- has counsellors, one psychiatrist, several part time GP's
- Inpatient, outpatient, detox programs
- ER to WGH to ADS to community to GP; difficult transitions
- Transitions are where you lose people to follow up.
- No UDS program
- No training program to build capacity in the system
- Not enough screening being done in MH, primary care to identify patients at risk, and start an appropriate treatment

When Methadone (OST) is done well…

- When methadone maintenance, … is integrated with a comprehensive treatment service including individual and group psychotherapies and ancillary services such as occupational counseling, it has an efficacy and safety profile that has been solidly and repeatedly established in the clinical outcomes literature since 1965. (ASAM)

Office based treatment

- Additionally, there is a growing European and North American literature supporting the efficacy and safety of office-based treatment with buprenorphine and methadone.
- As opioid use disorders are chronic conditions
- Enhanced availability of screening, identification, assessment and treatment of the SUD patient
  - In the GP's office
  - With support from ADS and MHS
  - Collaborating pharmacies
  - How to address communities access?

Office based care

- Good level of care includes some or all of these components:
- Counselling, individual and group, 12 step, harm reduction, etc.
- General medical care
- Psychiatric care
- Family services
- Educational, vocational programs
- Financial counselling
- Legal services
- These components wax and wane in the course of treatment

Office based Care

- Needs structure UDS, contracts, clear adherence to goals, etc.
- When a greater intensity of treatment is needed, it is recognized and addressed quickly. Ditto for lesser intensity of treatment.
- Waiting lists and barriers to care (intake assessments and processes) are not acceptable. (remember transitions?)
- Close affiliation and communication between the GP and the specialist services

How about underserved areas?

- However, in areas where such services are not available, … pharmacological treatment alone with support of the treating clinician may still represent an important option for some patients.
- Suboxone is easier to use
- Theoretically less risk of diversion
- Witnessed ingestion, until person has shown stability
- Follow up with the primary care practitioner, who knows the patient

Office based opioid treatment

- The decision to provide OBOT should not have to be made on the choice of the opioid agonist medication to be used.
- That means both Suboxone and methadone
- The needs of patients change as their time in treatment lengthens and as they accomplish treatment goals and life changes associated with recovery. One size does not fit all, and ASAM strongly supports the need for a full continuum of service.

Follow the clinical guidelines

- Specific physician training
- The basics for safe suboxone prescribing are achievable within about 6 hours training
- Should we do initiation in a community or have it done in Whitehorse, then follow up RX done in the community with backup expertise available?
- Once stable on a dose of Sub or Methadone, this should be done in the GP office, with backup available.

Methadone is more complicated

- Initiation or continuation?
- Which intensity of treatment at what time in the course of the illness?
- How about once stable, exemption for the regular GP to continue to RX the opioid?
- Otherwise the initiating physician is bogged down with routine refills in stable patients, access to care would suffer.

ASAM recommends

- For methadone,
- One time training, 16 hours of accredited category 1 CME specific to pharmacotherapy with methadone

Suboxone initiation

- Patient has to be in early (to avoid drop out) but definite withdrawal
- 2-4 mg sl first dose
- If opioid use is severe, you can repeat 4 mg after observing in the office for about half an hour (waiting room is fine)
- Next day 8mg
- Next day 16 mg
- Usual dose is somewhere between 12-14 to 24 mg sl per day.
- Basically titrate to cravings or side effects

Suboxone maintenance

- If afternoon peak to cravings, add in pm dose. Total amount still under 24 mg per 24 hour period.
- We really don't know how long a person should be on maintenance. But it should be long term, in order for them to attain and maintain sobriety
- If still craving on maximum dose of Sub, then you probably have to switch to methadone

Chronic non cancer pain

- I would prefer more of a collaborative, education based approach as compared to a proscribed course of action
- Personally in favour of the BC approach
- Screening and identifying who are the most at risk patients, referral for appropriate treatment
- Continue with triplicate program
- Don't throw out the baby with the bath water.
- Most of the negative outcomes research is registry based, so causality is difficult to assess. This applies to benzos, opiates and z-drugs
- Think: co-morbid, undiagnosed SUD, etc.

Thank you!

- Questions?

References

- American Society of Addiction Medicine http://www.asam.org/
- CPSA: http://www.albertahealthservices.ca/assets/info/res/mhr/if-res-mhr-hp-opioid-info.pdf
- BC guidelines: http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf
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- The ASAM Principles of Addiction Medicine, RK RIES et al, eds. Elsevier 2014